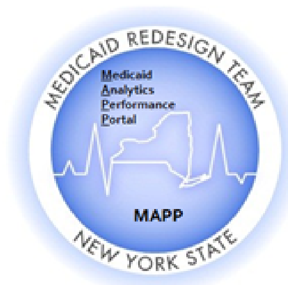

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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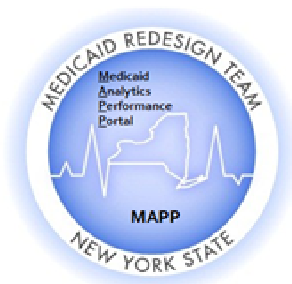

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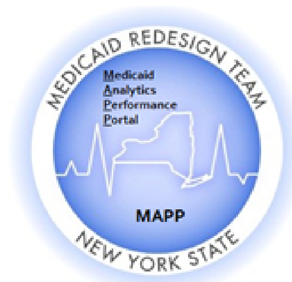

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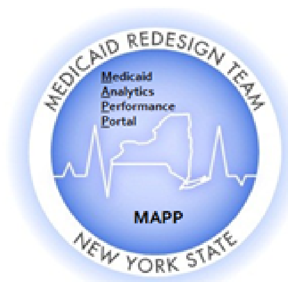

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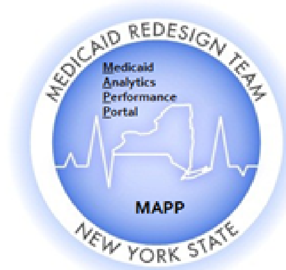

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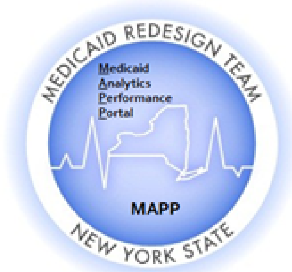


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Quarterly Report - Implementation Plan for NYU Lutheran Medical Center

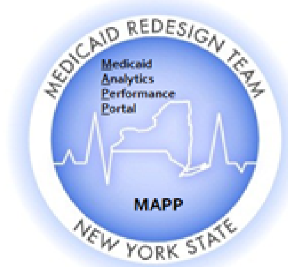
Year and Quarter: DY1, Q3 **Quarterly Report Status:** Adjudicated

Status By Section

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

Status By Project

Project ID	Project Title	Status
2.a.i	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management	Completed
2.b.iii	ED care triage for at-risk populations	Completed
2.b.ix	Implementation of observational programs in hospitals	Completed
2.c.i	Development of community-based health navigation services	Completed
3.a.i	Integration of primary care and behavioral health services	Completed
3.c.i	Evidence-based strategies for disease management in high risk/affected populations (adults only)	Completed
3.d.ii	Expansion of asthma home-based self-management program	Completed
4.b.i	Promote tobacco use cessation, especially among low SES populations and those with poor mental health.	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

NYU Lutheran Medical Center (PPS ID:32)

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	10,948,848	11,667,873	18,868,415	16,707,909	10,948,848	69,141,892
Cost of Project Implementation & Administration	**7,554,705**	**5,133,864**	**5,283,156**	**3,090,963**	**2,737,212**	**23,799,900**
Implementation	0	0	0	0	0	0
Administration	0	0	0	0	0	0
Revenue Loss	**0**	**2,916,968**	**3,773,683**	**4,594,675**	**2,737,212**	**14,022,538**
Internal PPS Provider Bonus Payments	**0**	**1,750,181**	**6,603,945**	**6,683,164**	**4,489,028**	**19,526,318**
Cost of non-covered services	**656,931**	**700,073**	**1,320,789**	**1,169,553**	**985,396**	**4,832,742**
Other	**2,737,212**	**1,166,787**	**1,886,842**	**1,169,554**	**0**	**6,960,395**
Contingency Fund	2,737,212	1,166,787	1,886,842	1,169,554	0	6,960,395
Total Expenditures	**10,948,848**	**11,667,873**	**18,868,415**	**16,707,909**	**10,948,848**	**69,141,893**
Undistributed Revenue	**0**	**0**	**0**	**0**	**0**	**0**

Current File Uploads

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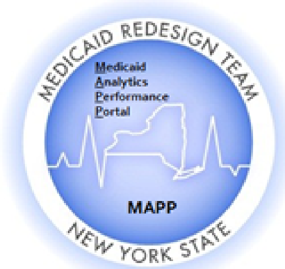
Narrative Text :

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

NYU Lutheran Medical Center (PPS ID:32)

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
10,948,848	69,141,892	8,129,356	66,322,400

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	176,950	2,819,492	4,735,213	62.68%	20,980,408	88.15%
Implementation	127,076					
Administration	49,874					
Revenue Loss	0	0	0		14,022,538	100.00%
Internal PPS Provider Bonus Payments	0	0	0		19,526,318	100.00%
Cost of non-covered services	0	0	656,931	100.00%	4,832,742	100.00%
Other	0	0	2,737,212	100.00%	6,960,395	100.00%
Contingency Fund	0					
Total Expenditures	**176,950**	**2,819,492**				

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

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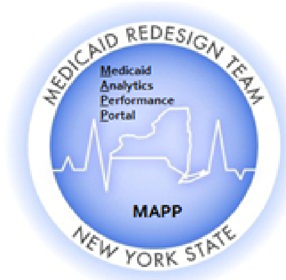
Narrative Text :

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

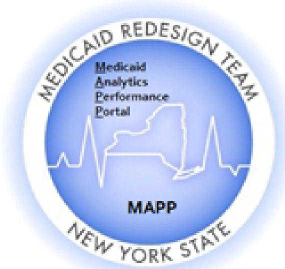


As per guidance provided by the DOH, PPSs were required to create sub-headers for Cost of Implementation and Cost of Administration, respectively.

The Brooklyn Bridges PPS used the following definitions for the sub-headers under Cost of Project Implementation & Cost of Administration:
(i) Cost of Implementation is defined as dollars spent for work related to planning for DSRIP and clinical projects
(ii) All other dollars spent for the DSRIP Program outside the Cost of Implementation definition will be defined as Cost of Administration

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

NYU Lutheran Medical Center (PPS ID:32)

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	10,948,848	11,667,873	18,868,415	16,707,909	10,948,848	69,141,892
Practitioner - Primary Care Provider (PCP)	1,888,676	1,370,975	1,650,986	1,106,899	908,755	6,926,291
Practitioner - Non-Primary Care Provider (PCP)	0	52,506	198,119	200,495	134,671	585,791
Hospital	1,057,659	3,664,879	4,985,035	5,465,992	3,432,464	18,606,029
Clinic	1,510,941	1,201,791	1,717,026	1,286,509	996,345	6,712,612
Case Management / Health Home	656,931	700,072	1,320,789	1,169,554	985,396	4,832,742
Mental Health	377,735	431,711	924,552	822,865	585,763	3,142,626
Substance Abuse	0	70,007	264,158	267,326	179,561	781,052
Nursing Home	0	320,867	849,079	898,050	585,763	2,653,759
Pharmacy	0	0	0	0	0	0
Hospice	0	52,505	198,118	200,495	134,671	585,789
Community Based Organizations	226,641	241,525	488,692	426,887	306,568	1,690,313
All Other	0	0	0	0	0	0
PPS PMO	0	0	0	0	0	0
Total Funds Distributed	**5,718,583**	**8,106,838**	**12,596,554**	**11,845,072**	**8,249,957**	**46,517,004**
Undistributed Revenue	**5,230,264**	**3,561,035**	**6,271,861**	**4,862,837**	**2,698,890**	**22,624,888**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

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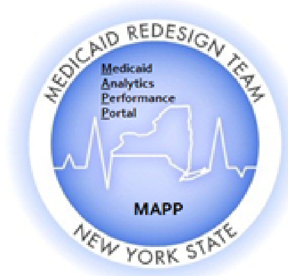

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Module Review Status

Review Status	IA Formal Comments
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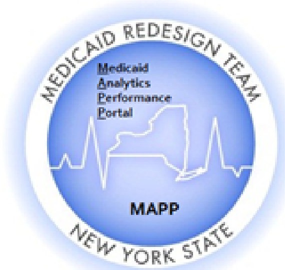

New York State Department Of Health
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NYU Lutheran Medical Center (PPS ID:32)

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
10,948,848	69,141,892	10,648,848	68,841,892

Funds Flow Items	DY1 Q3 Quarterly Amount - Update	Total Amount Disbursed	Percent Spent By Project											DY Adjusted Difference	Cumulative Difference
			Projects Selected By PPS												
			2.a.i	2.b.iii	2.b.ix	2.c.i	3.a.i	3.c.i	3.d.ii	4.b.i	4.c.ii				
Practitioner - Primary Care Provider (PCP)	0	0	0	0	0	0	0	0	0	0	0			1,888,676	6,926,291
Practitioner - Non-Primary Care Provider (PCP)	0	0	0	0	0	0	0	0	0	0	0			0	585,791
Hospital	0	0	0	0	0	0	0	0	0	0	0			1,057,659	18,606,029
Clinic	0	300,000	0	0	0	0	0	0	0	0	0			1,210,941	6,412,612
Case Management / Health Home	0	0	0	0	0	0	0	0	0	0	0			656,931	4,832,742
Mental Health	0	0	0	0	0	0	0	0	0	0	0			377,735	3,142,626
Substance Abuse	0	0	0	0	0	0	0	0	0	0	0			0	781,052
Nursing Home	0	0	0	0	0	0	0	0	0	0	0			0	2,653,759
Pharmacy	0	0	0	0	0	0	0	0	0	0	0			0	0
Hospice	0	0	0	0	0	0	0	0	0	0	0			0	585,789
Community Based Organizations	0	0	0	0	0	0	0	0	0	0	0			226,641	1,690,313
All Other	0	0	0	0	0	0	0	0	0	0	0			0	0
PPS PMO	0	0												0	0
Total Funds Distributed	**0**	**300,000**													

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
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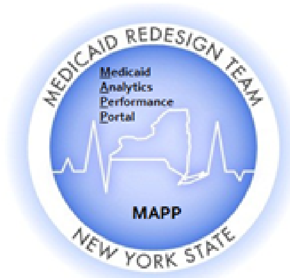
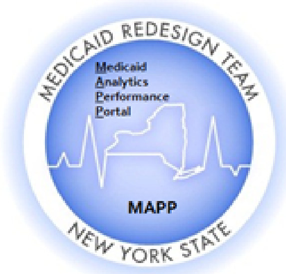


For PPS to provide additional context regarding progress and/or updates to IA.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	



New York State Department Of Health
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DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

IPQR Module 1.5 - Prescribed Milestones

Instructions :

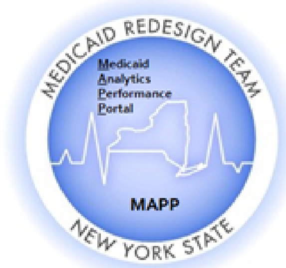
Please provide updates to baseline target dates and work breakdown tasks with target dates for required milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement. Any explanations regarding altered or missed target commitments 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	Completed	Review final PPS attribution and valuation.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2	Completed	Define PPS baseline funding schedule.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3	Completed	Define PPS project-specific funding schedule.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4	Completed	Negotiate and finalize individual funding schedules with PPS partners.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5	Completed	Create mechanism for generating quarterly reports of earned waiver revenue and partner payments.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6	Completed	Create processes to review and update PPS budget and flow of funds estimates on a quarterly basis.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7	Not Started	Engage PPS Committees and stakeholders to develop criteria and processes for administering DSRIP internal PPS provider bonus payments and revenue loss funds.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found



New York State Department Of Health
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NYU Lutheran Medical Center (PPS ID:32)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

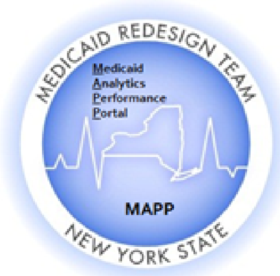
No Records Found

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	



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

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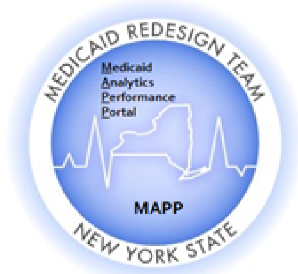
PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found



New York State Department Of Health
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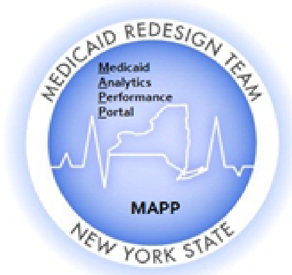
DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

IPQR Module 1.7 - IA Monitoring

Instructions :



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

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

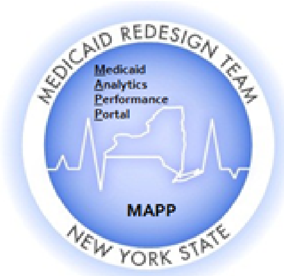
Section 02 – Governance

IPQR Module 2.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize governance structure and sub-committee structure	Completed	This milestone must be completed by 9/30/2015. Governance and committee structure, signed off by PPS Board.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task Step 1	Completed	Identify size and number of standing committees.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2	Completed	Solicit and appoint members of the Executive Committee.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3	Completed	Solicit and appoint members of the Nominating Committee, Clinical Sub-Committee, Finance Sub-Committee, and Information Technology Sub-committee.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4	Completed	Obtain Executive approval of final governance structure.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Completed	This milestone must be completed by 12/31/2015. Clinical Quality Committee charter and committee structure chart	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1	Completed	Draft, and obtain approval from Executive Committee on, charter for Clinical Sub-Committee. The charter will describe the responsibilities of the Clinical Sub-Committee, the process for appointing members to the Clinical Sub-committee, and the consensus-based decision making process of the Clinical Sub-committee.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2	Completed	Solicit and appoint members of the Clinical Sub-committee. Clinical Sub-Committee members to include broad representation of PPS partners including behavior health providers, FQHCs, primary care physicians, and community	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	



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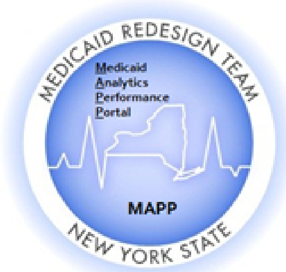
Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		based organizations.							
Task Step 3	Completed	Draft and obtain Clinical Sub-Committee approval of initial clinical operational plans for each project (with consensus-based decision-making process set forth in charter).	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4	Completed	Draft, and obtain approval from Clinical Sub-Committee on, scope, charge and meeting frequency of the workgroups that will be established for each DSRIP project and charged with project-specific mandates.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5	Completed	Solicit and appoint members of clinical workgroups. Workgroup members to include broad representation of PPS partners including behavior health providers, FQHCs, primary care physicians, quality and community based organizations.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 6	Completed	Develop and adopt initial reports for clinical workgroups.	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	Completed	Draft, and obtain approval from the Executive Committee and Lutheran of, charters for Executive Committee, Nominating Committee, Clinical Sub-Committee, Finance Sub-Committee, and Information Technology Sub-committee (collectively, the "Governance Charters"). The Clinical Quality Sub-Committee will represent every PPS project including behavioral health and will be closely integrated into all aspects of the PPS governance structure.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2	Completed	Draft, and obtain approval from Executive Committee on, PPS policies and procedures, including conflicts of interest policy, compliance plan, data sharing policies and antitrust policies.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3	Completed	Draft, and obtain approval from Executive Committee on, process for addressing underperformance of partners.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4	Completed	Appoint PPS compliance officer.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #4 Establish governance structure reporting and monitoring processes	Completed	This milestone must be completed by 12/31/2015. Governance and committee structure document, including description of two-way reporting processes and governance monitoring processes	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES



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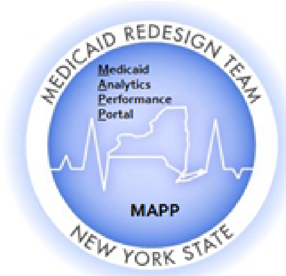
Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 1	Completed	Draft procedures by which the Executive Committee and Committees will (a) keep minutes, (b) send minutes to the Executive Committee, other Committees and Lutheran, as applicable and (c) make minutes available to partners ("Reporting Process"). The Reporting Process will include limitations on availability of Executive Committee minutes to partners for security and confidentiality purposes, e.g., when the minutes concern the performance of a partner.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2	Completed	Include Reporting Process in charters to be finalized per milestones described above.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3	Completed	Monitor committee and sub-committee performance through review of minutes and other means.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	Not Started	Community engagement plan, including plans for two-way communication with stakeholders.	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1	Not Started	PPS leadership drafts preliminary community engagement plan. The community engagement plan will be rooted in and drafted to ensure commitment to grassroots engagement and will be based on bi-directional communication with partners. The PPS will endeavor to develop accessible messaging and open dialogue on the goals of DSRIP in reducing avoidable hospitalizations and emergency room use. The PPS also hopes to establish avenues of communication for community feedback and input.	10/01/2015	12/31/2015	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2	Not Started	Identify key partners and stakeholders and review plan based on membership survey and analysis. Key partners and stakeholders will include, but not be limited to, public schools, community-based organizations, faith organizations, food pantries/soup kitchens, housing organizations, and Medicaid beneficiaries.	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3	Not Started	Revise plan to reflect input from key stakeholders.	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4	Not Started	Obtain Executive Committee approval of draft community engagement plan.	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	



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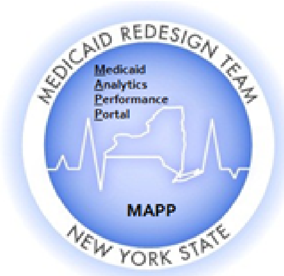
Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #6 Finalize partnership agreements or contracts with CBOs	In Progress	Signed CBO partnership agreements or contracts.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1	Completed	Draft and obtain review/feedback from Executive Committee on Master Services Agreement and exhibits, which will describe legal terms and conditions of participating CBOs' 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	Completed	Obtain feedback from CBOs on Base Agreement and revise based on feedback received.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3	Completed	Send Base Agreement to each CBO.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4	In Progress	Finalize Base Agreement; execute with each CBO.	04/01/2015	12/31/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5	In Progress	Review schedules to Base Agreement with CBOs. Identify CBOs to be contracted with based on Clinical Sub-Committee recommendations. Schedules will describe obligations of CBOs with respect to DSRIP projects and the funding related to performance of those obligations. Some schedules will likely be added later and throughout the DSRIP period as project needs evolve.	04/01/2015	12/31/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6	In Progress	Finalize schedules, as appropriate to date, to Base Agreement and attach to Base Agreement.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #7 Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	Not Started	Agency Coordination Plan.	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1	Not Started	Identify public agencies at state and local level with which PPS will coordinate including the NYS and NYC agencies that focus on health, mental hygiene and substance abuse.	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2	Not Started	Refine project implementation plans, including collaboration with public agencies. For example, the HIV Clinical Implementation Plan will actively engage the NYC Department of Health and Mental Hygiene.	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	



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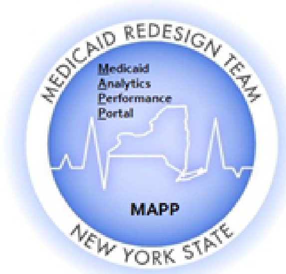
Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 3	Not Started	Connect with agencies and engage agencies in implementation activities on an on-going basis based on recommendations from Clinical Sub Committees and in coordination with PPS Central Services.	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #8 Finalize workforce communication and engagement plan	Not Started	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).	10/01/2015	12/31/2015	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1	Not Started	PPS Workforce Impact Analysis Coordinator to draft workforce communication and engagement plan in coordination with PPS leadership overseeing partner and community engagement. Workforce communication and engagement plan will include on-going updates and two way communication on the workforce impact gap analysis, workforce transition road map, and training strategy.	10/01/2015	12/31/2015	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 2	Not Started	Develop input/revise workforce communication and engagement plan from 1199 and Clinical Sub-Committee members.	10/01/2015	12/31/2015	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3	Not Started	Obtain Executive Committee approval of workforce communication and engagement plan.	10/01/2015	12/31/2015	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Milestone #9 Inclusion of CBOs in PPS Implementation.	In Progress	Explain your plans for contracting with CBOs and their continuing role as your PPS develops over time; detail how many CBOs you will be contracting with and by when; explain how they will be included in project delivery and in the development of your PPS network.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1	Completed	Solicit and appoint CBOs to standing committees and sub-committees	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2	Completed	Establish CBO communication infrastructure for bi-directional communication and feedback including email listserv, PPS partner meetings and one-on-one meetings	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3	Completed	Assign PPS Lead for on-going CBO engagement and communication	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4	Completed	Solicit input from CBOs on Masters Service Agreement	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 5	In Progress	Execute Masters Service Agreement with 20 CBOs	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	



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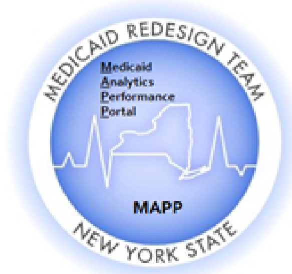
Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 6	In Progress	Review schedules to Base Agreement with CBOs. Schedules will describe obligations of CBOs with respect to DSRIP projects and the funding related to performance of those obligations. Some schedules will likely be added later and throughout the DSRIP period as project needs evolve.	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 7	Not Started	Finalize schedules, as appropriate to date, to Base Agreement and attach to Base Agreement.	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 8	Not Started	Conduct CBO surveys to assess strengths/gaps and to further implementation of all workstreams; surveys will include IT, workforce and clinical project planning	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 9	Not Started	Engage CBOs in clinical project planning and implementation	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	

IA Instructions / Quarterly Update

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

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	kbatchoo	Templates	32_MDL0203_1_3_20160311163739_Clinical_Governance_Committees_Template_030916_-_Remediated.xlsx	Clinical Governance Committees Template 030916 - Remediated	03/11/2016 04:37 PM
	kbatchoo	Templates	32_MDL0203_1_3_20160201141139_Meeting_Schedule_Template_-_Clinical_Sub-Committee_and_Clinical_Work_Groups_(DY1,_Q3).xlsx	Meeting Schedule Template - Clinical Sub-Committee and Clinical Work Groups (DY1, Q3)	02/01/2016 02:11 PM
	kbatchoo	Templates	32_MDL0203_1_3_20160201140438_Clinical_Governance_Committees_Template.xlsx	Clinical Governance Committees Template	02/01/2016 02:04 PM
	kbatchoo	Documentation/Certific	32_MDL0203_1_3_20160201140149_Clinical_Gov	Clinical Governance Structure Organization Chart	02/01/2016 02:01 PM



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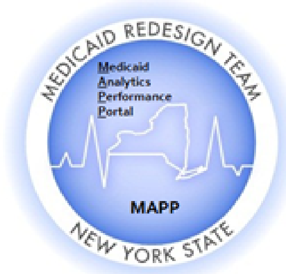
Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
		ation	ernance_Structure_Organization_Chart.pdf		
	kbatchoo	Documentation/Certification	32_MDL0203_1_3_20160126152545_Brooklyn_Bridges_PPS_Clinical_Sub-Committee_Charter_112415.pdf	Brooklyn Bridges PPS Clinical Sub-Committee Charter	01/26/2016 03:25 PM
Establish governance structure reporting and monitoring processes	kbatchoo	Report(s)	32_MDL0203_1_3_20160311165313_IT_Sub-Committee_Monitoring_and_Progress_Report_(DY1_Q3)_030816.pdf	IT Sub-Committee Monitoring and Progress Report (DY1, Q3)	03/11/2016 04:53 PM
	kbatchoo	Report(s)	32_MDL0203_1_3_20160311165234_Finance_Sub-Committee_Monitoring_and_Progress_Report_(DY1_Q3)_030816.pdf	Finance Sub-Committee Monitoring and Progress Report (DY1, Q3)	03/11/2016 04:52 PM
	kbatchoo	Report(s)	32_MDL0203_1_3_20160311165152_Compliance_Sub-Committee_Monitoring_and_Progress_Report_(DY1_Q3)_030816.pdf	Compliance Sub-Committee Monitoring and Progress Report (DY1, Q3)	03/11/2016 04:51 PM
	kbatchoo	Report(s)	32_MDL0203_1_3_20160311165047_Clinical_Sub-Committee_Monitoring_and_Progress_Report_(DY1_Q3)_030816.pdf	Clinical Sub-Committee Monitoring and Progress Report (DY1, Q3)	03/11/2016 04:50 PM
	kbatchoo	Documentation/Certification	32_MDL0203_1_3_20160126115955_Finance_Sub-Committee_Monitoring_and_Progress_Report_Template_(Governance_Milestone_#4).pdf	Monitoring and Progress Report Template: Uploaded document is an example of monitoring and progress reporting applicable to the Brooklyn Bridges PPS Finance Sub-Committee	01/26/2016 11:59 AM
	kbatchoo	Documentation/Certification	32_MDL0203_1_3_20160126112756_Governance_Committee_Structure_Reporting_and_Monitoring_Document_122315.pdf	Governance & Committee Structure Reporting & Monitoring Document	01/26/2016 11:27 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize governance structure and sub-committee structure	
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	SUBMITTED UNDER REMEDIATION The PPS has remediated the Clinical Governance Committees Template based on feedback from the Independent Assessor, providing additional detail on the "responsibilities" of each member of the Clinical Subcommittee. The remediated template has been uploaded for this Governance Milestone #2.



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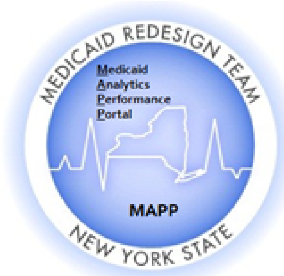
Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	AS ORIGINALLY SUBMITTED The NYU Lutheran PPS (f/k/a Brooklyn Bridges PPS) has met the requirements to complete Governance Milestone #2. Specific to the DSRIP Program, a clinical governance structure has been established for each DSRIP project.
Finalize bylaws and policies or Committee Guidelines where applicable	
Establish governance structure reporting and monitoring processes	SUBMITTED UNDER REMEDIATION The PPS has uploaded the DY1 Q3 Monitoring and Progress Reports for all Sub-Committees (Clinical, Finance, IT, and Compliance) reporting to the Executive Committee. These reports have been reviewed by the Executive Committee and includes their feedback on each respective report. The completed DY1 Q3 Monitoring and Progress Reports have been uploaded for this Governance Milestone #4. AS ORIGINALLY SUBMITTED The NYU Lutheran PPS (f/k/a Brooklyn Bridges PPS) has met the requirements to complete Governance Milestone #4. Governance structure reporting and monitoring processes have been established and are outlined in the PPS's Governance & Committee Structure Reporting & Monitoring Document, which the Executive Committee reviewed and approved.
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	Together with other PPSs, Brooklyn Bridges PPS is working with a Workforce strategy vendor, including on (1) compensation & benefits and (2) current & future state analyses. To align the efforts with the other PPSs and with our own internal milestone timeline, Brooklyn Bridges PPS has pushed the due date of this Governance Milestone #8.
Inclusion of CBOs in PPS Implementation.	

Milestone Review Status

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



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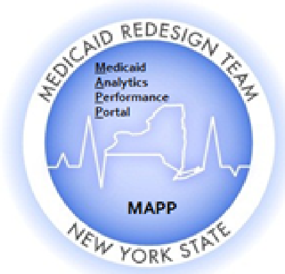
Milestone Review Status

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



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

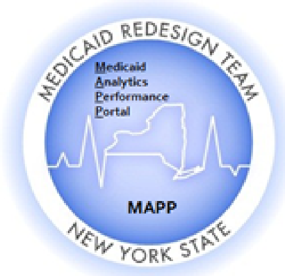
Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found



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.

One challenge will be developing and negotiating the Base Agreement, the project schedules and funding schedules among the partners due to the broad range of partners by type and size. The various partners will have largely different interests, capabilities and limitations. The planned review of the Base Agreement and project schedules with partners' legal counsel will be transparent and will aim to reach mutually agreeable terms among all partners.

Another challenge will be engaging members of the committees in a meaningful and productive way to achieve the PPS's goals over a short timeline. In order to build a strong and working governance structure, the members appointed to the various committees must prepare for meetings (e.g., read materials distributed in advance of meetings), attend and be attentive during meetings, be otherwise be actively involved in the committees and, importantly, follow up to execute committee decisions. However, Lutheran recognizes that committee members have significant obligations to their organizations outside of the PPS and will aim to be respectful of their time commitments.

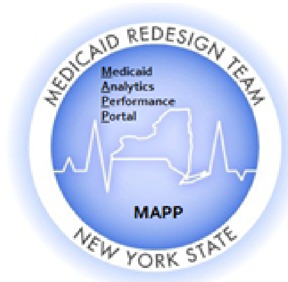
A third challenge will be integrating the disparate health care providers, CBOs and other organizations that will be partners in Brooklyn Bridges. While Lutheran has been providing health care services to the Brooklyn community for over 130 years, and has worked closely with other health care and social services organizations in the course of doing so, the level of coordination that will be required to implement and operationalize a successful DSRIP project will far exceed the coordination that has occurred in Brooklyn in the past. Lutheran will leverage the relationships it has built (and continues to build) due to its participation in the Southwest Brooklyn Health Home, the relationships that have been developed by Lutheran's affiliates, including the Lutheran Augustana Center for Extended Rehabilitation and Care and the Lutheran Family Health Network, and the relationships that Lutheran has built throughout the DSRIP planning process, to work to establish the integrated, coordinated care network that is necessary to the success of the Brooklyn Bridges PPS.

IPQR Module 2.4 - Major Dependencies on Organizational Workstreams

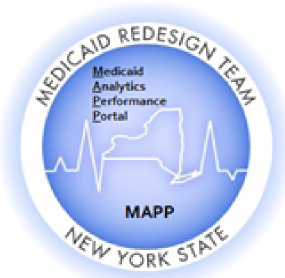
Instructions :

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 work plans and partner obligations by DSRIP project. Creation of the funding schedules is dependent upon outputs of the finance work stream, which will include the funding amount that the Lutheran will receive, the distribution of partners among the projects and the allocation of funding to each project-level budget. More generally, the success of the governance process will require active



engagement of the partners, and that active engagement will depend on the PPS's ability to meet its goals, which will require, among other things, (1) sufficient numbers of appropriately trained workforce members, which is dependent on the PPS's workforce strategy; (2) the ability of the PPS and its partners to exchange patient data, coordinate care, and engage in the required data analytics and reporting activities necessary, which is dependent on the PPS's establishment of the enterprise clinical platform that will serve as the core technology infrastructure of the PPS; and (3) the success of the performance management work stream, which will be critical to ensuring to the PPS's success.

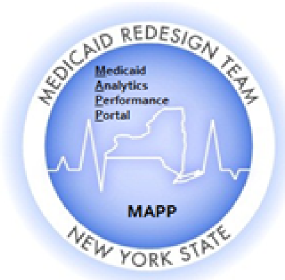


IPQR Module 2.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Lead development of PPS governance and clinical governance structures	Hilton Marcus, PPS Project Coordinator, NYU Lutheran	Develop and finalize governance and clinical governance structures; appoint Committee/Subcommittee membership
Major hospital, health center and physician Partners. Key partners to include, but not limited to NYU Lutheran, NYU, ODA, Addabbo, and Ezra Medical Center.	Brooklyn Bridges PPS Partners	Committee and Subcommittee membership; key document review
PPS Partners including community based organizations (including those providing behavioral health and social services such as CAMBA, Visiting Nurse Services and Brooklyn Perinatal Network)	Brooklyn Bridges PPS Partners	Committee and Subcommittee membership; key document review
Community engagement	Brooklyn Bridges PPS Central Services	Develop and oversee community engagement plan



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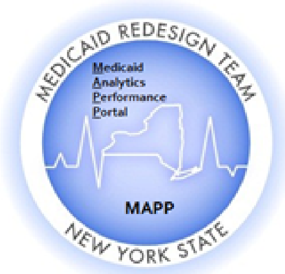
Module 2.6 - IPQR Module 2.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Brooklyn Bridges PPS Leadership	Hilton Marcus, PPS Project Coordinator, NYU Lutheran	Committee chairs
Brooklyn Bridges Partners and Providers. (includes representatives from FQHCs, NYU Lutheran, physicians, behavioral health agencies, social service agencies and other clinical partners). Key partners to include, but not limited to NYU Lutheran, NYU, ODA, Addabbo, and Ezra Medical Center.	Partners and providers	Committee chairs and membership
External Stakeholders		
State agencies	Impacted by public agency coordination plan	Participate in development of Public Agency coordination plan
Community-based organizations (including those providing behavioral health and social services such as CAMBA, Visiting Nurse Services and Brooklyn Perinatal Network and the Brooklyn Health Home)	Participating providers	Committee membership



IPQR Module 2.7 - IT Expectations

Instructions :

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

The IT infrastructure that is established will be used to track progress, governance decisions, and facilitate partner communications (e.g. sharing and storing secure documents via IT platforms, offering in-person and virtual communication technologies for partner communication and data sharing to support governance activities).

IPQR Module 2.8 - Progress Reporting

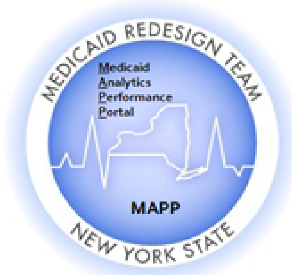
Instructions :

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

Success of our governance work stream will be measured through meeting milestones and quarterly reporting and will be informed by periodic updates from committees. The PPS will establish a reporting structure that will allow us to track our progress against our milestones.

IPQR Module 2.9 - IA Monitoring

Instructions :



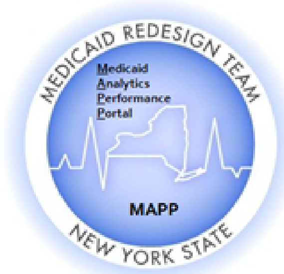
Section 03 – Financial Stability

IPQR Module 3.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize PPS finance structure, including reporting structure	Completed	This milestone must be completed by 12/31/2015. PPS finance structure chart / document, signed off by PPS Board.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1	Completed	Revise PPS Finance Subcommittee charter as necessary (including a schedule of subcommittee meetings) and present to PPS Executive Committee for review and approval.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2	Completed	Revise Finance Subcommittee membership as necessary.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3	Completed	Convene regular Finance Subcommittee meetings.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4	Completed	Document Finance Subcommittee actions and minutes and provide regular reports to PPS Executive Committee.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5	Completed	Review PPS finance and reporting structure.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6	Completed	Obtain Executive Committee sign off of PPS finance structure, policies and procedures.	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; -- 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	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES



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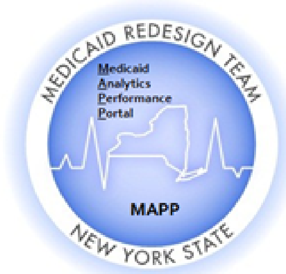
Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		necessary for monitoring the financial sustainability of their network providers							
Task Step 1	Completed	Conduct financial health current state 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 2	Not Started	Review all results of financial health current state assessment and, if applicable, identify financially fragile partners.	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3	Not Started	Develop process for monitoring and assisting financially fragile partners including the involvement of the Finance Subcommittee.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4	Not Started	Develop Financial Stability Plan – including metrics and ongoing monitoring – and obtain approval from Finance Subcommittee.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5	Not Started	Establish an annual schedule to monitor partner financial status and a quarterly schedule for those deemed financially fragile.	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).	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1	Completed	Determine how to fill the need to staff PPS Compliance function in accordance with the DSRIP Compliance Program.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2	Completed	Establish PPS chain-of-command for compliance enforcement.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3	Completed	Incorporate NYS Social Services Law 363-d requirements such as training, education and disciplinary policies into lead PPS's existing compliance plan.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4	Completed	Customize PPS lead's existing compliance plan and programs (e.g., HIPAA) for the PPS, consistent with NYS Social Services Law 363-d, and present to the Executive Committee for approval.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5	Completed	Conduct first quarterly PPS compliance workgroup meeting.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6	Completed	Publish PPS Compliance Plan (including standards of conduct, receipt of complaints/non-retaliation policies, and monitoring procedures, annual report on conflicts of interest), distribute to PPS partners.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	



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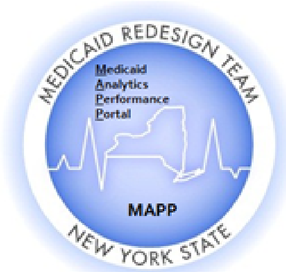
Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	In Progress	This milestone must be completed by 3/31/2016. Value-based payment plan, signed off by PPS board	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task Step 1	Completed	Review final State value-based payment roadmap upon release.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2	Not Started	Develop value-based payment assessment and partner value-based payment reporting framework.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3	Not Started	Assess the baseline of value-based payment arrangements and associated revenue across all PPS partners. (To be completed/updated on an annual basis or as required).	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4	Not Started	Develop preferred compensation and MCO strategy framework (including a regular schedule of meetings with MCOs) through Finance subcommittee.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5	Not Started	Develop provider education and engagement strategy, and conduct education sessions with PPS provider partners, focused on value-based payment concepts and potential contracting arrangements.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6	Not Started	Incorporate findings from assessments into a baseline PPS value-based payment plan.	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 Step 1	In Progress	Review final State value-based payment roadmap upon release.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2	Not Started	Review baseline assessment of PPS partners' value-based payment revenue to inform development of PPS value-based payment plan.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3	Not Started	Conduct gap assessment between current volume of value-based revenue across the PPS network and State target of 90%.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4	Not Started	Establish annual targets for volume of value-based revenue across the PPS network (To be completed on an ongoing basis).	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	



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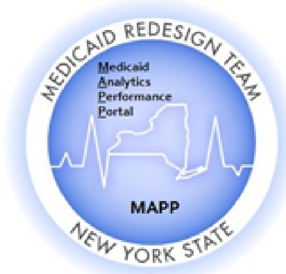
Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 5	Not Started	Finalize PPS value-based payment plan and present to Executive Committee for approval.	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 6	Not Started	Establish partner value-based payment reporting requirements and procedures to enable ongoing monitoring of PPS value-based payment revenue.	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 7	Not Started	Provide quarterly updates to Executive Committee on progress toward value-based payment and revise PPS plan as needed.	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 8	Not Started	As part of a provider adoption strategy, develop provider and MCO education and engagement strategy for PPS provider partners and MCOs, to facilitate understanding of the process and requirements necessary for engaging in various levels of value-based payment arrangements.	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 9	Not Started	Develop value-based payment educational materials and share with PPS provider partners and MCOs (e.g., "lessons learned" from providers with advanced value-based payment arrangements, the role of the PPS in assisting with value-based payment transition for its provider partners, etc.).	07/01/2016	12/31/2016	07/01/2016	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



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IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

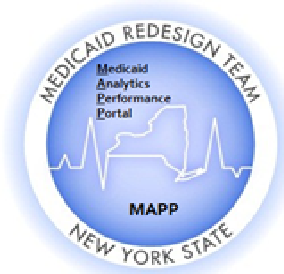
No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize PPS finance structure, including reporting structure	kbatchoo	Documentation/Certification	32_MDL0303_1_3_20160126154846_Meeting_Schedule_Template_-_Finance_Sub-Committee_(DY1,_Q3).xlsx	Meeting Schedule Template - Finance Sub-Committee (DY1, Q3)	01/26/2016 03:48 PM
	kbatchoo	Documentation/Certification	32_MDL0303_1_3_20160126154336_PPS_Letter_Domain_1_Org_Component_Milestone_#1_121015.pdf	PPS Letter evidencing approval of the various committees	01/26/2016 03:43 PM
	kbatchoo	Documentation/Certification	32_MDL0303_1_3_20160126153807_Governing_Body_Organizational_Chart.pdf	Governing Body Organizational Chart	01/26/2016 03:38 PM
	kbatchoo	Documentation/Certification	32_MDL0303_1_3_20160126153636_Finance_Structure_Document_(Brooklyn_Bridges_PPS)_121815.pdf	Finance Structure Document (Brooklyn Bridges PPS)	01/26/2016 03:36 PM
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	kbatchoo	Documentation/Certification	32_MDL0303_1_3_20160126160004_NYS_OMIG_Compliance_Certification_(SSL).pdf	A copy of the NYS OMIG Certification Confirmation (SSL) indicating that the Brooklyn Bridges PPS Compliance Program meets the requirements of the law and regulation	01/26/2016 04:00 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize PPS finance structure, including reporting structure	The Brooklyn Bridges PPS has met the Financial Sustainability Milestone #1 requirements. The PPS's finance structure, including its reporting structure, has been successfully and formally established. Documentation is evidenced within the PPS's Finance Structure Document, which both the Finance Sub-Committee and Executive Committee approved.
Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	The Brooklyn Bridges PPS has met the requirements to complete Financial Sustainability Milestone #3. The PPS has created and finalized a Compliance Plan consistent with New York State Social Services Law 363-d (SSL 363-d) and Title 18 of the New York Codes Rules and Regulations, Part 521 (18 NYCRR 521). Attached is a copy of the certification confirmation received from the New York State Office of the Medicaid Inspector General (OMIG) indicating that the PPS's Compliance Program meets the State's particular legal requirements.
Develop detailed baseline assessment of revenue linked to	



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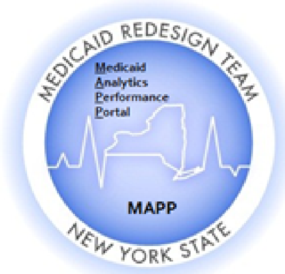
Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	
Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	
Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	
Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	
>=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	

Milestone Review Status

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



IPQR Module 3.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

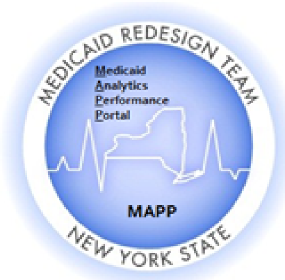
Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found



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

Instructions :

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

• Provider engagement: 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.

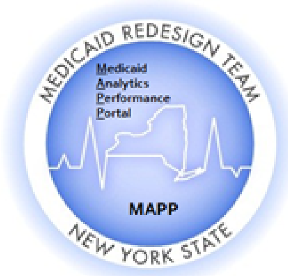
• Availability of DSRIP waiver funds/ability of PPS to achieve and draw down incentive payments: The PPS must successfully achieve and report on State-established milestones and metrics to draw down incentive payments and subsequently distribute funds to its partners. The PPS has and will continue to 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.

• 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. 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.

• PPS resources will be insufficient to address substantial financial fragility of partners: If partners are financially fragile, the PPS will face a challenge in supporting it through possible transitions to financial health or organizational evolution. The PPS will work to identify issues early and work with PPS partners to identify and implement strategies as practicable.

• MCO engagement and willingness to meaningfully participate: The transition to value-based payment across the PPS will require the engagement and willingness of Medicaid managed care organizations (MCOs) to transform their existing fee-for-service contracts into value-based payment contracts that sustain safety net providers over five years. DSRIP goals to reduce unneeded ED visits and hospital admissions provide direct benefits to the bottom line of MCOs, while reducing hospital revenues. The PPS will continue engaging Medicaid MCOs through DSRIP implementation planning and through monthly meetings to ensure Medicaid MCOs are meaningfully engaged in the development of transition plans and have sufficient lead time and benefit sharing to prepare for the transition to value-based payment.

• Partners in multiple PPSs will face challenges participating in managed care strategy: Partners participating in multiple PPSs face nearly unprecedented challenge in the complexity of their coming value based reimbursement landscape. Not only will reimbursement shift away from FFS, but they may have multiple contracts with the same MCO due to participation in multiple PPSs. The PPS will continue to engage partners through partner meetings and on-going communication and coordinate with other PPSs with shared partners to maximize efficiencies, where possible.



• Formation of a contracting entity: The structure/composition of the legal entity that is created for the purposes of value-based contracting has yet to be defined.

IPQR Module 3.4 - Major Dependencies on Organizational Workstreams

Instructions :

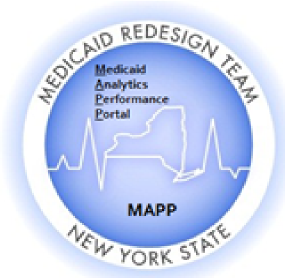
Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

• Performance reporting: The PPS will need to identify a point-of-contact in each partner organization for finance-related matters (e.g., reporting and policies/procedures).

• Governance: The PPS governance structure must be capable of executing financial responsibilities; the PPS governance structure must evolve to incorporate Medicaid MCOs to support transition to value-based payments.

• IT: The PPS IT systems must support central finance and performance reporting to inform and track PPS and project-level budgets and funds flow; the PPS IT systems must support population health management to enable partners to improve patient outcomes that will drive the transition to value-based payments with Medicaid MCOs and other payers.

• Physician and Provider Engagement: The PPS must effectively engage and educate physicians regarding population health management and project-specific clinical interventions, requirements and payment schedules associated with entering into contracts with the PPS.

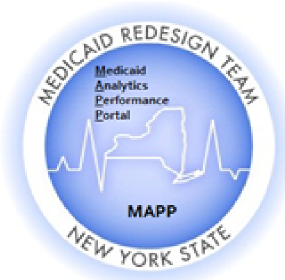


IPQR Module 3.5 - Roles and Responsibilities

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 Executive Committee	Larry McReynolds, Chair, NYU Lutheran Family Health Centers	Review and approve recommendations from Finance Committee.
PPS Controller	Mohamood Ishmael, NYU LMC	Review and manage PPS expenditures.
PPS Compliance Officer	Danette Slevinsky, NYU Lutheran	Implement and maintain PPS compliance plan.
Internal Auditor	NYU Lutheran team lead by Rick Langfelder	Review PPS financial ledgers.
External Auditor	TBD	Review PPS financial ledgers.
Finance Subcommittee	Rick Langfelder, Co-Chair, NYU Lutheran Lisa Vanchieri, Co-Chair, NYU	Review and monitor financial health of PPS partners; generate recommendations on PPS finance activities.



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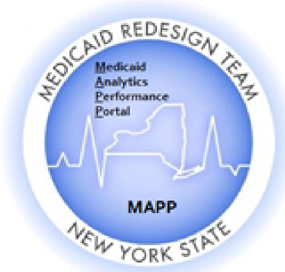
IPQR Module 3.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Provider Partners (includes representatives from FQHCs, NYU Lutheran, physicians, behavioral health agencies, social service agencies and other clinical partners). Key partners to include, but not limited to NYU Lutheran, NYU, ODA, Addabbo, and Ezra Medical Center.	Participant in PPS and recipient of funds.	Responsible for performance on program metrics, participation in clinical project implementation, accountability for use of funds.
External Stakeholders		
Managed Care Organizations	Partner in establishing value-based payment arrangements.	In collaboration with the PPS, develop value-based payment arrangements within the five-year DSRIP period.
NYS Department of Health	Oversight over value based payment arrangements	Provide feedback and support as the PPS establishes and enters into value-based payment arrangements



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 its financial health, including the ability to track expenditures submitted by partners and receipt of payments from DOH as well as access to financial sustainability data and project performance reporting. A robust IT infrastructure will also be vital to the ongoing tracking of financial compliance and to the annual financial audits performed by internal and external auditors. A shared IT infrastructure is also a critical cornerstone which will enable the PPS to transition to value based payments, by tracking and leveraging population health data.

IPQR Module 3.8 - Progress Reporting

Instructions :

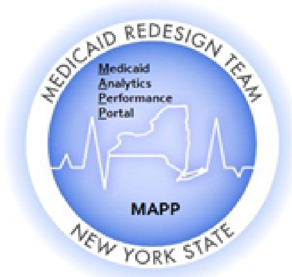
Please describe how you will measure the success of this organizational workstream.

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

- Identify, monitor, and improve 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 value-based payment revenues

IPQR Module 3.9 - IA Monitoring

Instructions :



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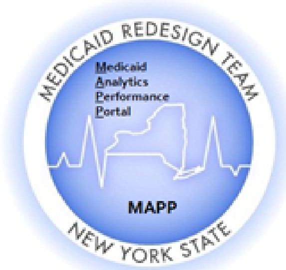
Section 04 – Cultural Competency & Health Literacy

IPQR Module 4.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize cultural competency / health literacy strategy.	Completed	This milestone must be completed by 12/31/2015. Cultural competency / health literacy strategy signed off by PPS Board. The strategy should: -- Identify priority groups experiencing health disparities (based on your CNA and other analyses); -- Identify key factors to improve access to quality primary, behavioral health, and preventive health care -- Define plans for two-way communication with the population and community groups through specific community forums -- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors); and -- Identify community-based interventions to reduce health disparities and improve outcomes.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1	Completed	Identify oversight staff and process for Cultural Competency/Health Literacy Strategy.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2	Completed	Based on Community Needs Assessment, identify priority populations experiencing health disparities.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3	Completed	Develop and conduct a PPS-wide best practices and gap analysis in Cultural Competency and Health Literacy across existing programs and interventions (possibly in conjunction with other Brooklyn PPSs).	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4	Completed	Research and identify PPS best practices/centers of excellence in achieving provider Cultural Competency;	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	



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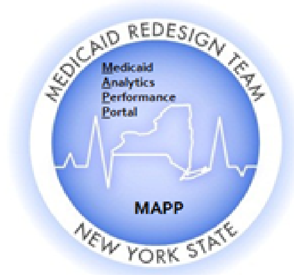
Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		research industry best practices on health literacy enhancement strategies (including assessments and tools to assist patients with self-management of conditions).							
Task Step 5	Completed	Consult with Partners, providers and CBOs to inform the strategy.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6	Completed	Develop a written Cultural Competency/Health Literacy strategy, action plan and monitoring process to address the prioritized areas, signed off by the PPS Executive Committee.	10/01/2015	12/31/2015	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).	Not Started	This milestone must be completed by 6/30/2016. Cultural competency training strategy, signed off by PPS Board. The strategy should include: -- Training plans for clinicians, focused on available evidence-based research addressing health disparities for particular groups identified in your cultural competency strategy -- Training plans for other segments of your workforce (and others as appropriate) regarding specific population needs and effective patient engagement approaches	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	YES
Task Step 1	Not Started	Identify existing clinician and broader workforce training programs that exist across the PPS to leverage or enhance (do as part of Milestone 1 strengths/gap analysis).	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2	Not Started	Collaborate with training vendor on cultural competency training development and delivery options.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3	Not Started	Identify champions (including clinicians and community based organizations) that will support training strategies addressing the drivers of health disparities	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4	Not Started	Develop strategy for encouraging partner participation in health disparities training	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5	Not Started	Determine scope, scale, audience, format and content for training programs, focused on targeted populations and health disparities identified in Milestone 1 strengths/gaps analysis.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6	Not Started	Develop a written Cultural Competency Training Strategy (signed off by PPS Executive Committee).	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 7	Not Started	Establish process for on-going assessments to identify gaps and needs	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	



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IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

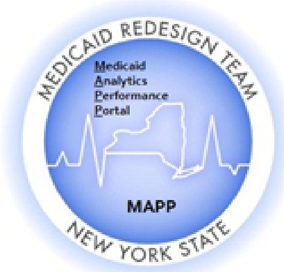
No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize cultural competency / health literacy strategy.	kawd01	Templates	32_MDL0403_1_3_20160316124232_Meeting_Schedule_Template_-_Cultural_Competency_Health_Literacy_(DY1,_Q3).xlsx	Template (identical to that uploaded by KBatchoo on 01/29/2016 at 12:17pm), in response to IA's request for a template.	03/16/2016 12:42 PM
	kawd01	Documentation/Certification	32_MDL0403_1_3_20160316123739_NYU_Lutheran_PPS_DSRIP_DY1Q3_CCHL_Strategy_Meeting_Response.pdf	Response to the IA's request to provide template that "shows the meetings conducted to finalize cultural competency / health literacy strategy." Template sent as separate file.	03/16/2016 12:37 PM
	kawd01	Documentation/Certification	32_MDL0403_1_3_20160316123313_Brooklyn_Bridges_Cultural_Competency_Health_Literacy_Strategy_-_remediated.pdf	Remediated to include discussion of to defining plans for two-way communication with the population and community groups, as directed by the IA (see page 7 (red text) of attached)	03/16/2016 12:33 PM
	kawd01	Documentation/Certification	32_MDL0403_1_3_20160316122949_Cult_CompHealth_Lit_Strategy_Approval_(Exec_Comm).pdf	Evidence of Executive Committee approval of Cultural Competency and Health Literacy Strategy (as required under remediation)	03/16/2016 12:29 PM
	kbatchoo	Templates	32_MDL0403_1_3_20160129121744_Meeting_Schedule_Template_-_Cultural_Competency_Health_Literacy_(DY1,_Q3).xlsx	Meeting Schedule Template - Cultural Competency and Health Literacy (DY1, Q3)	01/29/2016 12:17 PM
	kbatchoo	Documentation/Certification	32_MDL0403_1_3_20160129121018_Brooklyn_Bridges_Cultural_Competency_and_Health_Literacy_Strategy_123015.pdf	Brooklyn Bridges PPS Cultural Competency and Health Literacy Strategy	01/29/2016 12:10 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize cultural competency / health literacy strategy.	AS SUBMITTED DURING REMEDIATION: The PPS has uploaded the following: 1. meeting minutes as documentation that the cultural competency / health literacy strategy was approved by the Executive Committee;



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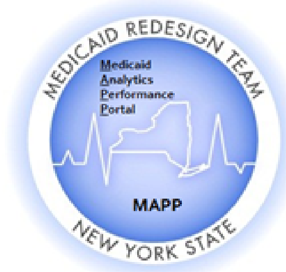
Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	2. remediated cultural competency / health literacy strategy based on feedback from the Independent Assessor to include more discussion on two-way communications with population and community groups; 3. an explanation in response to the Meeting Schedule Template remediation item; and 4. meeting template (identical to that uploaded in MAPP in February 2016). ________________ AS ORIGINALLY SUBMITTED: The NYU Lutheran PPS (f/k/a Brooklyn Bridges PPS) has established a cultural competency and health literacy strategy, thereby fulfilling the requirements to complete Cultural Competency & Health Literacy Milestone #1. The PPS's strategy identifies priority groups experiencing health disparities; key factors to improve access to quality primary, behavioral, and preventive health care; assessments and tools to assist patients with self-management of conditions; and community-based interventions to reduce health disparities and improve outcomes. The strategy also defines plans for two-way communication with the CNA-identified population and community groups through specific community forums. Please note that the Meeting Schedule Template lists meetings and forums during which the DSRIP program was discussed, and may have included other non-DSRIP related topics relevant to the PPS Lead, NYU Lutheran. As a nationally recognized and long-standing leader in this arena, NYU Lutheran will share its developed best practices with fellow Brooklyn Bridges PPS partners, which employs a culturally competent and patient-centered approach to benefit the patient population.
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	

Milestone Review Status

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



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

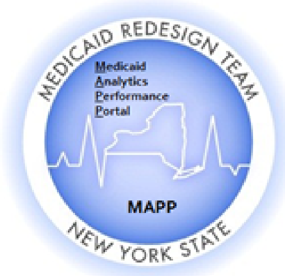
Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found



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.

We see several risks to implementing the Cultural Competency/Health Literacy (CC/HL) strategy and trainings. Key risks include:

• Workforce capacity issues, including resources and the capacity to identify a CC/HL coordinating body/staff in a timely fashion and to activate sufficient training staff with the necessary skills and competencies in CC/HL, and the ability of staff to be available, and released to attend training.
• Ensuring the IT infrastructure is in place to support training program development, delivery and tracking.
• Ability to develop and execute a contract with a training vendor in a timely fashion.
• Partner communication and engagement issues, including the ability to ensure active participation of all PPS partners in a CC/HL strengths and gap analysis.
• Practitioner communication and engagement issues, including the ability to ensure providers and CBOs engagement in training programs and to successfully change provider/practitioner behavior around CC/HL best practices.

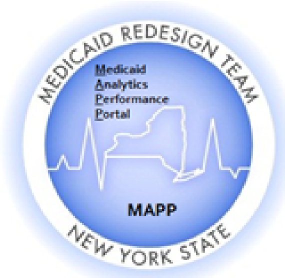
The Brooklyn Bridges PPS intends to mitigate these risks through broad partner and practitioner communication and planning strategies and activities, incorporating CC/HL standards and training parameters into partner contracts (or expectation-setting where there are no contracts) and enforcing or reinforcing those standards/expectations, and significant and dedicated Brooklyn Bridges PPS Leadership and project management oversight and coordination.

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.)

The CC/HL strategy development and training strategy are highly dependent on several other work streams, including Workforce strategy (regarding training staff), IT infrastructure (regarding tracking of training participants), and partner and practitioner engagement (all described above), as well as the widespread adoption of culturally competent population health management functions and capabilities and successful clinical integration across the PPS partners. Additionally, this Work Stream will depend on the Finance Work Stream which will determine the available funding for each project. This funding level may present significant challenges given project requirements.

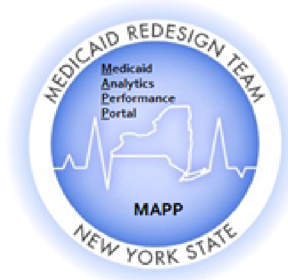


IPQR Module 4.5 - Roles and Responsibilities

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
CC/HL strategy and training oversight	Hilton Marcus, PPS Project Coordinator, NYU Lutheran	Input and approval of CC/HL and training strategies (ultimately responsible for the strategies).
Day-to-day coordination and implementation of the strategy	Virginia Tong, Lutheran Family Health Center	CC/HL coordination policies and processes.
Training Strategy planning and development	Brooklyn Bridges PPS Central Services	Lead training program development and implementation.
Approval of CC/HL strategy and training	Brooklyn Bridges PPS Executive Committee	Oversee CC/HL strategy and training plan for the PPS



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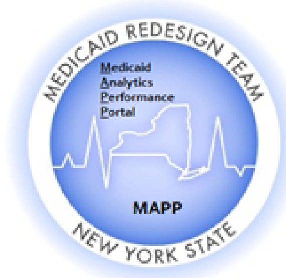
IPQR Module 4.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Brooklyn Bridges PPS Partners (including NYU Lutheran, FQHCs, physicians, behavioral health agencies, and community based organizations). Key partners to include, but not limited to NYU Lutheran, NYU, ODA, Addabbo, and Ezra Medical Center.	Role in identifying best practices/centers of excellence	Participate in strengths/gap analysis.
Brooklyn Bridges PPS Practitioners, clinical and non-clinical providers	Recipients of training programs	Commit to and undertake CC transformation.
External Stakeholders		
1199/Training Vendor	Training development and delivery	Curriculum and format development, Subject Matter Expertise, presenters.
Brooklyn Bridges PPS attributed members and their families	Ultimate recipient of transformed care delivery	Feedback through patient surveys.



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.

Electronic access to cross-PPS data on patients' health services, health status, demographics, etc. (through EHRs and HIE) is critical to this work stream. Shared IT infrastructure across the PPS is critical to enable population-wide data analytics/clinical informatics to identify target populations for prioritized interventions, track patients and measure care quality and outcomes across clinical projects and ensure true population health management. The IT tools the Patient Navigation Center will deploy, including a centralized repository of community resources, will help address the social determinants impacting patients' health. The use of patient portals across the PPS will facilitate patient communication, education and engagement to help ensure patients are receiving the care and information they need in a culturally competent manner. Finally, cross-PPS IT tools will be critical to administer and track the performance of training programs and other interventions to know what is working and what is not.

IPQR Module 4.8 - Progress Reporting

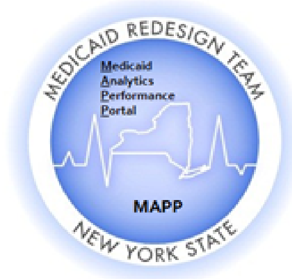
Instructions :

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

Success of our CC/HL strategy will be measured through the clinical project-specific metrics and quarterly reporting, and by periodically reviewing whether the strategy and training are successful (e.g., through provider and/or patient feedback surveys) and need to be revised.

IPQR Module 4.9 - IA Monitoring

Instructions :



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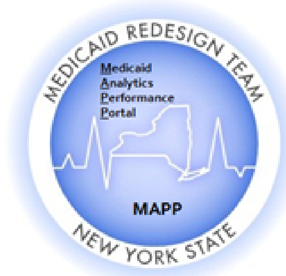
Section 05 – IT Systems and Processes

IPQR Module 5.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	In Progress	Detailed IT current state assessment. Relevant QEs (RHIOs/HIEs) should be involved in performing this assessment.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1	Completed	Identify/validate contacts at each partner organization.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2	Completed	Develop data sharing & interoperability requirements and plan for using existing external resources (e.g., RHIOs).	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3	Completed	Develop, distribute and collect detailed survey to determine current state.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4	Completed	Establish process for partners to conduct IT self-assessment and to validate those assessments.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5	Completed	Establish process for periodic data reporting on IT capabilities.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6	Not Started	Conduct gap identification and analysis.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 7	Not Started	Develop mitigation strategies to resolve IT interoperability and data sharing gaps.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #2 Develop an IT Change Management Strategy.	In Progress	IT change management strategy, signed off by PPS Board. The strategy should include: -- Your approach to governance of the change process; -- A communication plan to manage communication and involvement of all stakeholders, including users; -- An education and training plan; -- An impact / risk assessment for the entire IT change	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO



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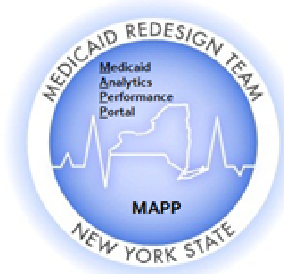
Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		process; and -- Defined workflows for authorizing and implementing IT changes							
Task Step 1	Completed	Meet to determine general governance approach to IT Change Management, including accountabilities and deliverables.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2	Completed	Design communication plan to partner end-users as part of overall DSRIP communications strategy.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3	In Progress	Use survey tool to help identify user education and training requirements.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4	Not Started	Develop education and training plan.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5	Not Started	Leverage NYU ITIL methodology current IT change management model to develop PPS model for IT change management (e.g. demand management/workflows for authorizing and implementing IT changes, prioritization, approvals, testing, release management, etc.).	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6	Not Started	Conduct initial risk assessment & risk mitigation approach.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 7	Not Started	Finalize change management plan at the PPS and obtain Executive Board authorization on IT change management strategy.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 8	Not Started	Develop plan for how central PPS IT services will be made available to providers.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 9	Not Started	Communicate IT change management model to partners.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
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	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO

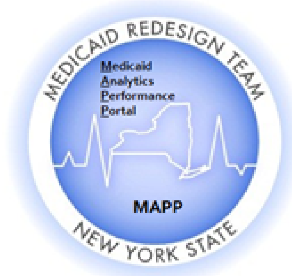


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		between all providers within the PPS, including care management records (completed subcontractor DEAAs with all Medicaid providers within the PPS; contracts with all relevant CBOs including a BAA documenting the level of PHI to be shared and the purpose of this sharing).							
Task Step 1	Completed	Engage with SHIN-NY & RHIOs on pre-planning.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2	Completed	Identify PPS leadership who will be responsible for developing roadmap.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3	Completed	Develop strategies for connectivity based on interoperability requirements and current state assessment, including setting technical standards for sharing and using common clinical data sets.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4	In Progress	Develop governance framework and PPS policies/standards; ensure Board approval of the same.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5	Not Started	Draft and execute all legally binding agreements related to data exchange, including subcontractor Data Exchange Applications & Agreements and HIPAA Business Associate Agreements.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6	Not Started	Estimate and identify resource requirements, in addition to those provided in gap analysis.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 7	Not Started	Develop training plan.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 8	Not Started	Develop phased implementation roadmap.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	Not Started	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	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1	Not Started	Engage and ready all partners to gain consent from patients for use of data.	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2	Not Started	Assess communication channel options and establish communications approach (e.g. portals, email, etc.).	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3	Not Started	Identify process for working with front office provider staff on patient engagement. Assess RHIO use across PPS for Medicaid beneficiaries and MU adoption.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task	Not Started	Develop and obtain approval on plan for outreach to patients	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	



New York State Department Of Health
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DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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 4		actively engaged in clinical projects including culturally and linguistically isolated patient populations.							
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	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1	In Progress	Develop data security (including 2-factor authorization) & confidentiality plan (including CFR42/BH) based on State and Federal requirements (e.g., DEAAs and HIPAA BAAs) and on existing Lutheran and NYU plans.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2	Not Started	Assess risks and design mitigation approaches that are tailored to the risk type and include monitoring and oversight.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3	Not Started	Obtain Executive Board approval for final plan.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

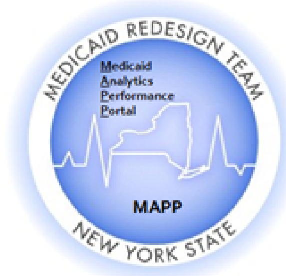
IA Instructions / Quarterly Update

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
Develop a data security and confidentiality plan.	hiltonm	Documentation/Certification	32_MDL0503_1_3_20160316115433_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(PS_Family)_UPDATED.docx	Remediated, password-protected PS Family Workbook	03/16/2016 11:54 AM
	hiltonm	Documentation/Certification	32_MDL0503_1_3_20160316115350_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(PE_Family)_UPDATED.docx	Remediated, password-protected PE Family Workbook	03/16/2016 11:53 AM
	hiltonm	Documentation/Certification	32_MDL0503_1_3_20160316115250_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(IR_Family)_UPDATED.docx	Remediated, password-protected IR Family Workbook	03/16/2016 11:52 AM
	hiltonm	Documentation/Certific	32_MDL0503_1_3_20160316115158_OHIP_DOS_	Remediated, password-protected AU Family	03/16/2016 11:51 AM



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

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NYU Lutheran Medical Center (PPS ID:32)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
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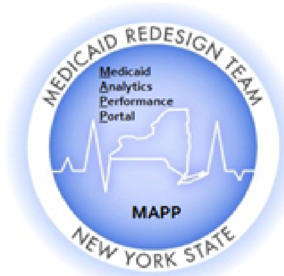
	hiltonm	Documentation/Certification	32_MDL0503_1_3_20160316115011_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(AT_Family)_UPDATED.docx	Remediated, password-protected AT Family Workbook	03/16/2016 11:50 AM
	kbatchoo	Documentation/Certification	32_MDL0503_1_3_20160202093115_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(PS_Family)_(pword_protected).docx	OHIP DOS System Security Plan (SSP) Moderate Plus Workbook (PS Family) (pword protected)	02/02/2016 09:31 AM
	kbatchoo	Documentation/Certification	32_MDL0503_1_3_20160202093023_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(PE_Family)_(pword_protected).docx	OHIP DOS System Security Plan (SSP) Moderate Plus Workbook (PE Family) (pword protected)	02/02/2016 09:30 AM
	kbatchoo	Documentation/Certification	32_MDL0503_1_3_20160202092939_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(IR_Family)_(pword_protected).docx	OHIP DOS System Security Plan (SSP) Moderate Plus Workbook (IR Family) (pword protected)	02/02/2016 09:29 AM
	kbatchoo	Documentation/Certification	32_MDL0503_1_3_20160202092828_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(AU_Family)_(pword_protected).docx	OHIP DOS System Security Plan (SSP) Moderate Plus Workbook (AU Family) (pword protected)	02/02/2016 09:28 AM
	kbatchoo	Documentation/Certification	32_MDL0503_1_3_20160202092444_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(AT_Family)_(pword_protected).docx	OHIP DOS System Security Plan (SSP) Moderate Plus Workbook (AT Family) (pword protected)	02/02/2016 09:24 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	
Develop a data security and confidentiality plan.	Uploaded remediated, password-protected IT workbooks (AT, AU, IR, PE, and PS) on Mar. 16, 2016.



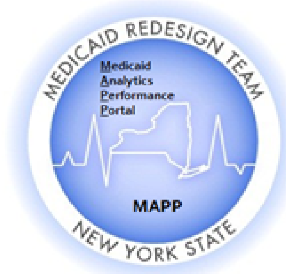
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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

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NYU Lutheran Medical Center (PPS ID:32)

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

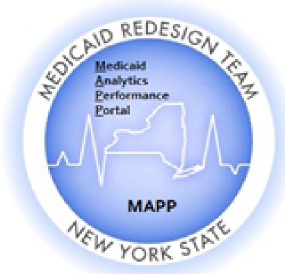
Milestone Name	User ID	File Type	File Name	Description	Upload Date

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

NYU Lutheran Medical Center (PPS ID:32)

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

Instructions :

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

IT Systems Design
• Risk: Ability to anticipate and define access, use and interoperability requirements (e.g. data elements that need to be shared, unique user access requirements, workflow integration requirements, end user limitations, etc.).
• Mitigation Strategy: Engage PPS partners early; develop robust IT current state survey and review thereof; develop robust technical support, training and communications strategies; leverage industry best practices and NYU implemented strategies.

IT Systems Implementation
• Risk: Integration with third party systems (disparate IT systems), end user availability for training and education, relative lack of technical resources within PPS partner organizations, incompatible EHRs, lack of critical information systems.
• Mitigation Strategy: Conduct detailed technical review during planning phase; identify IT leads within each partner organization and engage them early, and throughout the planning and implementation process; develop robust technical support, training and communications strategies; provide guidance on preferred EHR platforms; leverage Lutheran and NYU expertise and experience.

• Risk: Timing and availability of RHIO/SHIN-NY capabilities.
• Mitigation Strategy: Work with RHIO/SHIN-NY on pre-planning to align timelines and implementation planning activities.

IT Governance Structure:
• Risk: Ability to develop and enforce IT standards and policies across the PPS.
• Mitigation Strategy: Leverage PPS governance structure with senior representation from range of partner organizations; educate and communicate value of standards.

• Risk: Process for capturing and prioritizing requests in support of Brooklyn Bridges PPS DSRIP clinical program objectives.
• Mitigation Strategy: Establish and communicate process for demand management and assign required responsibilities.

Data Sharing:
• Risk: Obtaining accurate PPS partner IT information.
• Mitigation Strategy: Conduct detailed technical review during planning phase.

• Risk: Obtaining consents.
• Mitigation Strategy: Establish program and process for obtaining patient consents including educating patients and providers, using the State-sanctioned RHIO consent form as a template; leverage NYU accepted process and procedures.

• Risk: Obtaining partner contracts for data sharing.
• Mitigation Strategy: Communicate PPS expectations and value of data sharing; ensure all contracts include HIPAA BAAs and DEAAs as appropriate.

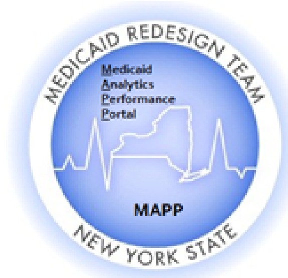
Data Security & Confidentiality:
• Risk: Many PPS partners lack detailed knowledge regarding security and confidentiality regulations.
• Mitigation Strategy: Leverage Lutheran and NYU technology and security services; educate PPS partners regarding security and confidentiality policies; periodically review compliance with BAAs and other legally binding agreements.

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 Work Stream will require each other organizational Work Stream to address, and each PPS clinical project implementation team to define and help prioritize, that Work Stream's/team's requirements for IT support and/or capabilities. Additionally, the IT Work Stream will require a governance structure and processes that prioritize projects and requests from other Work Streams/teams, set funding and other resource levels, and define and enforce IT-related policies. Additionally, this Work Stream will depend on the Finance Work Stream which will determine the available funding for each project. This funding level may present significant challenges given project requirements.

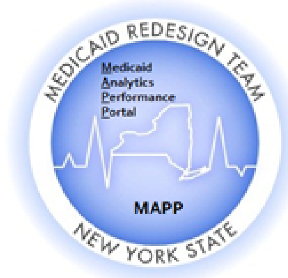


IPQR Module 5.5 - Roles and Responsibilities

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
Program Management	Anthony Antinori, NYU	Current state analysis, methodology, project management, budget management, resource management, etc.
EHR Design & Implementation	Nancy Beale/NYU IT, PPS PMO	Analysts, Subject Matter Experts (including clinicians), Systems Architects, End Users, Trainers, Testers, etc.
Security	Hai Ngo/NYU, Lutheran IT Security Team	Design, implement and manage security; enforce HIPAA-related and other agreements as fiduciary.
Infrastructure Implementation	Anthony Antinori/NYU	Desktop, network, server, data center, help desk, etc.
HIE Design & Implementation	Anthony Antinori/NYU, PPS PMO	Design, implement and manage HIE for PPS.
Data & Analytics Implementation	NYU EDW and Analytics Teams, PPS PMO	Design data and analytics strategy and approach, leverage existing and new tools to deliver required capabilities.
IT Governance	PPS IT Steering Committee	Design, implement and manage PPS IT governance.
Change Management	PPS IT Steering Committee	Establish and manage IT change management policies and processes.

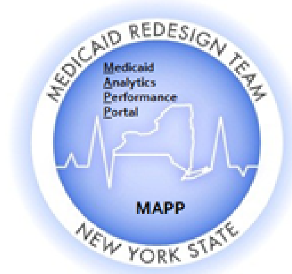


IPQR Module 5.6 - Key Stakeholders

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		
End Users/Partners (e.g. Clinicians, administrators, community based partners, and a range of other users of the new IT systems) Key partners to include, but not limited to NYU Lutheran, NYU, ODA, Addabbo, and Ezra Medical Center.	Users of the IT systems	Participate in design and training, and use systems to meet DSRIP objectives.
Patient Navigation Center (PNC)	User of the systems	Participate in design and training, and use systems to meet DSRIP objectives.
External Stakeholders		
Patients	Will use IT tools to access PPS capabilities and information	None.
Non-Brooklyn Bridges PPS Providers, payers, State agencies	May access data generated by the PPS	Use of the data in compliance with regulations.
RHIO/SHIN-NY	Technology partner	Provide connectivity/interoperability support.



IPQR Module 5.7 - Progress Reporting

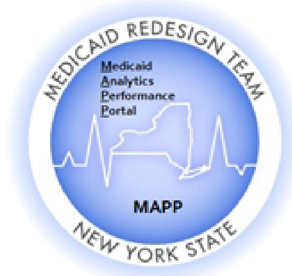
Instructions :

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

PPS will measure the success of this organizational Work Stream based on progress against the milestones and steps detailed above, on our ability to generate timely and accurate progress reports as judged by the Independent Assessor and achieving system transformation and outcome measures and goals as required within DSRIP program.

IPQR Module 5.8 - IA Monitoring

Instructions :



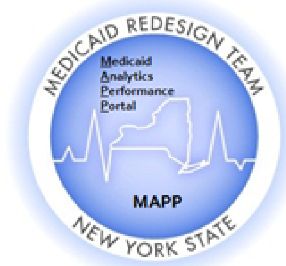
Section 06 – Performance Reporting

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	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1	In Progress	Identify PPS members with responsibility for outcomes/impacting performance measurements.	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2	Not Started	Align data and performance requirements with PPS member-type categories (e.g. clinical operations, finance, clinical domain/specialty, etc.) and clinical program (e.g. Diabetes, HIV, etc.).	10/01/2015	12/31/2015	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3	Not Started	Design reports & dashboards.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4	Not Started	Work with MCOs to get more timely data than the State provides.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5	Not Started	Develop communication plan – including frequency of communication and process for rapid cycle evaluation.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6	Not Started	Draft Performance Reporting and Communications strategy (e.g. who receives which performance reports/dashboards, how often, etc.).	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 7	Not Started	Obtain Executive Board approval for Performance Reporting and Communications strategy.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #2 Develop training program for organizations and	Not Started	Finalized performance reporting training program.	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	NO



New York State Department Of Health
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DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
individuals throughout the network, focused on clinical quality and performance reporting.									
Task Step 1	Not Started	Identify PPS members requiring training.	10/01/2015	12/31/2015	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2	Not Started	Identify scope of training (e.g., quality/process improvement strategies and monitoring, performance reporting, and pay for performance and pay for reporting)	10/01/2015	12/31/2015	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3	Not Started	Identify PPS team and develop a comprehensive strategy to lead and provide oversight over training	10/01/2015	12/31/2015	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4	Not Started	Design training content tailored for user communities.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5	Not Started	Develop model and tools to track/manage the training program.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6	Not Started	Communicate training program including access, goals, benefits, etc.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 7	Not Started	Implement program, track participation, continuously improve program based on feedback.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

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	

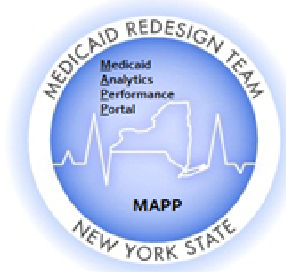
NYU Lutheran Medical Center (PPS ID:32)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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	



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

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

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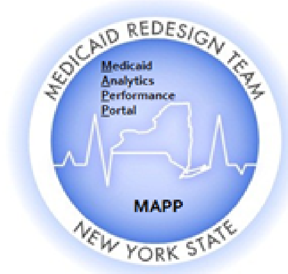


IPQR Module 6.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions :

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

Data:
• Risk: The quality and range of data available to measure and understand quality and performance may not be sufficient.
• Mitigation Strategy: Develop customized data and analytics capabilities; leverage Lutheran and NYU advanced analytics resources.

Alignment and Communication:
• Risk: PPS performance may not represent a significant percentage of each providers business and they may not focus sufficiently on the metrics.
• Mitigation Strategy: Engage members and communicate the benefits and requirements of PPS participation; incent performance.

• Risk: Members may not understand the performance measures or they may feel that they can't significantly influence the measures.
• Mitigation Strategy: Tailor training for the different groups that will be accessing and using the reports and dashboards; provide performance reporting down to the practice or individual level wherever possible; share successful implementation strategies among partners to develop best practices within the PPS.

• Risk: PPS leaders (e.g. Central Services and/or clinical program leadership) may not understand how the performance is measured or who they should work with to address specific performance gaps.
• Mitigation Strategy: Provide analytics expertise to support leadership in understanding performance and assessing high impact areas.

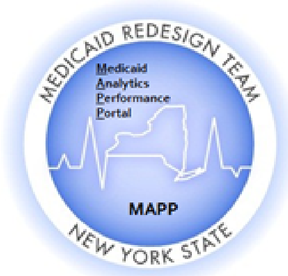
Logistics:
• Risk: PPS resources are distributed across Brooklyn and have many demands on their time.
• Mitigation Strategy: Provide a flexible training approach that includes online/on-demand as well as in-person training program alternatives.

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.)

The performance reporting Work Stream will be dependent on IT to aggregate and integrate the necessary data and produce the necessary reports and dashboards. Additionally, this Work Stream will depend on the Finance Work Stream which will determine the available funding for each project. This funding level may present significant challenges given project requirements.

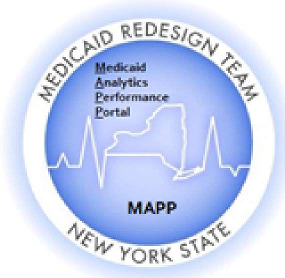


IPQR Module 6.5 - Roles and Responsibilities

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
Reporting Leader	Kris Batchoo, Project Manager, NYU Lutheran	Manage this Work Stream.
Reporting Analysts	Kris Batchoo, Project Manger, NYU Lutheran	Provide clinical and business data domain expertise and analytical support.
Training Leaders	PPS PMO & Clinical Programs	Develop training curriculum and coordinate/manage training program.
Trainers	PPS PMO and/or Contracted Service	Conduct training.
IT Data Integrators	Anthony Antinori, NYU	Integrate data required for reporting and analytics.
IT Developers	NYU IT	Develop on-line training tools, reports and dashboards.

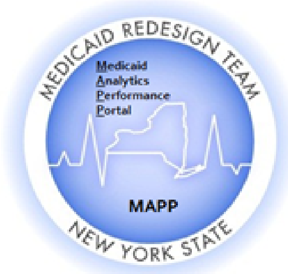


IPQR Module 6.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
IT	Deliver IT capabilities	Data, analytics tools, reports, dashboards, training modules, training administrative tools.
Communications	Organize and manage communications	Coordinate stakeholder communications.
End-Users/Partners. (includes representatives from FQHCs, NYU Lutheran, physicians, behavioral health agencies, social service agencies and other clinical partners). Key partners to include, but not limited to NYU Lutheran, NYU, ODA, Addabbo, and Ezra Medical Center.	Receive and use the performance reporting information	Appropriate use of the tools and information & provide input/feedback on usefulness of the tools.
External Stakeholders		
State DOH	Prescribe reporting requirements	Provide feedback on performance.



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.

Shared IT infrastructure will be critical in standardizing and aggregating data for reporting and analytical purposes. Additionally, reporting tools can be standardized and efficiently deployed and managed across the PPS. The PPS anticipates leveraging Salient and the MAPP tool to help populate dashboards and deliver performance data to the PPS providers.

IPQR Module 6.8 - Progress Reporting

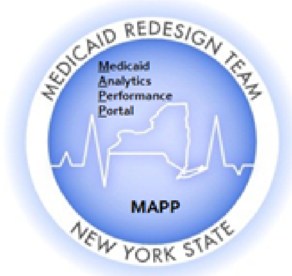
Instructions :

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

The success of this Work Stream will be measured based on our ability to meet the established milestone targets by leveraging IT infrastructure (described in previous module) and the PPS's ability to use data to influence quality and performance. The governance committees, PMO and clinical program leadership will use these tools to monitor progress and identify areas for improvement/intervention. Additionally, PPS will track system transformation and outcome measures as required within DSRIP program.

IPQR Module 6.9 - IA Monitoring

Instructions :



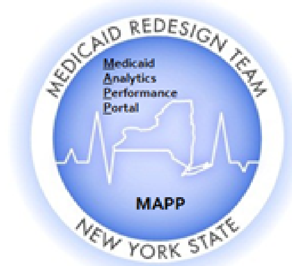
Section 07 – Practitioner Engagement

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	Completed	Establish practitioner engagement and communication infrastructure for overseeing outreach, education and engagement of practitioners; strategy to be coordinated with partner communication and engagement strategy.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2	In Progress	Create listserv, newsletter and website for providing on-going update and performance reports to practitioners; establish communication mechanism for receiving comments and questions.	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3	Not Started	Engage professional practioner organizations including MSSNY, county associations, ACP chapters or AAFP affiliations.	10/01/2015	12/31/2015	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4	Not Started	Assign practitioner representatives to PPS committees including Governance, Clinical Project Planning, IT, and Finance.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5	Not Started	Conduct outreach with practitioners, through face-to-face meetings and webinars, to develop better understanding of PPS goals, metrics and clinical project plans.	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

NYU Lutheran Medical Center (PPS ID:32)

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 #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.	Not Started	Practitioner training / education plan.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1	Not Started	Identify needed training capacity for practitioners through engagement of Clinical Sub-Committee and partner surveys.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2	Not Started	Identify vendor/internal resources for practitioner training/education development.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3	Not Started	Set up training/education curriculum that is specifically designed for practitioners.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4	Not Started	Establish plan for evaluating on-going training needs.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5	Not Started	On-going tracking and monitoring of training programs including: evidence of training take-up, description of training programs delivered, participant level data and training outcomes.	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

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Prescribed Milestones Current File Uploads

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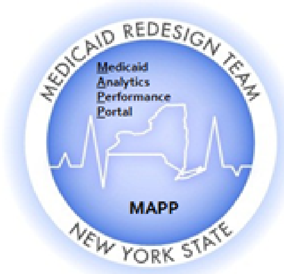
Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop Practitioners communication and engagement plan.	
Develop training / education plan targeting practioners and	



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

DSRIP Implementation Plan Project

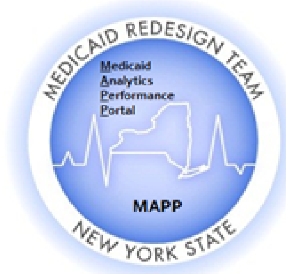
NYU Lutheran Medical Center (PPS ID:32)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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	



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

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

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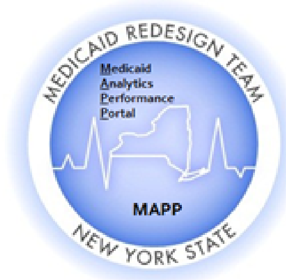


IPQR Module 7.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions :

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

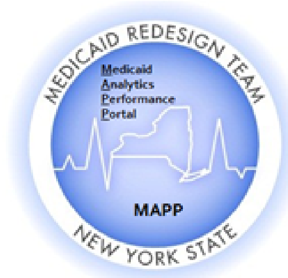
The PPS has had preliminary communication and engagement with practitioners and will embark on a comprehensive and on-going education and engagement strategy to ensure successful DSRIP implementation. Ambulatory care practitioners are essential to achieving the Brooklyn Bridges' goal of reducing hospitalizations and readmissions. Practitioner buy-in to the PPS's clinical projects' evidence-based protocols, population health management strategies, required IT infrastructure, and focus on care coordination and patient navigation are important for the PPS to achieve its desired milestones and outcomes. Providers need to be continuously engaged in order to understand and effectuate their role and responsibilities in system transformation. Because practitioner engagement is so essential to meeting DSRIP goals, the PPS will identify "practitioner champions" who will play a key role in engaging practitioners and informing implementation. The PPS will also leverage existing professional group communication channels to ensure on-going communication and engagement.

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.)

Practitioner engagement will be closely interdependent with many other work streams including clinical integration, clinical project planning, population health management, partner engagement, governance workforce training and value-based reimbursement. The PPS will need to work very closely with practitioners to ensure an understanding of and engagement with the DSRIP goals, metrics, and outcomes and to ensure their perspectives are incorporated into every step of the implementation. Practitioner engagement will also interact with workforce training as part of the retraining, recruiting, and redeploying staff with appropriate skill sets.

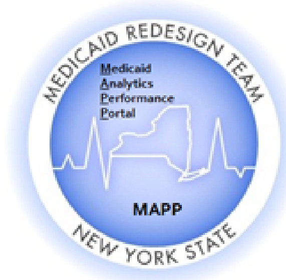


IPQR Module 7.5 - Roles and Responsibilities

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
Practitioner Engagement Oversight	Dr. Gregory Kerr, NYU Lutheran	Oversees practitioner engagement and communication infrastructure to ensure outreach, education and engagement of practitioners.
Practitioner Training Oversight	Brooklyn Bridges PPS Central Services, TBD	Oversees practitioner education and training.

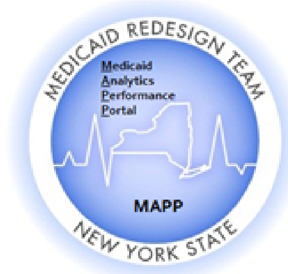


IPQR Module 7.6 - Key Stakeholders

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		
Brooklyn Bridges PPS Leadership	Oversight and on-going communication and engagement.	Lead communication, outreach and engagement with practitioners.
External Stakeholders		
"Practitioner champions"	TBD	Represent physicians on various committees; play a key role in driving professional engagement.
Leads of Professional Groups	TBD	Provide natural communication channel to professions to ensure communication and engagement.
Practitioner partners (includes representatives from FQHCs, NYU Lutheran, physicians, behavioral health agencies, social service agencies and other clinical partners). Key partners to include, but not limited to NYU Lutheran, NYU, ODA, Addabbo, and Ezra Medical Center.	TBD	Participate in various PPS committees.



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

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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.

At the highest level, a successful IT strategy and clinical project implementation structure and implementation plan development process are critical to achieving clinical integration across providers involved in a specific project and across the PPS. The integrated delivery system will establish shared connectivity, registries, care coordination tools, and analytics across the PPS in order to meet DSRIP performance goals and successfully implement DSRIP clinical projects. This shared IT infrastructure will support and promote practitioner engagement through the use and sharing of data and by providing access to IT tools.

IPQR Module 7.8 - Progress Reporting

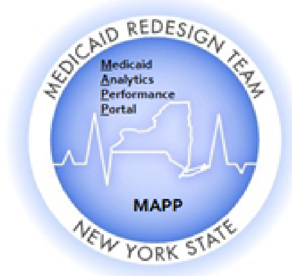
Instructions :

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

The PPS will measure the success of its practitioner engagement strategy by providing quarterly updates on the development of the practitioner communication and engagement plan and practitioner training strategy. The PPS will use the clinical metrics, speed and scale tables and provider ramps up to measure progress towards achieving practitioner engagement milestones.

IPQR Module 7.9 - IA Monitoring

Instructions :



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

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

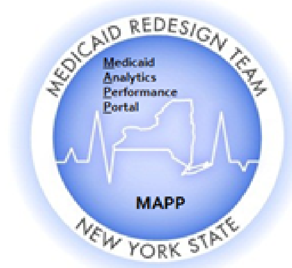
Section 08 – Population Health Management

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	In Progress	Identify those responsible for population health management roadmap development, monitoring and reporting.	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2	In Progress	Conduct current state IT assessment, including those elements needed to support population health management.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3	In Progress	Assess PCMH status of primary care partners and establish a strategy to address needed progress.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4	Not Started	Conduct workforce assessment that includes functions needed for population health management.	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5	Not Started	Analyze data from IT, PCMH and workforce assessments.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6	Not Started	Using the PPS's Community Needs Assessment, identify priority target populations, including those with targeted chronic conditions aligned with chosen DSRIP projects and to reduce excess readmissions and ED visits.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 7	Not Started	Draft and finalize population health management roadmap.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 8	Not Started	Obtain approval of population health management roadmap from Brooklyn Bridges PPS Leadership.	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	



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

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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 #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.	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1	In Progress	Identify staff responsible for developing and reporting on bed reduction plan.	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2	Completed	Develop implementation plans for the ED Triage and Observation Unit projects.	10/01/2015	03/31/2016	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3	Not Started	Develop method to monitor the impact of DSRIP and care activities on utilization.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4	Not Started	Draft and finalize bed reduction plan.	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

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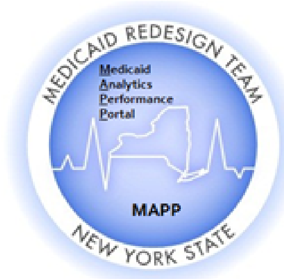
Prescribed Milestones Narrative Text

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



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

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Milestone Review Status

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

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

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

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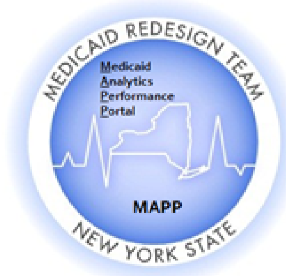


IPQR Module 8.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions :

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

The Brooklyn Bridges PPS has identified the following key challenges and risks that could impact our ability to achieve the milestones for the Population Health Management section:

• Limited implementation (e.g., due to delays, unforeseen challenges) of any of the interdependent work streams (see below), including the PPS's IT strategy, PCMH strategy, central services and patient navigation strategies, workforce strategy, cultural competency/health literacy strategy, etc.
• Limited success in educating and engaging providers and CBOs on the PPS's IDS and PHM approach (bridging the disconnect between system-level expectations and provider-level understanding or realities), and to facilitate their adoption of the IT, staffing and workflow changes necessary to implement PHM in a timeframe that meets the PPS's milestone and speed/scale targets.
• Limited success in engaging Brooklyn Bridges PPS patients in the PPS's population health management activities and initiatives.

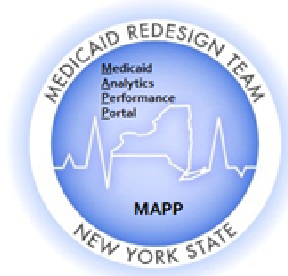
The Brooklyn Bridges PPS intends to mitigate these risks through broad Partner, practitioner and patient communication and planning strategies and activities, formal Brooklyn cross-PPS discussions and efforts, and significant and dedicated Brooklyn Bridges PPS Leadership and project management oversight (ensuring each of the clinical projects get implemented as planned and in a timely manner) and coordination of all of these intersecting work streams.

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.)

This Work Stream is one of the key goals and underpinnings of the DSRIP initiative. It is highly dependent on each and every one of the other organizational Work Streams and clinical projects, which together will help the Brooklyn Bridges PPS effectuate its population health management approach, goals and functionality across the PPS. Most critical are the patient navigation center, information technology and informatics, practitioner engagement to ensure practitioners have a deep understanding of and skills to implement PHM and effective clinical integration, and to ensure that patients are actively engaging in their care processes. Also important are cultural competency/health literacy and performance reporting to ensure that providers are delivering and patients are receiving care in a way they understand, and that providers are being monitored and measured on their performance in meeting the PPS's population health management goals. Additionally, this Work Stream will depend on the Finance Work Stream which will determine the available funding for each project. This funding level may present significant challenges given project requirements.



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
Lead the PHM Roadmap development	Brooklyn Bridges PPS Central Services Population Health Management Lead, TBD	Oversight of PHM roadmap development; oversight and/or coordination across the moving parts (e.g., IT assessment; PCMH assessment and certification).
Lead assessments integral to PHM Roadmap	Anthony Antinory, NYU	Oversight of IT, PCMH and workforce assessments, and coordination with PHM Lead.
Lead the Bed Reduction strategy	TBD	Ensuring modeling of impact of clinical projects on hospital/community care utilization.

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		
Brooklyn Bridges PPS Central Services	Hilton Marcus, PPS Project Coordinator, NYU Lutheran	Oversight of PHM roadmap development.
Brooklyn Bridges PPS Partners (includes representatives from FQHCs, NYU Lutheran, physicians, behavioral health agencies, social service agencies and other clinical partners). Key partners to include, but not limited to NYU Lutheran, NYU, ODA, Addabbo, and Ezra Medical Center.	Impacted by bed reduction strategy	Member of coordinating body or workgroup.
External Stakeholders		
Medicaid beneficiaries	End user of reformed care delivery system	Feedback through surveys.
Workforce	Impacted by shifts in patient utilization in various care settings	Feedback through training programs.
CBOs (e.g., CAMBA, Visiting Nurse Service, Brooklyn Perinatal Network)	Impact patient engagement	Feedback through surveys or other tools
Health plans	Partners in value-based purchasing	Share experiences and tools for PHM; ultimately participate in DSRIP payment reforms.

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.

Lutheran Family Health Centers, a key partner in the Brooklyn Bridges PPS, uses a clinical risk stratification algorithm and a set of reports including patient registries, provider reports and pre-visit planning as part of its community case management program to identify patients at risk for readmissions. NYU also brings tremendous population health management IT assets and capabilities. Both will be leveraged to support the PPS's population health management goals and strategies.

The integrated delivery system will establish shared connectivity, registries, care coordination tools, and analytics across the PPS in order to meet DSRIP performance goals and successfully implement DSRIP clinical projects.

IPQR Module 8.8 - Progress Reporting

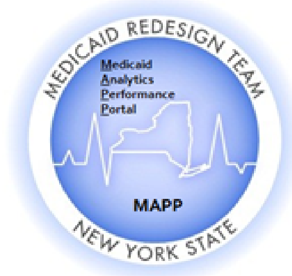
Instructions :

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

The PPS will measure the success of its population health management by providing updates on each of the work streams incorporated into the road map (e.g., IT, Workforce, PCMH status, Clinical Projects), including its bed reduction plan. The PPS also will use other data sources, including what the state will provide and health plan data to measure patient service utilization and outcomes. The PPS will use the clinical metrics, speed and scale tables and provider ramp ups to measure progress towards achieving population health management milestones.

IPQR Module 8.9 - IA Monitoring

Instructions :



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

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

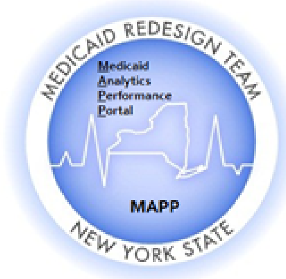
Section 09 – Clinical Integration

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	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1	Completed	Establish clinical project work groups (to include key providers and practitioners from partner sites) to inform the clinical integration needs assessment and strategy development (review and provide feedback).	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2	In Progress	Map the provider landscape participating in each clinical project.	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3	In Progress	Utilize workgroups to develop and implement CI needs assessment framework (coordinated with related needed surveys, such as a Workforce or IT survey).	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4	Not Started	Finalize clinical integration needs assessment.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5	Not Started	Obtain approval of clinical integration needs assessment by Clinical Sub Committee.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #2 Develop a Clinical Integration strategy.	Not Started	Clinical Integration Strategy, signed off by Clinical Quality Committee, including: -- Clinical and other info for sharing	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	NO



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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		-- Data sharing systems and interoperability -- A specific Care Transitions Strategy, including: hospital admission and discharge coordination; and care transitions and coordination and communication among primary care, mental health and substance use providers -- Training for providers across settings (inc. ED, inpatient, outpatient) regarding clinical integration, tools and communication for coordination -- Training for operations staff on care coordination and communication tools							
Task Step 1	Not Started	Utilize clinical project workgroups to define desired future CI state; analyze clinical integration needs assessment to identify gaps to future state (re: IT, care management staffing and protocols, clinical protocols, etc.).	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2	Not Started	Utilize clinical project workgroups to develop prioritized steps (possibly to include a workforce training plan, workflow standardization protocols, or standardize care management protocols, for example) for closing the identified CI gaps, with a particular focus on closing care transition gaps.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3	Not Started	Finalize a clinical integration strategy across all clinical projects signed off by the Clinical Committee. The clinical integration strategy will include transition strategy across care continuum and leverage care management/care coordination expertise.	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	

IA Instructions / Quarterly Update

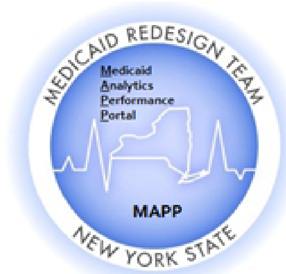
Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found



New York State Department Of Health
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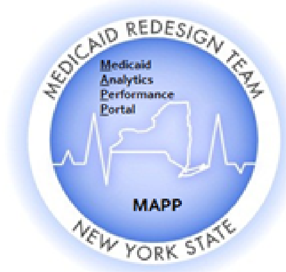
Prescribed Milestones Narrative Text

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

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IPQR Module 9.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

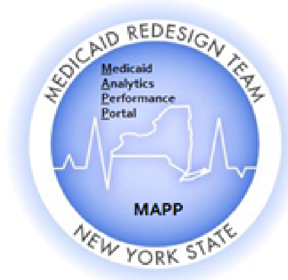
Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found



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

DSRIP Implementation Plan Project

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

Instructions :

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

At the highest level, successfully delivering needed IT and implementing the clinical projects are critical to achieving clinical integration across providers involved in a specific project and across the PPS. Each of those IP sections describe the processes the PPS is putting in place to mitigate any risks to achieving those Work Streams. Other risks similarly could impact the implementation of this Work Stream, including:

• Inability of providers and practitioners of all sizes to financially, administratively or operationally be able to adopt the HIT/HIE tools and processes necessary to effectuate clinical integration across the PPS.
• Educating and engaging practitioners sufficiently to ensure PPS-wide adoption of evidence-based clinical pathways, care models, and care transitions protocols to ensure true clinical integration across projects. Practitioners must be resourced appropriately to adopt these new care models and protocols.

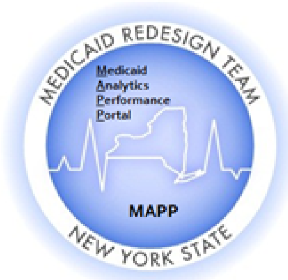
The PPS has several mechanisms to mitigate these risks, including an active multi-dimensional communication and collaboration strategy with its partners and practitioners (e.g., All Partner meetings; PPS Newsletter; Regular email exchanges; Clinical Project Workgroups), including key partners/practitioners on the key Committees or workgroups necessary to oversee or implement these Work Streams, and ensuring active linkages across the Work Streams (e.g., IT and Clinical Projects). The clinical project general implementation section describes the PPS's general approach to ensuring provider engagement and capacity, and each clinical project describes the PPS's risk and mitigation strategy related to provider engagement and capacity.

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.)

As noted in this section, this work stream is highly dependent on the IT and Clinical Project Work Streams, particularly, but also is dependent on successful Workforce, Cultural Competency/Training, and Practitioner Engagement Work Streams. Successful IT delivery and clinical project implementation are critical to achieving clinical integration across providers involved in specific projects and across the PPS. Additionally, this Work Stream will depend on the Finance Work Stream which will determine the available funding for each project. This funding level may present significant challenges given project requirements.

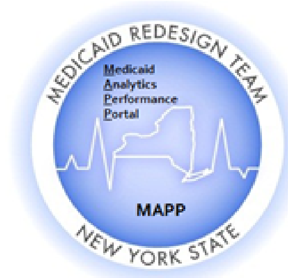


IPQR Module 9.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Oversight of CI Work Stream	Clinical Sub-Committee	Oversight and approval body.
Lead clinical integration work stream	Tamar Renaud, PPS Clinical Workgroups Lead	Oversee and monitor clinical integration activities.
Support development of clinical integration needs assessment and strategy	Project-specific clinical workgroups	Clinical integration needs assessment and strategy development.

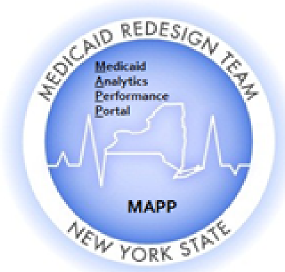


IPQR Module 9.6 - Key Stakeholders

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		
Brooklyn Bridges PPS Partners (includes representatives from FQHCs, NYU Lutheran, physicians, behavioral health agencies, social service agencies , health homes and other clinical partners). Key partners to include, but not limited to NYU Lutheran, NYU, ODA, Addabbo, and Ezra Medical Center.	Active workgroup participation; acceptance and adoption of clinical integration strategy	Engage in the process and related trainings.
External Stakeholders		
Brooklyn Bridges PPS patients/families	Recipients of improved care delivery/caregivers or supports for these patients	Feedback through surveys.
CBOs	Critical patient resources/supports	Feedback through surveys.
Health plans	Source of member data to monitor outcomes	Patient data.



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IPQR Module 9.7 - IT Expectations

Instructions :

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

IT infrastructure across the PPS will be critical to supporting this Work Stream. Practitioners across the PPS, and particularly across projects, will need ready access to existing and new information and data (e.g., patient electronic health records; care management and care transitions tools and protocols; patient registries, appointment scheduling and reminder tools, provider communication tools, etc.) to be able to transform their practice to achieve clinical integration across providers in the PPS. The Brooklyn Bridges PPS will establish an integrated delivery system that will connect patients and providers, and build deeply integrated and transformative clinical and care management workflows. The integrated delivery system will establish shared connectivity, registries, provider and patient portals, care coordination tools, and analytics across the PPS in order to meet DSRIP performance goals and successfully implement DSRIP clinical projects.

IPQR Module 9.8 - Progress Reporting

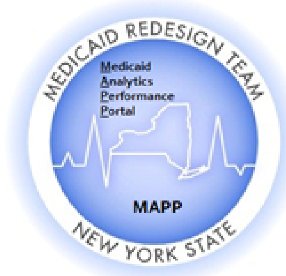
Instructions :

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

The PPS will measure the success of clinical integration across time and in several ways. We will be monitoring and reporting on the project-specific process and outcome measures; monitoring and reporting on the implementation of our IT strategy; and conducting periodic patient and provider surveys about their care delivery experience (e.g., through satisfaction surveys) and practice transformation (e.g., PCMH status assessment), respectively.

IPQR Module 9.9 - IA Monitoring:

Instructions :



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.

The Brooklyn Bridges PPS's approach to successful clinical project implementation centers on 1) leveraging Lutheran and NYULMC's existing infrastructure, resources, and clinical expertise to develop robust clinical operational plans and to provide access to clinical expertise, technical assistance and central support to implement each project; 2) establishing clinical project governance and management structures that enable efficiency, effectiveness and transparency; 3) coordinating with and actively engaging key partners; and, 4) establishing IT connectivity between and among PPS partners to share data, track progress against project milestones, and report on results to ensure meaningful patient outcomes.

Partner engagement is the crux of successfully implementing this approach. Brooklyn Bridges' PPS partners bring clinical expertise, as well as culturally-competent and community-centered knowledge, relationships and resources. Each project's success hinges on harnessing this expertise and channeling it to the wider PPS's benefit. As such, partners will be integral to the individual project teams as well as the clinical project oversight structure to develop and implement each project.

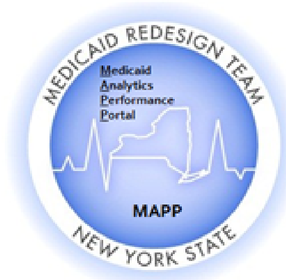
This integrated, collaborative approach will enable the Brooklyn Bridges PPS to transform from a disparate group of providers to a highly integrated network where each clinical project works in concert to achieve DSRIP's goals. The PPS clinical projects governance and project implementation structure will leverage individual project work groups, each responsible for focusing on their project goals, interventions, and milestones, to share data-driven, evidence-based best practices and other learnings to contribute to each project's successful implementation. These work groups will be co-led by both a Lutheran and community-based partner representative and comprised of NYU Lutheran, NYU, primary care and other partners. The Clinical Sub-Committee, which will report to the PPS Executive Committee and be comprised of each work group's co-leads and additional PPS clinical and administrative leadership, will oversee all clinical projects and monitor each project's implementation to lift up cross-cutting project successes and challenges. Following implementation planning, work groups will shift to assume responsibility for on-going project monitoring and performance management and provider engagement with support from the PPS central services group.

The PPS will support this implementation approach by deploying coordinated IT systems and the Patient Navigation Center, providing actionable data for care management and coordination, and facilitating technical assistance for partners to meet the challenges of implementing specific project elements.

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

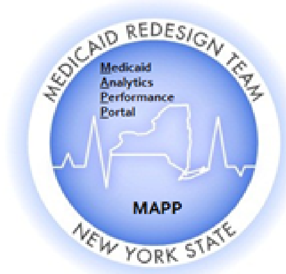
Instructions :

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.

Successful project implementation will depend on efforts within and across the PPS-specific work streams and also cross-PPS initiatives. Specifically, the following major inter dependencies have been identified by our PPS will be addressed via cross work stream and cross PPS initiatives. These will include, but not be limited to: 1) supporting relevant partners to achieve PCMH NCQA 2014 Level 3 status; 2) successfully implementing IT systems, including EMRs and HIE connectivity; 3) contracting with MCOs to support financial sustainability; 4) engaging patients, as well as engaging providers to consistently employ evidence-based, best practice clinical protocols to achieve standardization in care coordination, quality and outcomes; 5) developing a PPS-wide budget approach to ensure adequate funds are available across projects; 6) coordinating with other PPSs and 7) coordinating the PPS's workforce strategy and priorities across projects.

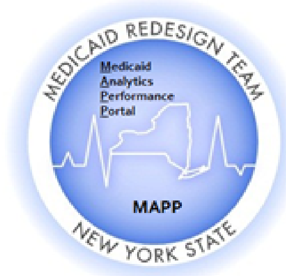


IPQR Module 10.3 - Project Roles and Responsibilities

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
Project Management Office	Brooklyn Bridges PPS PMO	Coordinate PPS-wide functionality and provide day-to-day operational support for PPS, including implementation management of selected cross-project initiatives (e.g., support PCMH objectives).
Clinical Project Sub-Committee	Brooklyn Bridges PPS	Oversee PPS-wide clinical project implementation and on-going monitoring.
Behavioral Health Work Group	Brooklyn Bridges PPS	Develop plan and oversee implementation of the Behavioral Health and Primary Care integration project.
Diabetes Work Group	Brooklyn Bridges PPS	Develop plan and oversee implementation of the Diabetes project.
HIV Work Group	Brooklyn Bridges PPS	Develop plan and oversee implementation of the HIV project.
Tobacco Use Cessation Work Group	Brooklyn Bridges PPS	Develop plan and oversee implementation of the Tobacco Use Cessation project.
Asthma Work Group	Brooklyn Bridges PPS	Develop plan and oversee implementation of the Asthma project.
ED Care Triage Work Group	Brooklyn Bridges PPS	Develop plan and oversee implementation of ED Care Triage project.
Observation Unit Work Group	Brooklyn Bridges PPS	Develop plan and oversee implementation of the Observation Unit project.
Care Management and Navigation Work Group	Brooklyn Bridges PPS	Develop plan and oversee implementation of the Care Management and Navigation project.



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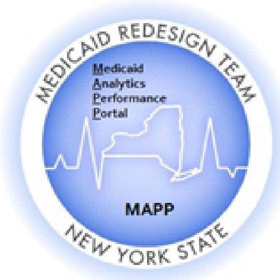
IPQR Module 10.4 - Overview of key stakeholders and how influenced by your DSRIP projects

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
PPS Finance Sub-Committee	Conduct PPS-wide financial impact monitoring.	Responsible for on-going monitoring of the impact of the DSRIP projects on the financial health of the network and individual providers.
Project Advisory Committee	Represent partners in PPS governance.	Serve on PPS-wide committees as organizational and provider-type representative.
External Stakeholders		
BB PPS attributed members	Impacted positively by the nine clinical projects resulting in improved access and coordination of care and overall health and health outcomes.	Beneficiaries of the PPS infrastructure and clinical projects. Responsible for playing an active role in their care.
Medicaid Managed Care Organizations	Contract to support financially sustainable clinical projects.	Partners in sharing claims and EHR data, negotiating and piloting new payment models.
NYC Department of Health and Mental Hygiene	Collaborate with the PPS to implement several Domain 3 and 4 projects (i.e., Asthma, Tobacco, HIV).	The PPS project implementation planning teams are working with DOHMH representatives to determine DOHMH responsibilities to support interventions.
Brooklyn-area PPSs, including OneCity Health, Community Care of Brooklyn, and Advocate Community Partners	Collaborate with the PPS on implementation of our HIV and tobacco use cessation projects. For Domain 2 and 3 projects, collaborate with the PPS by sharing best practices, lessons learned for Asthma, Diabetes and Behavioral Health projects and coordinating patient data-sharing of other PPSs lives who seek care by our PPS providers (e.g. ED Care Triage, Observation Unit).	PPSs will share best practices and avoid duplication of effort.
1199	Serves as PPS primary workforce vendor.	Assist PPS with workforce engagement, development, and training.
OPWDD	Committed to ensuring representation and coordination among DD providers.	Provide technical assistance to PPS, as needed, to promote and establish participation of DD providers.
OMH	Committed to ensuring representation and coordination among providers of mental health services.	Provide technical assistance to PPS, as needed, to support integration of behavioral health and primary care.
OASAS	Committed to ensuring representation and coordination among providers of substance abuse services.	Provide technical assistance to PPS, as needed to ensure integration of substance abuse providers.



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.

The development of a robust information technology platform will play a critical and central role in the success of the Brooklyn Bridges PPS. This platform will help ensure a cohesive and effective partnership to advance population health and value based payments between NYU Lutheran Medical Center and its various key partners. The IT infrastructure will be supported by experts at NYU Langone Medical Center (NYULMC), leveraging its private health information exchange and the State's Regional Health Information Organization (RHIO) in Brooklyn, HealthIx.

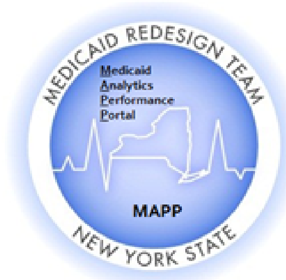
NYULMC has consistently demonstrated its commitment to building a strong health information technology (HIT) infrastructure to support the mission and vision of becoming a world-class, patient-centered, integrated academic medical center. Their commitment is exemplified by the development and expansion of the hospital and clinically integrated network (CIN) dashboards, the NYULMC Health Information Exchange (HIE), and the implementation of Epic, our enterprise-wide electronic medical record system. These systems are the cornerstone of the Brooklyn Bridges PPS's Enterprise Clinical Platform (ECP), which, along with our Patient Navigation Center, will successfully integrate our mission to eliminate avoidable hospital use and improve access and delivery of appropriate clinical services in Brooklyn.

The hospital dashboard leverages HIT systems and administrative data for the purpose of monitoring key indicators for operational, financial, and quality performance. Building on this, the CIN dashboard layers external claims data and additional clinical information from HIE. These tools support information-sharing and transparency while allowing clinical and administrative teams to identify areas for improvement. Metrics are available on the site, physician, population and patient level, allowing for sufficient drill down to support actionable quality improvement. These tools also advance risk stratification, predictive and population analytics, and may be provided to the PPS.

NYULMC launched the HIE, an electronic platform to mobilize patient information across physicians and organizations. All physicians in inpatient and outpatient settings are required to be electronically connected to this exchange. In addition, NYULMC has connected to approximately 200 physician practices in its voluntary network accounting for 26 EMRs. The PPS's IT team is currently in process of planning our connectivity strategy to our PPS partners and its Patient Navigation Center in order to share clinical data and track patient progress in the community. Further, connecting post-acute facilities to the HIE will provide a platform for increased communication and information exchange between providers. The HIE will allow care protocols to be shared and clinical issues to be communicated within and across care settings to improve the efficiency and quality of care provided to our patients. The HIE will also be supported by a consistent EMR system in Epic, which will be implemented throughout the Lutheran hospital system by Autumn 2016. Protocols, developed as part of care redesign for DSRIP, will be incorporated into Epic to guide providers along the clinical continuum.

By enhancing the capacity for providers across the care community to connect and share information about patients, Brooklyn Bridges PPS will continue to create the ability to measure and improve quality of care, enable care redesign, and coordinate care for our attributed population and across our community.

IPQR Module 10.6 - Performance Monitoring



New York State Department Of Health
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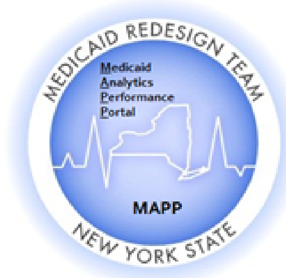
DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Instructions :

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

As part of the State's goal to "better understand[] the patterns of health outcomes and healthcare within each region of the state to assist with network formation," the Brooklyn Bridges PPS will foster an environment of quality performance reporting and culture through our main clinical projects. This includes setting common, evidence-based protocols where applicable, and tracking the improvement in health outcomes through the State's tools, such as its DSRIP Performance Chartbooks, DSRIP Dashboards, DSRIP Domain 3 Clinical Metrics Dataset, Salient Performance Data, and other DSRIP relevant performance data. Examples of how the projects will fit into the development of a quality performance reporting system and culture include the development of collaborative, evidence-based standards of care including medication management and care engagement process in Project 3.a.i, the implementation of evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings for Project 3.c.i, and the development and implementation of evidence-based asthma management guidelines for Project 3.d.ii.



IPQR Module 10.7 - Community Engagement

Instructions :

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

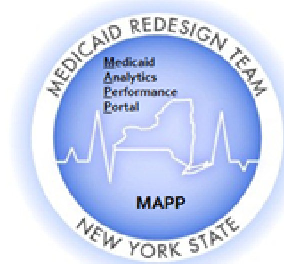
The Lutheran DSRIP program recognizes the value of community collaboration, including community-based organizations as equal and active partners and embracing true and meaningful community engagement. This model provides the best opportunity for creating a truly integrated delivery system, with prevention as the cornerstone of the system, with the aim of bringing healthcare services deep into the community and stabilizing and improving the health of fragile populations.
Our plan achieves this goal by defining DSRIP as a health program that incorporates the social determinants of health as fundamental to improving the outcomes of medical interventions. This recognizes the unique character of CBOs whose inherent cultural and social competence provide a vector to addressing these social determinants. Lutheran DSRIP leverages the special skills, assets and contributions of CBOs, embedding their representation in the governance structure and in working groups. The program's Clinical Projects Workplan delineates specific functions that capitalize on CBO expertise. Examples of current plans to embed CBO participation in clinical activities include:

• Leveraging culturally-specific organizations to serve as cultural brokers for messaging on appropriate use of the emergency department
• Promoting training and employment opportunities to build a community-based and linguistically and culturally competent community health workforce;
• Subcontracting with CBOs to provide health education and wellness prevention services;
• Capitalizing on CBO existing expertise on particular health issues such as asthma prevention through home inspection; and
• Developing and disseminating health information to hard to reach populations

Potential associated risk includes assuring that DSRIP has sufficient infrastructure and financial resources to oversee CBO partnerships, including establishing a standard of practice expectation, provide training, and monitor activities.

IPQR Module 10.8 - IA Monitoring

Instructions :



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Section 11 – Workforce

IPQR Module 11.1 - Workforce Strategy Spending

Instructions :

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

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

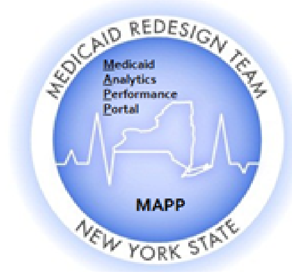
Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

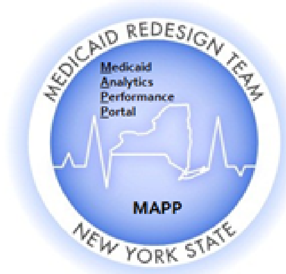


IPQR Module 11.2 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Define target workforce state (in line with DSRIP program's goals).	In Progress	Finalized PPS target workforce state, signed off by PPS workforce governance body.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1	Completed	Establish oversight and review process over Workforce Impact Analysis and defined workforce state.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2	Not Started	Identify and map out the specific requirements of each DSRIP project and the new services each of the projects will require or deliver.	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3	Not Started	Determine project-by-project workforce impact on the PPS to develop target workforce state.	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4	Not Started	Develop "To Be" Workforce analysis including specifications for the kinds, numbers, and location of workers needed to accomplish the PPS's strategic project requirements and milestones.	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5	Not Started	Obtain approval from Executive Committee on target workforce state.	10/01/2015	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.	Not Started	Completed workforce transition roadmap, signed off by PPS workforce governance body.	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	NO
Task Step 1	Not Started	Develop decision-making model that defines how and by whom any decisions around resource availability, allocation, training, redeployment and hiring will be made and signed off.	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 2	Not Started	Coordinate with clinical sub-committees to prioritize workforce training, redeployment and hiring to achieving "target state".	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Sep 3	Not Started	Create five year workforce transition roadmap for addressing workforce impacts, filling workforce gaps, and building workforce "target state"	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4	Not Started	Define timeline of when these workforce changes will need to take place and what the dependencies are for training,	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	



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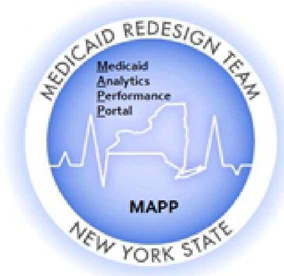
Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		redeployment and hiring.							
Task Step 5	Not Started	Obtain approval of workforce transition roadmap from Executive Committee.	10/01/2015	09/30/2016	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.	Not Started	Current state assessment report & gap analysis, signed off by PPS workforce governance body.	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1	Not Started	Develop and implement workforce survey to assess partners' provider and staff capacity and determine "As Is" workforce status.	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 2	Not Started	Map current state analysis against future state analysis to develop gap analysis	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3	Not Started	Identify percentage of employees impacted from full placement, partial placement, no placement.	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4	Not Started	Develop recruitment plan and timeline for new hires, if needed	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5	Not Started	Conduct refined workforce budget analysis for submission to the State.	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6	Not Started	Finalize current state assessment and obtain PPS governance approval	10/01/2015	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.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES
Task Step 1	In Progress	Develop process and work plan for conducting a compensation benefit analysis	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 2	In Progress	Determine whether compensation and benefit analysis will be conducted by PPS staff, vendor, or coordinated across multiple Brooklyn PPSs	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3	Not Started	Work with partners to gather compensation and covered benefits of existing roles that may potentially be redeployed	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4	Not Started	Compare obtained compensation and benefit information against future positions' compensation and covered benefits.	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5	Not Started	Create compensation and benefit analysis.	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	



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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 6	Not Started	Develop policies for impacted staff who face partial placement, retraining or redeployment	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 7	Not Started	Review and obtain approval of compensation and benefit analysis plan from Executive Committee.	10/01/2015	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.	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	NO
Task Step 1	Not Started	Define current state training needs (through partner and stakeholder engagement) and in consultation with clinical sub-committees	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 2	Not Started	Conduct a skills assessment to understand existing staff capability for training assessment	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 3	Not Started	Contract with training vendor(s)	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4	Not Started	Develop training needs assessment.	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 5	Not Started	Develop training strategy, including identifying existing training resources, gaps and needed capacity	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 6	Not Started	Develop training timeline and workplan	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 7	Not Started	Establish training budget	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 8	Not Started	Launch training/retraining.	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 9	Not Started	On-going tracking and monitoring of training programs including: evidence of training take-up, description of training programs delivered, participant level data and training outcomes.	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

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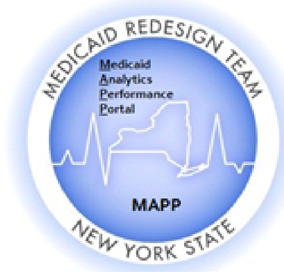

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

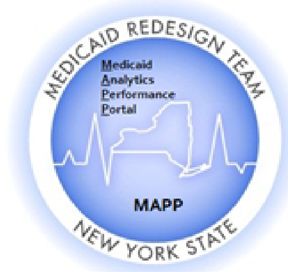
No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Define target workforce state (in line with DSRIP program's goals).	In response to guidance promulgated on February 1, 2016, the Brooklyn Bridges PPS's progress on the various Workforce-related milestones includes the following: - Together with other PPSs, the Brooklyn Bridges PPS has retained a vendor to collect salary and compensation information from our various partners in order to respond to the State's requirement while ensuring compliance with Federal and State antitrust laws and requirements; - Together with other PPSs, to encourage regional consistency and utility, retaining the same vendor to provide current state assessment and gap analysis; - Further advancement on the PPS's training strategy
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.	
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	



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IPQR Module 11.3 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

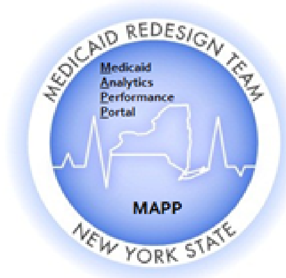
Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found



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

Instructions :

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

The Brooklyn Bridges PPS has identified the following key challenges and risks that could impact our ability to achieve the above-described milestones:

• The State has laid out an extremely tight timeframe to conduct a robust workforce analysis, including the numbers of workers who will need to be retrained or redeployed and the number of new hires. The PPS is also required to present exact numbers of new hires by type and conduct a detailed compensation and benefits analysis. To complete this analysis, the PPS will need to gather detailed information from each of its partners, many of whom are participating in multiple PPSs who will also be seeking similar information. In addition to the Workforce "As Is" analysis, the partners will also be required to respond to IT, clinical project planning and cultural competency survey assessments. Many partners will be overwhelmed with the amount of information they are required to submit to the PPS and may be challenged to return necessary information in the prescribed timeframe. To mitigate this risk, the PPS will align survey assessments, to the maximum extent possible, with other Brooklyn PPSs and will explore the possibility of sharing a vendor with other PPSs to conduct the workforce impact analysis. Furthermore, the heterogeneity of the partners' workforce and compensation systems will make a PPS-wide strategy challenging. Finally, projecting specific numbers of jobs by types many years in the future is challenging. Given the significant transformation of the health system is undergoing due to DSRIP as well as many other economic and political forces these projections will become less accurate further into the future.

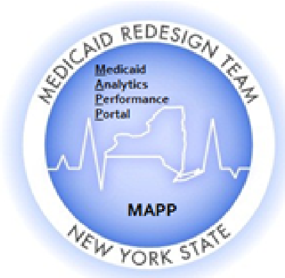
• The PPS may have difficulty recruiting and hiring dedicated professionals, particularly for certain jobs for which there will be demand coming from multiple PPSs across the city.

IPQR Module 11.5 - Major Dependencies on Organizational Workstreams

Instructions :

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

The Workforce Work Stream will be dependent on multiple PPS work streams. The workforce impact analysis and the development of the target workforce state will need to be conducted in close coordination with the clinical project planning team in order to define the types, numbers and locations of needed workers. Workforce training should also be closely coordinated with cultural competency and health literacy training needs and both should be integrated to the maximum extent possible. Workforce will also be dependent on the IT infrastructure to ensure tracking of training programs.



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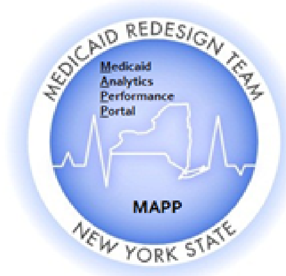
IPQR Module 11.6 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Workforce Impact Analysis Coordinator	Frank Scheets, NYU Lutheran Medical Center	Project management and oversight of Workforce Impact Analysis.
Data Analyst	Kris Batchoo, NYU Lutheran	Provides data support and analysis of workforce data; develops summary reports and analysis for approval.
Workforce Stakeholder Liaison	Jose LaBarca, Lutheran Augustana Center	Provide on-going updates and communication to PPS partners, unions, and workforce on Workforce Impact Analysis.
Workforce Impact Analysis Consultant	BDO	To provide on-going feedback and consultation.
Training Coordinator	Carmen Price, NYU Lutheran	Oversee deployment of workforce training and retraining.
Training Vendors	1199 TEF and possibly others TBD	A training vendor that can provide training modules and/or certification training to support workforce re-training needs.

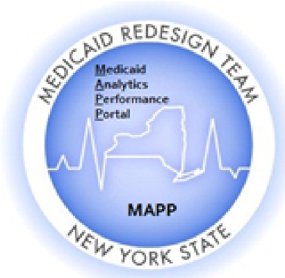


IPQR Module 11.7 - Key Stakeholders

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		
Workforce Staff reporting to Frank Scheets	Monitoring and implementing Workforce steps and ensuring compliance with milestones	Will oversee workforce implementation, quarterly reporting to the State, and monitoring of workforce impact analysis.
External Stakeholders		
1199 SEIU	Training Vendor	Training vendor to provide training modules; 1199 will also be engaged to provide feedback on workforce impact analysis
Other unions	Impacted Members	Provide feedback on workforce impact analysis.
Other Brooklyn PPSs (Maimonides and HHC)	PPS Strategic Partner	Coordinate workforce impact analysis, partner survey collection, training, and compensation and benefit analysis
Partners (includes representatives from FQHCs, NYU Lutheran, physicians, behavioral health agencies, social service agencies and other clinical partners). Key partners to include, but not limited to Lutheran NYU, Lutheran Health, ODA, Addabbo, and Ezra Medical Center.	Participants	Provide critical information to inform workforce impact analysis and participate in trainings.



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.

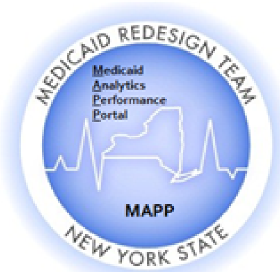
The IT infrastructure that is established will be used to track training progress, including how many people have been trained, the subject of the training and when the training took place. The PPS will leverage IT to provide analytics that support workforce planning and evaluation.

IPQR Module 11.9 - Progress Reporting

Instructions :

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

Success of our workforce strategy will be measured through meeting milestones and quarterly reporting. We will also measure the success of our workforce strategy against meeting the targets of redeployed, retrained, and hired staff and the workforce budget. The PPS will establish a reporting structure that will allow us to track our progress against our milestones.



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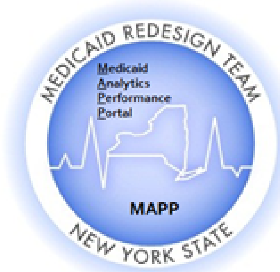
IPQR Module 11.10 - Staff Impact

Instructions :

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

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



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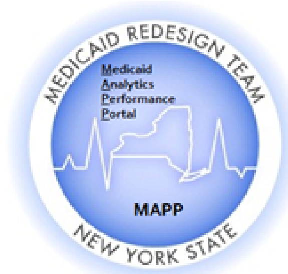
Staff Type	Workforce Staffing Impact Analysis					
	DY1	DY2	DY3	DY4	DY5	Total Impact
Clinical Laboratory Technologists and Technicians	0	0	0	0	0	**0**
Other	0	0	0	0	0	**0**
Behavioral Health (Except Social Workers providing Case/Care Management, etc.)	**0**	**0**	**0**	**0**	**0**	**0**
Psychiatrists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



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

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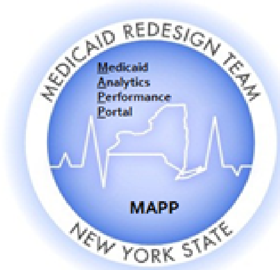
NYU Lutheran Medical Center (PPS ID:32)

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



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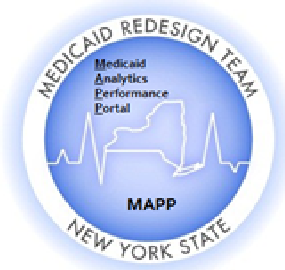
NYU Lutheran Medical Center (PPS ID:32)

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**

NYS Confidentiality – High



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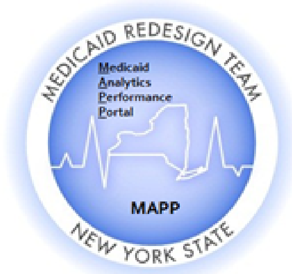
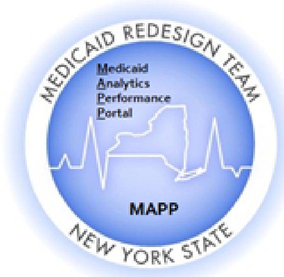


IPQR Module 11.11 - IA Monitoring:

Instructions :



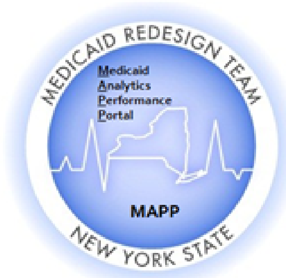
Project 2.a.i – Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management

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

Instructions :

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

1. PCMH Status- Significant funding required to support partners' meeting PCMH NCQA 2014 Level 3 status greater than resources provided by the State; no guarantee partners will buy in/comply. Mitigation: PPS will make best effort to conduct efficiently a current state assessment, develop plan to support deployment of PCMH solutions to eligible providers across the PPS; provide technical assistance to partners; incent providers through fund flow.
2. IT Connectivity- Significant money and expertise required to meet EHR, data sharing and HIE connectivity requirements which may be greater than PPS's resources. Mitigation: PPS will conduct current state assessment to help develop gap analysis, informing which partners to prioritize when expending resources required and timing to support partner's EHR/HIE connectivity implementation; leverage NYU's HIE solution that already connects 26 different EHRs from various institutions; provide technical assistance to partners without existing EHRs; and help establish connectivity to HIE and the RHIO.
3. MCO Contracting- Complexity and considerable legal structural impediments. Collaborative Contracting Model requires that each partner remain autonomous. Mitigation: PPS meeting with MCOs to better coordinate population health efforts and looking possibly to develop shared savings models and other risk-bearing structures with various MCOs. Plan to assist partners in developing the structure and capacity to enter into risk-based contracts.
4. Patient Engagement- Difficulties actively engaging hard to reach patients, many of whom may have little familiarity with the health care system; no insight which individuals comprise Medicaid non- or infrequent utilizers. Mitigation: PPS will actively target said patients through coordinating, training, equipping and deploying Community Health Workers as key element of the community-based patient navigation strategy; partner with CBOs to support outreach and navigation activities that are culturally competent and accessible; develop multilingual patient outreach and education materials.
5. Provider Engagement- Difficulty engaging some providers to follow IDS care coordination protocols, use standardized interventions/ tools and participate in performance management programs. Mitigation: PPS will identify clinical project leaders to serve as project champions and build support across the network leading to move from silos to optimally integrated network. Increase buy- in by including partners in PPS's governance structure. To minimize conflicting demands and over-burdening those providers committed to same projects across multiple PPSs (non-exclusive providers), seek collaboration with other Brooklyn-based PPSs. Select providers to pilot population health resources/tools to identify and track high-risk patients. Refine/ launch tools, resources and protocols across PPS based on feedback; provide technical assistance to those who struggle with implementing IDS requirements. Develop incentive programs and a communication plan to solicit feedback.
6. Data- Significant risk in State not transmitting timely, accurate, valid, & meaningful recent patient-specific data on our attributable population required for population health management. Mitigation- None available.



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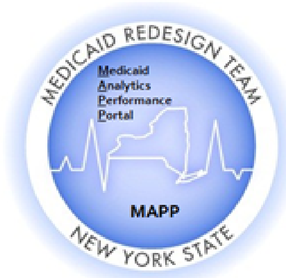
NYU Lutheran Medical Center (PPS ID:32)

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	Not Started	10/01/2015	09/30/2018	01/01/2016	09/30/2018	09/30/2018	DY4 Q2
Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.	Project		Not Started	10/01/2015	09/30/2018	01/01/2016	09/30/2018	09/30/2018	DY4 Q2
Task Step 1. Complete contracting with all PPS providers to ensure a robust integrated delivery system.	Project		Not Started	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. 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. Ensure that the milestone has been completed.	Project		Not Started	10/01/2015	09/30/2018	01/01/2016	09/30/2018	09/30/2018	DY4 Q2
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	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS produces a list of participating HHs and ACOs.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Participating HHs and ACOs demonstrate real service	Project		Not Started	10/01/2015	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4



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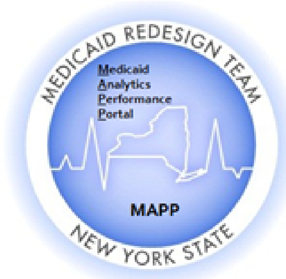
NYU Lutheran Medical Center (PPS ID:32)

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
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.	Project		Not Started	10/01/2015	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Continue to contract with the Brooklyn Health Home (BHH) for those patients who are HH-eligible.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. Conduct regular coordination meetings between the BHH and Brooklyn Bridges PPS.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3. Identify how PPS partners can best utilize BHH for appropriate PPS attributed patients or become HH providers.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Utilize Brooklyn Bridges PPS population health management system to identify appropriate health home patients.	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS. Ensure that the milestone has been completed.	Project		Not Started	10/01/2015	03/31/2017	01/01/2016	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	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	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		Not Started	10/01/2015	03/31/2017	01/01/2016	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	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task	Project		Not Started	10/01/2015	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4



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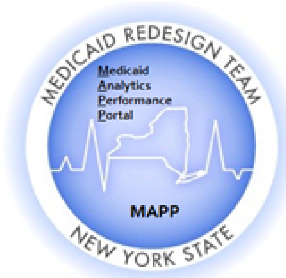
NYU Lutheran Medical Center (PPS ID:32)

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 trains staff on IDS protocols and processes.									
Task Step 1. Conduct an assessment of providers to identify best practices and lessons learned in care coordination protocols that could be expanded across the PPS.	Project		Not Started	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Establish PPS-wide clinical pathways for care coordination, with the Patient Navigation Center (PNC) as the coordinating hub of many care transitions.	Project		Not Started	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 3. Select sites/clinical programs to pilot and evaluate new care coordination models and protocols. Identify lessons learned and modify care coordination protocols for scheduled deployment across the PPS.	Project		Not Started	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4. Develop PPS-wide training program to roll out and support implementation of care coordination protocols.	Project		Not Started	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Design and deploy communication strategies to PPS partners, including community based organizations, to educate patients on how to use and navigate services at the Brooklyn Bridges PPS.	Project		Not Started	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 6. Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network (see IT section for details).	Project		Not Started	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 7. Communicate expectations and timeframes for achieving PPS-wide connectivity.	Project		Not Started	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 8. 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 the milestone has been completed.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 9. PPS will consider collaboration with MCOs, HHs, OPDs PEER advocacy organizations and residential providers that serve SMI individuals to expand access to clientele to educate and engage.	Project		Not Started	10/01/2015	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4



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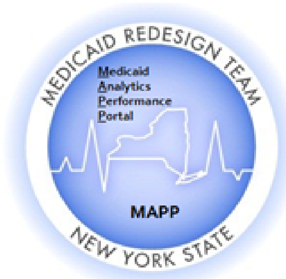
NYU Lutheran Medical Center (PPS ID:32)

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 #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	Project	N/A	In Progress	10/01/2015	03/31/2018	10/01/2015	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	10/01/2015	03/31/2018	10/01/2015	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	10/01/2015	03/31/2018	10/01/2015	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	10/01/2015	03/31/2018	10/01/2015	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	10/01/2015	03/31/2018	10/01/2015	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	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.	Project		Not Started	10/01/2015	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Complete current state assessment of interoperability and HIE requirements across the PPS safety net providers.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Identify gaps highlighting where PPS safety net members' EHRs fail to meet RHIO's HIE and SHIN-NY connectivity requirements.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network (see IT section for details).	Project		Not Started	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4. Identify resources and expertise required to implement HIE connectivity plan for PPS safety net provider partners.	Project		Not Started	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task	Project		Not Started	10/01/2015	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4



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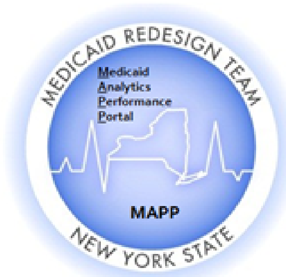
Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 5. Implement plan and achieve HIE connectivity across PPS safety net provider partners.									
Milestone #5 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	10/01/2015	03/31/2018	10/01/2015	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		Not Started	10/01/2015	03/31/2018	01/01/2016	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	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Complete current state assessment of EHR systems' MU certification and PCMH Level 3 standards across the PPS.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Identify gaps highlighting where PPS members' EHRs fail to meet MU and PCMH Level 3 certification requirements.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Develop roadmap to achieving EHR MU & PCMH Level 3 certification requirements across PPS provider partners.	Project		Not Started	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4. Work with Partners to identify resources and expertise required to implement EHR MU & PCMH Level 3 certification plan for PPS provider partners.	Project		Not Started	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Implement plan and support partners in completing their EHR MU & PCMH certification requirements.	Project		Not Started	10/01/2015	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	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	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Complete current state assessment of patient registries	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4



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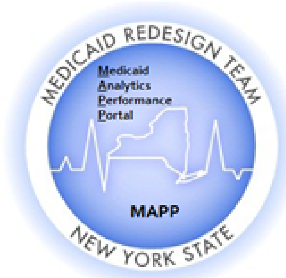
Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
active across the PPS safety net provider network, identifying the registry's objectives, data sources, architecture and users.									
Task Step 2. Identify gaps highlighting where a) current registries do not exist to meet PPS's clinical project requirements and target PPS populations, and, b) PPS safety net partners cannot easily upload appropriate patient data to a patient registry.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. Develop roadmap to achieving expansion and/or establishment of patient registries for clinical projects and target populations across the PPS safety net partners.	Project		Not Started	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4. Identify resources, timing and expertise required to implement the patient registry plan for PPS safety net provider partners.	Project		Not Started	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Implement plan across PPS safety net partners.	Project		Not Started	10/01/2015	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	Project	N/A	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.	Project		Not Started	10/01/2015	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	10/01/2015	03/31/2018	10/01/2015	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		Not Started	10/01/2015	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Complete current state assessment of EHR systems' MU certification and 2014 Level 3 PCMH standards across the PPS	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Identify gaps highlighting where PPS members' fail to meet EHR MU and 2014 PCMH Level 3 certification	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

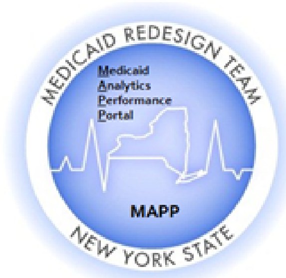


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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
requirements.									
Task Step 3. Develop roadmap to achieving EHR MU & 2014 PCMH Level 3 certification requirements across PPS provider partners.	Project		Not Started	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 4. Work with Partners to identify resources and expertise required to implement EHR MU & 2014 PCMH Level 3 certification plan for PPS provider partners.	Project		Not Started	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 5. Implement plan and support partners in completing EHR MU and 2014 PCMH Level 3 certification requirements.	Project		Not Started	10/01/2015	12/31/2017	04/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task Step 6. Confirm that partners have met EHR MU and 2014 PCMH Level 3 and/or APCM standards by the end of DY3.	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	Not Started	10/01/2015	09/30/2018	01/01/2016	09/30/2018	09/30/2018	DY4 Q2
Task Medicaid Managed Care contract(s) are in place that include value-based payments.	Project		Not Started	10/01/2015	09/30/2018	01/01/2016	09/30/2018	09/30/2018	DY4 Q2
Task Step 1. Understand current MCO contracts in place and identify opportunities to expand value-based contracting arrangements across providers and target populations.	Project		Not Started	10/01/2015	03/31/2016	01/01/2016	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		Not Started	10/01/2015	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Determine structure of legal entity (or entities) to be created for contracting.	Project		Not Started	10/01/2015	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 4. Negotiate contracts with at least one MCO. Selected MCOs must be willing to support clinical project interventions, such as timely access to claims data for reporting and implementation of clinical care and coordination protocols.	Project		Not Started	10/01/2015	09/30/2018	01/01/2016	09/30/2018	09/30/2018	DY4 Q2
Task	Project		Not Started	10/01/2015	09/30/2018	04/01/2016	09/30/2018	09/30/2018	DY4 Q2

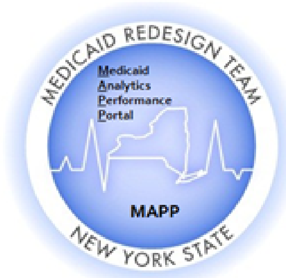


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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. Implement expanded 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	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Identify MCOs with which to schedule regular progress meetings.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Launch and conduct regular meetings to track PPS's utilization trends, performance metrics and flag issues to be addressed by the PPS leadership, MCO or both parties, collaboratively.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. 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. Ensure that the milestone has been completed.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	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	Not Started	10/01/2015	09/30/2018	01/01/2016	09/30/2018	09/30/2018	DY4 Q2
Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation	Project		Not Started	10/01/2015	09/30/2018	04/01/2016	09/30/2018	09/30/2018	DY4 Q2
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.	Project		Not Started	10/01/2015	09/30/2018	01/01/2016	09/30/2018	09/30/2018	DY4 Q2
Task Step 1. Identify current models being used in the PPS.	Project		Not Started	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2. Identify stakeholders who should be involved in each step of value based payment reform.	Project		Not Started	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 3. Develop provider incentive-based compensation	Project		Not Started	10/01/2015	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4



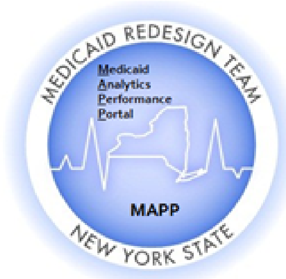
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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
model(s) to be implemented by PPS partners or across PPS clinical programs that reward achievement of patient outcomes.									
Task Step 4. Pilot and evaluate new incentive-based compensation models.	Project		Not Started	10/01/2015	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 5. Expand implementation of provider incentive-based compensation models.	Project		Not Started	10/01/2015	09/30/2018	04/01/2016	09/30/2018	09/30/2018	DY4 Q2
Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	Project	N/A	Not Started	10/01/2015	09/30/2018	01/01/2016	09/30/2018	09/30/2018	DY4 Q2
Task Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.	Project		Not Started	10/01/2015	09/30/2018	01/01/2016	09/30/2018	09/30/2018	DY4 Q2
Task Step 1. Develop objectives and components of the community outreach plan to achieve patient engagement with the PPS.	Project		Not Started	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Identify the timing, resource requirements, CHW recruitment/retraining strategies and culturally-competent expertise to launch the community outreach plan.	Project		Not Started	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. Implement the community outreach plan.	Project		Not Started	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4. 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		Not Started	10/01/2015	09/30/2017	04/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 5. Review impact of community outreach activities upon the PPS communities served and refine patient engagement interventions, accordingly	Project		Not Started	10/01/2015	09/30/2018	04/01/2016	09/30/2018	09/30/2018	DY4 Q2

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-										

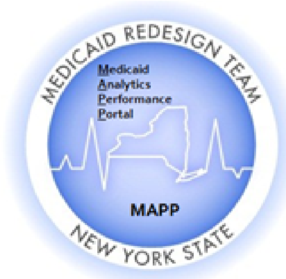


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
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. Complete contracting with all PPS providers to ensure a robust integrated delivery system.										
Task Step 2. 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. Ensure that the milestone has been completed.										
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. Continue to contract with the Brooklyn Health Home (BHH) for those patients who are HH-eligible.										
Task Step 2. Conduct regular coordination meetings between the BHH and Brooklyn Bridges PPS.										
Task Step 3. Identify how PPS partners can best utilize BHH for appropriate PPS attributed patients or become HH providers.										
Task Step 4. Utilize Brooklyn Bridges PPS population health management system to identify appropriate health home patients.										



New York State Department Of Health
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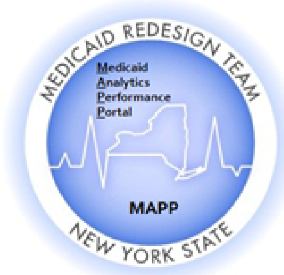
NYU Lutheran Medical Center (PPS ID:32)

Project 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. Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS. Ensure that the milestone has been completed.										
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. Conduct an assessment of providers to identify best practices and lessons learned in care coordination protocols that could be expanded across the PPS.										
Task Step 2. Establish PPS-wide clinical pathways for care coordination, with the Patient Navigation Center (PNC) as the coordinating hub of many care transitions.										
Task Step 3. Select sites/clinical programs to pilot and evaluate new care coordination models and protocols. Identify lessons learned and modify care coordination protocols for scheduled deployment across the PPS.										
Task Step 4. Develop PPS-wide training program to roll out and support implementation of care coordination protocols.										
Task Step 5. Design and deploy communication strategies to PPS partners, including community based organizations, to educate patients on how to use and navigate services at the Brooklyn Bridges PPS.										
Task Step 6. Develop roadmap to achieving clinical data sharing and										

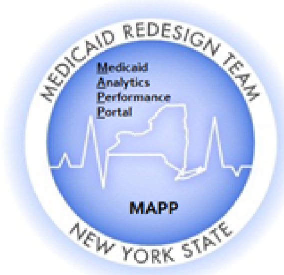


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
interoperable systems across PPS network (see IT section for details).										
Task Step 7. Communicate expectations and timeframes for achieving PPS-wide connectivity.										
Task Step 8. 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 the milestone has been completed.										
Task Step 9. PPS will consider collaboration with MCOs, HHs, OPDs PEER advocacy organizations and residential providers that serve SMI individuals to expand access to clientele to educate and engage.										
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	0	19	47
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	24	61
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	1	1
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	8	20
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	3	8
Task PPS uses alerts and secure messaging functionality.										
Task Step 1. Complete current state assessment of interoperability and HIE requirements across the PPS safety net providers.										
Task Step 2. Identify gaps highlighting where PPS safety net members' EHRs fail to meet RHIO's HIE and SHIN-NY										



New York State Department Of Health
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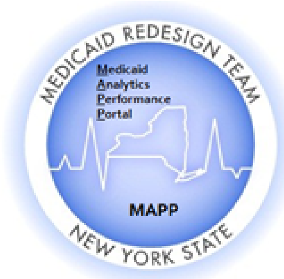
DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
connectivity requirements.										
Task Step 3. Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network (see IT section for details).										
Task Step 4. Identify resources and expertise required to implement HIE connectivity plan for PPS safety net provider partners.										
Task Step 5. Implement plan and achieve HIE connectivity across PPS safety net provider partners.										
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	5	19	37	56	75	94	131
Task Step 1. Complete current state assessment of EHR systems' MU certification and PCMH Level 3 standards across the PPS.										
Task Step 2. Identify gaps highlighting where PPS members' EHRs fail to meet MU and PCMH Level 3 certification requirements.										
Task Step 3. Develop roadmap to achieving EHR MU & PCMH Level 3 certification requirements across PPS provider partners.										
Task Step 4. Work with Partners to identify resources and expertise required to implement EHR MU & PCMH Level 3 certification plan for PPS provider partners.										
Task Step 5. Implement plan and support partners in completing their EHR MU & PCMH certification requirements.										
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										



New York State Department Of Health
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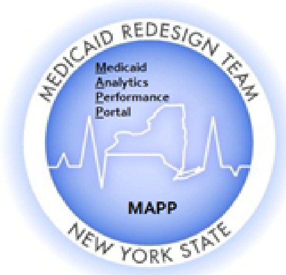
NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
able to track actively engaged patients for project milestone reporting.										
Task Step 1. Complete current state assessment of patient registries active across the PPS safety net provider network, identifying the registry's objectives, data sources, architecture and users.										
Task Step 2. Identify gaps highlighting where a) current registries do not exist to meet PPS's clinical project requirements and target PPS populations, and, b) PPS safety net partners cannot easily upload appropriate patient data to a patient registry.										
Task Step 3. Develop roadmap to achieving expansion and/or establishment of patient registries for clinical projects and target populations across the PPS safety net partners.										
Task Step 4. Identify resources, timing and expertise required to implement the patient registry plan for PPS safety net provider partners.										
Task Step 5. Implement plan across PPS safety net partners.										
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	5	39	78	118	157	196	274
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. Complete current state assessment of EHR systems' MU certification and 2014 Level 3 PCMH standards across the PPS										
Task Step 2. Identify gaps highlighting where PPS members' fail to meet EHR MU and 2014 PCMH Level 3 certification requirements.										



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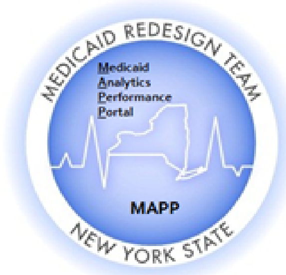
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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. Develop roadmap to achieving EHR MU & 2014 PCMH Level 3 certification requirements across PPS provider partners.										
Task Step 4. Work with Partners to identify resources and expertise required to implement EHR MU & 2014 PCMH Level 3 certification plan for PPS provider partners.										
Task Step 5. Implement plan and support partners in completing EHR MU and 2014 PCMH Level 3 certification requirements.										
Task Step 6. Confirm that partners have met EHR MU and 2014 PCMH Level 3 and/or APCM standards by the end of DY3.										
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. Understand 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 contracts with at least one MCO. Selected MCOs must be willing to support clinical project interventions, such as timely access to claims data for reporting and implementation of clinical care and coordination protocols.										
Task Step 5. Implement expanded 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										



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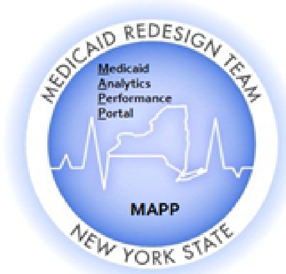
NYU Lutheran Medical Center (PPS ID:32)

Project 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 evaluate utilization trends and performance issues and ensure payment reforms are instituted.										
Task Step 1. Identify MCOs with which to schedule regular progress meetings.										
Task Step 2. Launch and conduct regular meetings to track PPS's utilization trends, performance metrics and flag issues to be addressed by the PPS leadership, MCO or both parties, collaboratively.										
Task Step 3. 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. Ensure that the milestone has been completed.										
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 models being used in the PPS.										
Task Step 2. Identify stakeholders who should be involved in each step of value based payment reform.										
Task Step 3. Develop provider incentive-based compensation model(s) to be implemented by PPS partners or across PPS clinical programs that reward achievement of patient outcomes.										
Task Step 4. Pilot and evaluate new incentive-based compensation models.										
Task Step 5. Expand implementation of provider incentive-based compensation models.										
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.										



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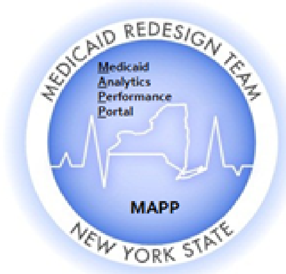
NYU Lutheran Medical Center (PPS ID:32)

Project 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 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.										
Task Step 2. Identify the timing, resource requirements, CHW recruitment/retraining strategies and culturally-competent expertise to launch the community outreach plan.										
Task Step 3. Implement the community outreach plan.										
Task Step 4. 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.										
Task Step 5. Review impact of community outreach activities upon the PPS communities served and refine patient engagement interventions, accordingly										

Project 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. Complete contracting with all PPS providers to ensure a robust integrated delivery system.										
Task Step 2. 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. Ensure that the milestone has										

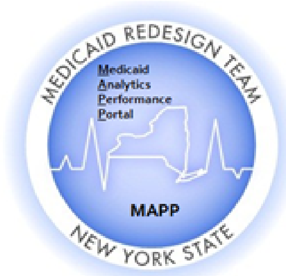


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
been completed.										
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. Continue to contract with the Brooklyn Health Home (BHH) for those patients who are HH-eligible.										
Task Step 2. Conduct regular coordination meetings between the BHH and Brooklyn Bridges PPS.										
Task Step 3. Identify how PPS partners can best utilize BHH for appropriate PPS attributed patients or become HH providers.										
Task Step 4. Utilize Brooklyn Bridges PPS population health management system to identify appropriate health home patients.										
Task Step 5. Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS. Ensure that the milestone has been completed.										
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.										

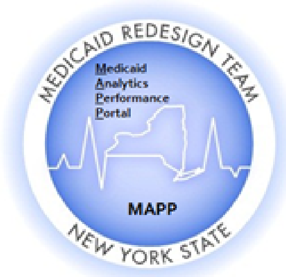


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.										
Task PPS trains staff on IDS protocols and processes.										
Task Step 1. Conduct an assessment of providers to identify best practices and lessons learned in care coordination protocols that could be expanded across the PPS.										
Task Step 2. Establish PPS-wide clinical pathways for care coordination, with the Patient Navigation Center (PNC) as the coordinating hub of many care transitions.										
Task Step 3. Select sites/clinical programs to pilot and evaluate new care coordination models and protocols. Identify lessons learned and modify care coordination protocols for scheduled deployment across the PPS.										
Task Step 4. Develop PPS-wide training program to roll out and support implementation of care coordination protocols.										
Task Step 5. Design and deploy communication strategies to PPS partners, including community based organizations, to educate patients on how to use and navigate services at the Brooklyn Bridges PPS.										
Task Step 6. Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network (see IT section for details).										
Task Step 7. Communicate expectations and timeframes for achieving PPS-wide connectivity.										
Task Step 8. 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 the milestone has been completed.										
Task Step 9. PPS will consider collaboration with MCOs, HHs, OPDs PEER advocacy organizations and residential providers that serve SMI individuals to expand access to clientele to educate and engage.										

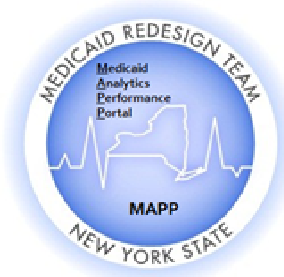


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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 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.	94	187	187	187	187	187	187	187	187	187
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	122	244	244	244	244	244	244	244	244	244
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	1	1	1	5	5	5	5	5	5	5
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	40	79	79	79	79	79	79	79	79	79
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	16	32	32	32	32	32	32	32	32	32
Task PPS uses alerts and secure messaging functionality.										
Task Step 1. Complete current state assessment of interoperability and HIE requirements across the PPS safety net providers.										
Task Step 2. Identify gaps highlighting where PPS safety net members' EHRs fail to meet RHIO's HIE and SHIN-NY connectivity requirements.										
Task Step 3. Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network (see IT section for details).										
Task Step 4. Identify resources and expertise required to implement HIE connectivity plan for PPS safety net provider partners.										
Task Step 5. Implement plan and achieve HIE connectivity across PPS safety net provider partners.										
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.										

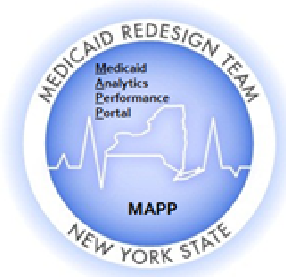


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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.	150	187	187	187	187	187	187	187	187	187
Task Step 1. Complete current state assessment of EHR systems' MU certification and PCMH Level 3 standards across the PPS.										
Task Step 2. Identify gaps highlighting where PPS members' EHRs fail to meet MU and PCMH Level 3 certification requirements.										
Task Step 3. Develop roadmap to achieving EHR MU & PCMH Level 3 certification requirements across PPS provider partners.										
Task Step 4. Work with Partners to identify resources and expertise required to implement EHR MU & PCMH Level 3 certification plan for PPS provider partners.										
Task Step 5. Implement plan and support partners in completing their EHR MU & PCMH certification requirements.										
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. Complete current state assessment of patient registries active across the PPS safety net provider network, identifying the registry's objectives, data sources, architecture and users.										
Task Step 2. Identify gaps highlighting where a) current registries do not exist to meet PPS's clinical project requirements and target PPS populations, and, b) PPS safety net partners cannot easily upload appropriate patient data to a patient registry.										
Task Step 3. Develop roadmap to achieving expansion and/or establishment of patient registries for clinical projects and target populations across the PPS safety net partners.										

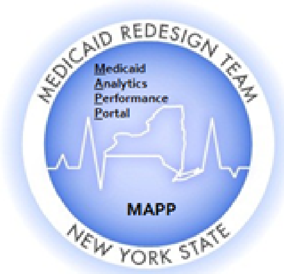


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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. Identify resources, timing and expertise required to implement the patient registry plan for PPS safety net provider partners.										
Task Step 5. Implement plan across PPS safety net partners.										
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.	314	392	392	392	392	392	392	392	392	392
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. Complete current state assessment of EHR systems' MU certification and 2014 Level 3 PCMH standards across the PPS										
Task Step 2. Identify gaps highlighting where PPS members' fail to meet EHR MU and 2014 PCMH Level 3 certification requirements.										
Task Step 3. Develop roadmap to achieving EHR MU & 2014 PCMH Level 3 certification requirements across PPS provider partners.										
Task Step 4. Work with Partners to identify resources and expertise required to implement EHR MU & 2014 PCMH Level 3 certification plan for PPS provider partners.										
Task Step 5. Implement plan and support partners in completing EHR MU and 2014 PCMH Level 3 certification requirements.										
Task Step 6. Confirm that partners have met EHR MU and 2014 PCMH Level 3 and/or APCM standards by the end of DY3.										
Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish										

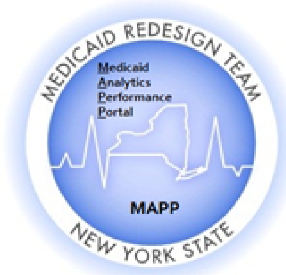


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
value-based payment arrangements.										
Task Medicaid Managed Care contract(s) are in place that include value-based payments.										
Task Step 1. Understand 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 contracts with at least one MCO. Selected MCOs must be willing to support clinical project interventions, such as timely access to claims data for reporting and implementation of clinical care and coordination protocols.										
Task Step 5. Implement expanded 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 regular progress meetings.										
Task Step 2. Launch and conduct regular meetings to track PPS's utilization trends, performance metrics and flag issues to be addressed by the PPS leadership, MCO or both parties, collaboratively.										
Task Step 3. 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										

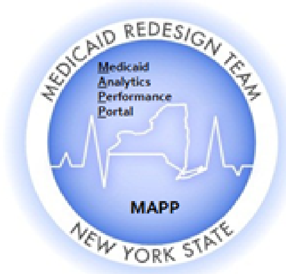


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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 DY 3. Ensure that the milestone has been completed.										
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 models being used in the PPS.										
Task Step 2. Identify stakeholders who should be involved in each step of value based payment reform.										
Task Step 3. Develop provider incentive-based compensation model(s) to be implemented by PPS partners or across PPS clinical programs that reward achievement of patient outcomes.										
Task Step 4. Pilot and evaluate new incentive-based compensation models.										
Task Step 5. Expand implementation of provider incentive-based compensation models.										
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.										
Task Step 2. Identify the timing, resource requirements, CHW recruitment/retraining strategies and culturally-competent expertise to launch the community outreach plan.										
Task Step 3. Implement the community outreach plan.										
Task Step 4. 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

NYU Lutheran Medical Center (PPS ID:32)

Project 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.										
Task Step 5. Review impact of community outreach activities upon the PPS communities served and refine patient engagement interventions, accordingly										

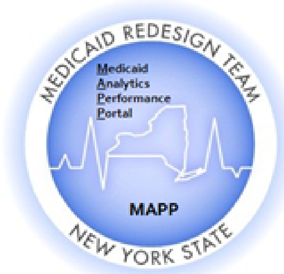
Prescribed Milestones Current File Uploads

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.	

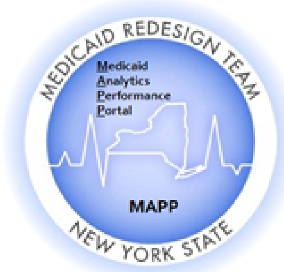


Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	
Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	
Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	
Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	
Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	

Milestone Review Status

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

NYU Lutheran Medical Center (PPS ID:32)

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

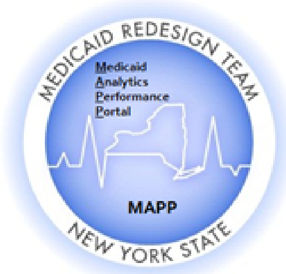
Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found



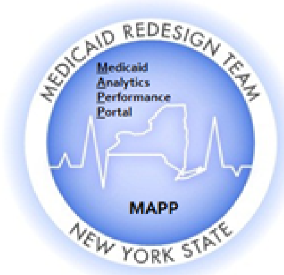
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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

NYU Lutheran Medical Center (PPS ID:32)

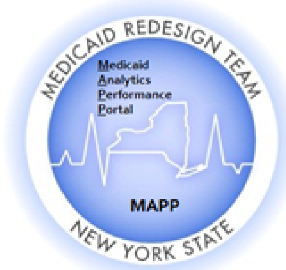
Project 2.b.iii – ED care triage for at-risk populations

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

Instructions :

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

1. Patient Engagement & Acceptance- Patient behavior is extremely difficult to change, especially in the short period of time required. Mitigation: The PPS will oversee the development of enhanced clinical pathways and training of staff in collaboration with partners to address social issues that drive ED frequent flyers; utilize patient tracking and compliance tools to identify hard to engage patients; prioritize hard to engage populations, based on scale, urgent need and potential impact of targeted, intensified intervention by the PNC, EDs and/or PCMHs; develop care navigation strategies, outreach, expertise and tools with which to engage and manage these ED frequent utilizer population and will develop multilingual patient outreach and education materials with a focus on the availability of primary care services in the community. In addition, as part of the PNC (2.c.i) project, the PPS will develop a Community Resource Guide, which will distinguish between MH and SUD providers in our network to guide quality patient referrals.
2. Existing Legal Structures- Federal EMTALA requirements, including screening/treating/stabilizing/transferring all patients who enter the ED. Mitigation: None available.
3. Infrastructure Development Time - Delay in the implementation of PNC will impede efficient and timely scheduling and tracking of patients going to an ED to PCPs across the PPS. Mitigation: The PPS will leverage NYU Lutheran's existing EHR and open-access scheduling to schedule and track follow-up appointments with PCPs; have case managers follow up with each patient's PCMH (as applicable) to schedule a follow-up appointment; case managers to identify the most appropriate PCMH location for follow-up PCP appointment and scheduling for patients without a PCP. Because IT/EHR systems among and between providers are separate and distinct, BB PPS will work with the NYU Langone IT Department to support integration and data exchange between systems.
4. Provider Engagement- Providers may resist adoption of standardized ED Care Triage project protocols. Mitigation: PPS will identify clinical project leaders to serve as project champions and liaise with partner champions to build support across the PPS provider network; engage partner providers to design and agree on standardized protocols to meet project requirements; optimize EMR and HIE functionality.
5. PCP Capacity- Insufficient number of PCPs available in the City, and existing practices cannot take on additional patients; Medicaid reimbursement structure to PCPs Mitigation: PPS will conduct an assessment to identify current capacity and analyze possible shortage areas and brainstorm ideas with provider practices to ease capacity issues, e.g. extend after-hours PCP availability in FQHCs and DTCs across the network where possible.
6. Data- Significant risk in State not transmitting timely, accurate, valid, & meaningful recent patient-specific data on our attributable population required to target patients in need for ED Care Triage services. Mitigation- None available.



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	6,056

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
2,121	3,555	167.69%	-1,435	58.70%

Current File Uploads

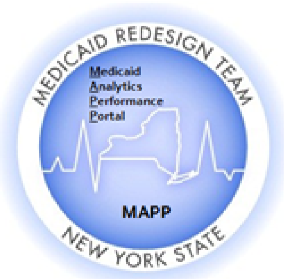
User ID	File Type	File Name	File Description	Upload Date
dbudman	Documentation/Certification	32_PMDL2715_1_3_20160115145851_2.b.iii_-_DY1,_Q3.pdf	Patient Engagement - DY1, Q3 Project - 2.b.iii - ED care triage for at-risk populations	01/15/2016 02:59 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	



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

DSRIP Implementation Plan Project

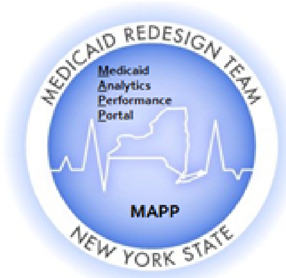
NYU Lutheran Medical Center (PPS ID:32)

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	05/01/2015	03/31/2018	05/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Stand up program based on project requirements	Project		In Progress	05/01/2015	03/31/2018	05/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Conduct a current state assessment at Lutheran MC ED and NYU Cobble Hill ED to understand current ED discharge workflows and processes related to ED screening, patient education, ED discharge and scheduling post-ED follow-up visits with primary care providers.	Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. Review research on effective strategies for reducing ED readmissions and for educating patients on proper use of the ED.	Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 3. Interview ED patients to get a better understanding what would encourage them to use primary care resources instead of the ED.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4. Develop patient education strategies on appropriate use of the ED based on key findings from patient survey in Step 3	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 5. Roll out patient education strategies with community partners	Project		Not Started	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 6. Develop a plan for a PPS ED discharge program that provides LMC and Cobble Hill ED patients with the following upon discharge: 1. Education on appropriate ED use 2. A scheduled appointment with a primary care provider of their choice	Project		Not Started	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4

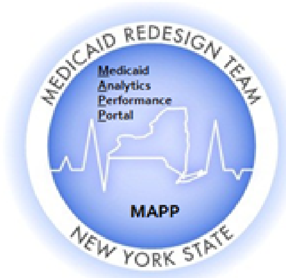


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
3. Enroll all eligible patients into health home 4. SBIRT screening to identify potential ED "frequent fliers" appropriate for referral to substance abuse care.									
Task Step 7. Identify ED discharge program lead	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 8. Determine resource needs to successfully implement the discharge program.	Project		Not Started	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 9. Recruit, train and assign staff to discharge unit	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 10. Train ED nurses and case managers on new ED discharge procedures.	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 11. Begin conducting ED care triage services at LMC	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 12. Begin conducting ED care triage services at Cobble Hill	Project		Not Started	04/01/2017	06/30/2017	04/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task Step 13. Initiate dialogue with skilled nursing facilities to reduce unnecessary ED visits and admissions.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 14. Engage ED care triage workgroup to review ED care triage performance	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 15. Identify continuous quality improvement initiatives	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable	Project	N/A	In Progress	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	Provider	Safety Net Practitioner - Primary Care Provider	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4



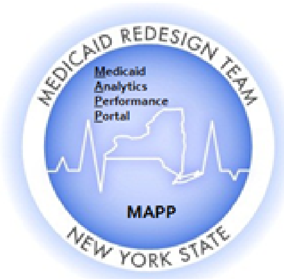
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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
standards.		(PCP)							
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		Not Started	10/01/2015	03/31/2018	01/01/2016	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)	Not Started	10/01/2015	03/31/2018	01/01/2016	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	Not Started	10/01/2015	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Conduct a current state assessment to determine which community primary care providers in the PPS will meet NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards or will meet them by DSRIP Year 3.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Establish partnerships with providers identified in Step 1.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. Engage the IT Sub-Committee to: 1. Establish connectivity between participating EDs and providers identified in Step 1 2. Build real time notifications to Health Home care managers as applicable Note: These steps will be implemented in phases.	Project		Not Started	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 4. Employ the Patient Navigation Center (PNC)/Care Management strategy to coordinate open access scheduling between participating EDs and providers identified in Step 1.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and	Project	N/A	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4

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
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.	Project		Not Started	10/01/2015	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Develop a network of primary care providers throughout the PPS community to serve as a central referral list for ED patients without a primary care provider.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Develop protocols for discharge management to assist ED patients with: 1. Receiving an immediate appointment with a primary care provider. 2. Identifying and accessing needed community support resources. 3. Receiving a timely appointment with a primary care provider (if the patient has an established relationships with a primary care physician) 4. Receiving appropriate reminders of scheduled appointments 5. Determining if local PPS CHWs are required to educate and/or accompany some "frequent flier" ED patients to referred primary care site	Project		Not Started	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Train staff on protocols developed in Step 2.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Evaluate success of providing patients with timely access primary care providers and determine if any revisions, training, or communication interventions are needed	Project		Not Started	03/31/2017	03/31/2018	03/31/2017	03/31/2018	03/31/2018	DY3 Q4
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	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

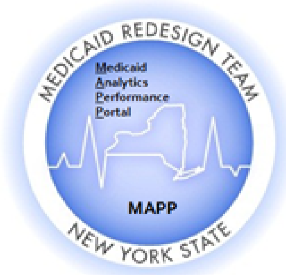


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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
optional.)									
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	01/01/2016	03/31/2017	10/01/2015	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	01/01/2016	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Complete current state assessment of EHRs and ED patient registries in use across the PPS primary care provider network.	Project		In Progress	01/01/2016	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Identify gaps highlighting where a) current registries do not exist to meet PPS's clinical project requirements and target PPS populations; b) PPS primary care partners cannot easily upload appropriate EHR patient data to a patient registry; and c) PPS PCP partner organizations cannot make their schedules available to the PPS Patient Navigation Center for appointment scheduling	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. Develop roadmap to achieving expansion and/or establishment of patient registries, ability to identify "high risk" ED frequent fliers, ability for the PNC to access provider organizations' appointment schedules and EHR capabilities to track engaged ED visit populations across PPS primary care partners	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4. Identify resources, timing and expertise required to implement the patient registry plan for PPS primary care partners.	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Implement plan across PPS primary care partners	Project		Not Started	06/01/2016	03/31/2017	06/01/2016	03/31/2017	03/31/2017	DY2 Q4



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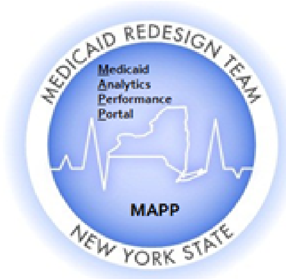
NYU Lutheran Medical Center (PPS ID:32)

Project 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. Conduct a current state assessment at Lutheran MC ED and NYU Cobble Hill ED to understand current ED discharge workflows and processes related to ED screening, patient education, ED discharge and scheduling post-ED follow-up visits with primary care providers.										
Task Step 2. Review research on effective strategies for reducing ED readmissions and for educating patients on proper use of the ED.										
Task Step 3. Interview ED patients to get a better understanding what would encourage them to use primary care resources instead of the ED.										
Task Step 4. Develop patient education strategies on appropriate use of the ED based on key findings from patient survey in Step 3										
Task Step 5. Roll out patient education strategies with community partners										
Task Step 6. Develop a plan for a PPS ED discharge program that provides LMC and Cobble Hill ED patients with the following upon discharge: 1. Education on appropriate ED use 2. A scheduled appointment with a primary care provider of their choice 3. Enroll all eligible patients into health home 4. SBIRT screening to identify potential ED "frequent fliers" appropriate for referral to substance abuse care.										
Task Step 7. Identify ED discharge program lead										
Task Step 8. Determine resource needs to successfully implement the discharge program.										
Task Step 9. Recruit, train and assign staff to discharge unit										
Task Step 10. Train ED nurses and case managers on new ED discharge procedures.										
Task Step 11. Begin conducting ED care triage services at LMC										



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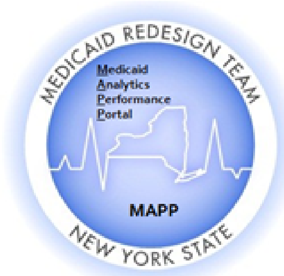
NYU Lutheran Medical Center (PPS ID:32)

Project 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 12. Begin conducting ED care triage services at Cobble Hill										
Task Step 13. Initiate dialogue with skilled nursing facilities to reduce unnecessary ED visits and admissions.										
Task Step 14. Engage ED care triage workgroup to review ED care triage performance										
Task Step 15. Identify continuous quality improvement initiatives										
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	5	16	33	49	66	82	115
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	0	16	41
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	0	0	0	0	0	0	0	0	1	1
Task Step 1. Conduct a current state assessment to determine which community primary care providers in the PPS will meet NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards or will meet them by DSRIP Year 3.										
Task Step 2. Establish partnerships with providers identified in Step 1.										
Task Step 3. Engage the IT Sub-Committee to:										



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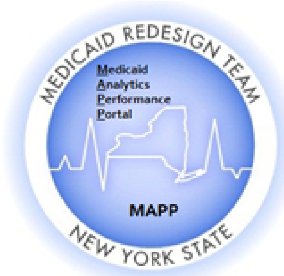
NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
1. Establish connectivity between participating EDs and providers identified in Step 1 2. Build real time notifications to Health Home care managers as applicable Note: These steps will be implemented in phases.										
Task Step 4. Employ the Patient Navigation Center (PNC)/Care Management strategy to coordinate open access scheduling between participating EDs and providers identified in Step 1.										
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. Develop a network of primary care providers throughout the PPS community to serve as a central referral list for ED patients without a primary care provider.										
Task Step 2. Develop protocols for discharge management to assist ED patients with: 1. Receiving an immediate appointment with a primary care provider. 2. Identifying and accessing needed community support resources. 3. Receiving a timely appointment with a primary care provider (if the patient has an established relationships with a primary care physician) 4. Receiving appropriate reminders of scheduled appointments 5. Determining if local PPS CHWs are required to educate and/or accompany some "frequent flier" ED patients to referred primary care site										



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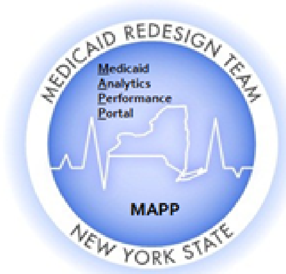
NYU Lutheran Medical Center (PPS ID:32)

Project 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. Train staff on protocols developed in Step 2.										
Task Step 4. Evaluate success of providing patients with timely access primary care providers and determine if any revisions, training, or communication interventions are 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. Complete current state assessment of EHRs and ED patient registries in use across the PPS primary care provider network.										
Task Step 2. Identify gaps highlighting where a) current registries do not exist to meet PPS's clinical project requirements and target PPS populations; b) PPS primary care partners cannot easily upload appropriate EHR patient data to a patient registry; and c) PPS PCP partner organizations cannot make their schedules available to the PPS Patient Navigation Center for appointment scheduling										
Task Step 3. Develop roadmap to achieving expansion and/or establishment of patient registries, ability to identify "high risk" ED frequent fliers, ability for the PNC to access provider organizations' appointment schedules and EHR capabilities to track engaged ED visit populations across PPS primary care partners										
Task Step 4. Identify resources, timing and expertise required to implement the patient registry plan for PPS primary care partners.										



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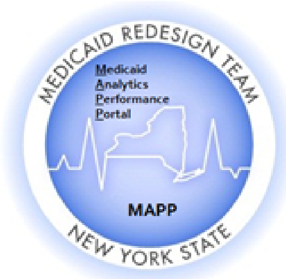
NYU Lutheran Medical Center (PPS ID:32)

Project 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. Implement plan across PPS primary care partners										

Project 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. Conduct a current state assessment at Lutheran MC ED and NYU Cobble Hill ED to understand current ED discharge workflows and processes related to ED screening, patient education, ED discharge and scheduling post-ED follow-up visits with primary care providers.										
Task Step 2. Review research on effective strategies for reducing ED readmissions and for educating patients on proper use of the ED.										
Task Step 3. Interview ED patients to get a better understanding what would encourage them to use primary care resources instead of the ED.										
Task Step 4. Develop patient education strategies on appropriate use of the ED based on key findings from patient survey in Step 3										
Task Step 5. Roll out patient education strategies with community partners										
Task Step 6. Develop a plan for a PPS ED discharge program that provides LMC and Cobble Hill ED patients with the following upon discharge: 1. Education on appropriate ED use 2. A scheduled appointment with a primary care provider of their choice 3. Enroll all eligible patients into health home 4. SBIRT screening to identify potential ED "frequent fliers" appropriate for referral to substance abuse care.										
Task Step 7. Identify ED discharge program lead										
Task Step 8. Determine resource needs to successfully implement the discharge program.										



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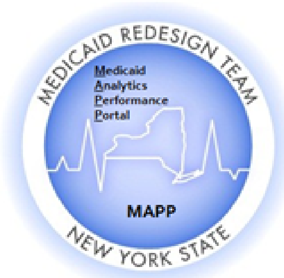
Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Step 9. Recruit, train and assign staff to discharge unit										
Task Step 10. Train ED nurses and case managers on new ED discharge procedures.										
Task Step 11. Begin conducting ED care triage services at LMC										
Task Step 12. Begin conducting ED care triage services at Cobble Hill										
Task Step 13. Initiate dialogue with skilled nursing facilities to reduce unnecessary ED visits and admissions.										
Task Step 14. Engage ED care triage workgroup to review ED care triage performance										
Task Step 15. Identify continuous quality improvement initiatives										
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.	131	164	164	164	164	164	164	164	164	164
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	82	164	164	164	164	164	164	164	164	164
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	1	5	5	5	5	5	5	5	5	5
Task Step 1. Conduct a current state assessment to determine which community primary care providers in the PPS will meet NCQA										



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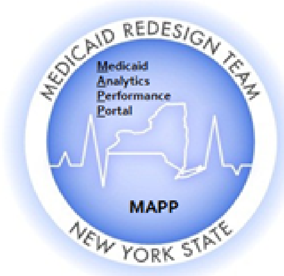
NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards or will meet them by DSRIP Year 3.										
Task Step 2. Establish partnerships with providers identified in Step 1.										
Task Step 3. Engage the IT Sub-Committee to: 1. Establish connectivity between participating EDs and providers identified in Step 1 2. Build real time notifications to Health Home care managers as applicable Note: These steps will be implemented in phases.										
Task Step 4. Employ the Patient Navigation Center (PNC)/Care Management strategy to coordinate open access scheduling between participating EDs and providers identified in Step 1.										
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. Develop a network of primary care providers throughout the PPS community to serve as a central referral list for ED patients without a primary care provider.										
Task Step 2. Develop protocols for discharge management to assist ED patients with: 1. Receiving an immediate appointment with a primary care provider. 2. Identifying and accessing needed community support resources. 3. Receiving a timely appointment with a primary care provider (if the patient has an established relationships with a										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
primary care physician) 4. Receiving appropriate reminders of scheduled appointments 5. Determining if local PPS CHWs are required to educate and/or accompany some "frequent flier" ED patients to referred primary care site										
Task Step 3. Train staff on protocols developed in Step 2.										
Task Step 4. Evaluate success of providing patients with timely access primary care providers and determine if any revisions, training, or communication interventions are 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. Complete current state assessment of EHRs and ED patient registries in use across the PPS primary care provider network.										
Task Step 2. Identify gaps highlighting where a) current registries do not exist to meet PPS's clinical project requirements and target PPS populations; b) PPS primary care partners cannot easily upload appropriate EHR patient data to a patient registry; and c) PPS PCP partner organizations cannot make their schedules available to the PPS Patient Navigation Center for appointment scheduling										
Task Step 3. Develop roadmap to achieving expansion and/or establishment of patient registries, ability to identify "high risk" ED frequent fliers, ability for the PNC to access provider organizations' appointment schedules and EHR capabilities to track engaged ED visit populations across PPS primary care										



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

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
partners										
Task Step 4. Identify resources, timing and expertise required to implement the patient registry plan for PPS primary care partners.										
Task Step 5. Implement plan across PPS primary care partners										

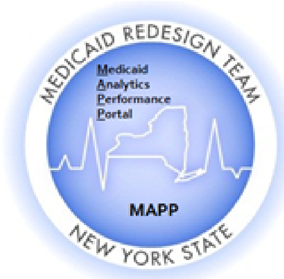
Prescribed Milestones Current File Uploads

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 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	



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

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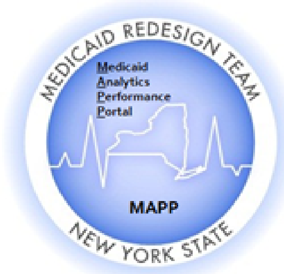
Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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
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NYU Lutheran Medical Center (PPS ID:32)

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

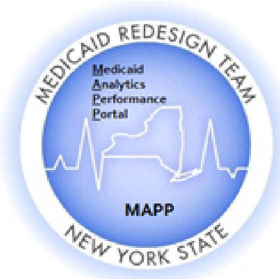
PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :



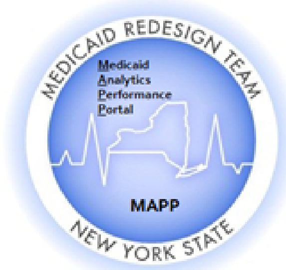
Project 2.b.ix – Implementation of observational programs in hospitals

IPQR Module 2.b.ix.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. Infrastructure Development Ramp Up
a. Availability of space and staff could delay in the opening of the permanent Observation Unit (OU) near NYU Lutheran Medical Center ED could impact available OU bed capacity to accommodate projected ramp-up of PPS patients. Mitigation: The PPS will develop a plan to locate temporary observation beds, develop clinical protocols, and identify the appropriate workforce to serve patients meeting observation status until the permanent unit opens.
b. Successful OU program relies on the Patient Navigation Center (PNC). Delays in PNC establishment would impact patient information flow to PCMHs, tracking of PPS patients, and timely scheduling of follow-up appointments, possibly resulting in avoidable admissions and/ or preventable ED visits. Mitigation: In lieu of a PNC, the PPS will leverage NYU Lutheran's existing EMR and open-access scheduling to schedule appointments with NYU Lutheran PCPs. OU case/care managers will direct patients to make appointments as part of discharge planning; OU discharge protocols will be established for hand-offs of patients between OU/ED care/case managers and community care/case managers in PCMH and HH sites. Discharge plans will include social work, home health and other services to ensure effective transition into community. NYU Lutheran's HIE will be leveraged where possible to enable information sharing across partners to enable timely hand-offs for patients moving from the OU into a community setting. The PPS will conduct a current state assessment to understand partners' implementation of EHRs and HIE connectivity. The PPS will provide technical assistance, including data and analytics support, to assist partners with meeting reporting requirements. Expense for this mitigation strategy is a significant concern.
2. Reimbursement & Contracts - Observation reimbursement structure or rate under Medicaid; no or little payment for these services stop long-term investments in OU. Mitigation: The PPS will work with State Medicaid and MCOs to design a reasonable rate structure based on Medicare.
3. Provider Engagement - Providers may resist adoption of standardized Observation Unit project protocols. Mitigation: The PPS will identify clinical project leader(s) to serve as project champions PPS among ED physicians and clinicians; achieve provider buy-in by engaging providers in design and to agree upon standardized protocols to meet requirements; provide training for providers engaged with the project; facilitate connections between OU physicians/other specialists to ensure access to appropriate tests required to support OU decision making; configure EMR/HIE functionality to ensure the system is user-friendly and provides the information critical to meet project goals; create tools for ED physicians identifying OU-appropriate conditions and protocols.
7. Cross-PPS Collaboration - No other Brooklyn-based PPSs implementing this project; insufficient number of PPSs to coordinate project implementation strategies and share best practices. Mitigation: The PPS will use the MIX to understand strategies and best practices among NYS PPSs.
8. Data- Significant risk in State not transmitting timely, accurate, valid, & meaningful recent patient-specific data on our attributable population required to measure OU performance. Mitigation- None available.
9. Ramp Up- OU services dissimilar to services such as screening; ramp up not dependent on patient engagement but rather demand for services and availability/capacity of the OU.



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NYU Lutheran Medical Center (PPS ID:32)

IPQR Module 2.b.ix.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	523

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
72	73	55.73%	58	13.96%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (131)

Current File Uploads

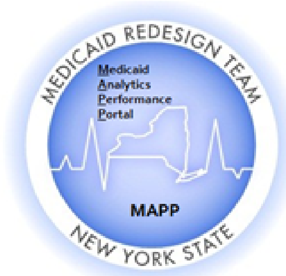
User ID	File Type	File Name	File Description	Upload Date
dbudman	Documentation/Certification	32_PMDL2915_1_3_20160119125527_2.b.ix_-_DY1,_Q3.pdf	Patient Engagement Project 2.b.ix - Implementation of observational programs in hospitals	01/19/2016 12:55 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	



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

DSRIP Implementation Plan Project

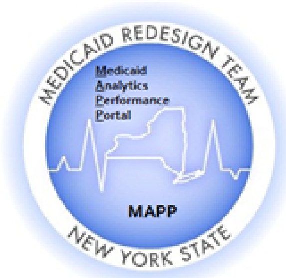
NYU Lutheran Medical Center (PPS ID:32)

IPQR Module 2.b.ix.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 appropriately sized and staffed observation (OBS) units in close proximity to ED services, unless the services required are better provided in another unit. When the latter occurs, care coordination must still be provided.	Project	N/A	In Progress	05/01/2015	09/30/2017	05/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Observation units established in proximity to PPS' ED departments.	Provider	Hospital	In Progress	05/01/2015	09/30/2017	05/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Care coordination is in place for patients routed outside of ED or OBS services.	Project		In Progress	05/01/2015	09/30/2017	05/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1. Determine preferred location for the NYU Lutheran OU and identify costs/timing to reconfigure and equip the OU.	Project		Completed	05/01/2015	09/01/2015	05/01/2015	09/01/2015	09/30/2015	DY1 Q2
Task Step 2. Identify ED physician and nurse to lead NYU Lutheran OU	Project		Completed	05/01/2015	09/01/2015	05/01/2015	09/01/2015	09/30/2015	DY1 Q2
Task Step 3. Identify preliminary set of conditions/diagnoses that will be evaluated & managed for Observation status, following best practice OU protocols	Project		Completed	06/01/2015	09/01/2015	06/01/2015	09/01/2015	09/30/2015	DY1 Q2
Task Step 4. Establish agreements with key NYU Lutheran clinical and ancillary departments to support goals, protocols and workflows of the OU	Project		Completed	08/01/2015	09/30/2015	08/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 5. Confirm OU workflow and documentation; install required OU workflow prompts & documentation templates to the NYU Lutheran EHR	Project		In Progress	08/01/2015	06/30/2017	08/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 6. Confirm OU staffing model	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2



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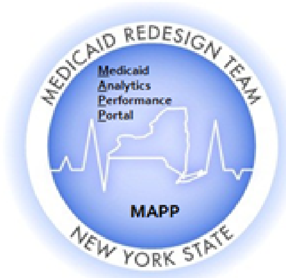
NYU Lutheran Medical Center (PPS ID:32)

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. Recruit, train and assign staff to the OU	Project		In Progress	08/01/2015	12/31/2015	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 8. Roll out OU communication/outreach strategy for Lutheran physicians, staff and patients (leverage materials from NYU Langone)	Project		In Progress	12/01/2015	12/31/2015	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 9. Open the NYU Lutheran OU	Project		In Progress	05/01/2015	03/31/2016	05/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 10. Evaluate ramp-up success of placing patients into the OU and determine if any revisions, additional training, or communication interventions are needed.	Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #2 Create clinical and financial model to support the need for the unit.	Project	N/A	In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has clinical and financial model, detailing: - number of beds - staffing requirements - services definition - admission protocols - discharge protocols - inpatient transfer protocols	Provider	Hospital	Not Started	10/01/2015	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 1. Establish the outcome metrics, benchmarks and goals the Lutheran OU team will use to measure its performance of the OU. Example of performance goals will include % of OU status patients admitted	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Engage NYU Lutheran OU clinical work group and the Clinical Sub-Committee to review OU performance	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3. Identify continuous quality improvement initiatives	Project		Not Started	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 4. Expand the number of conditions/diagnoses which OU protocols will be applied to	Project		Not Started	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #3 Utilize care coordination services to ensure safe discharge either to the community or a step down level of service, such as	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4



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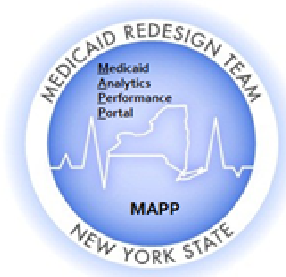
NYU Lutheran Medical Center (PPS ID:32)

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
behavioral health or assisted living/SNF.									
Task Standard 30-day care coordination services for safe discharge to community or step-down level are implemented and specifically fitted to short-stay situations.	Project		Not Started	10/01/2015	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Identify case management needs for people being discharged from OU.	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Develop case management protocols and train case management staff	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3. Initiate case management for patients being discharged from OU	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	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 exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including Direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.	Project	N/A	In Progress	01/01/2016	03/31/2018	10/01/2015	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		Not Started	01/01/2016	03/31/2018	01/01/2016	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)	Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Hospital	Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Complete current state assessment of interoperability and HIE requirements across the PPS safety net providers.	Project		In Progress	01/01/2016	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Identify gaps highlighting where PPS safety net members' EHRs fail to meet RHIO's HIE and SHIN-NY connectivity requirements.	Project		In Progress	01/01/2016	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task	Project		Not Started	03/31/2016	09/30/2016	03/31/2016	09/30/2016	09/30/2016	DY2 Q2



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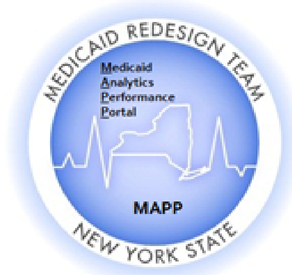
NYU Lutheran Medical Center (PPS ID:32)

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 3. Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network (see IT section of IDS project 2.a.i for details).									
Task Step 4. Identify resources and expertise required to implement HIE connectivity plan for PPS safety net provider partners.	Project		Not Started	03/31/2016	09/30/2016	03/31/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Implement plan and achieve HIE connectivity across PPS safety net provider partners.	Project		Not Started	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	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 targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Complete current state assessment of EHRs and patient registries in use across the PPS primary care provider network.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Identify gaps highlighting where a) current registries do not exist to meet PPS's clinical project requirements and target PPS populations; and, b) PPS primary care partners cannot easily upload appropriate EHR patient data to a patient registry	Project		In Progress	12/31/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. Develop roadmap to achieving expansion and/or establishment of patient registries, ability to identify "high risk" OU patients, ability for the PNC to access provider organizations' appointment schedules and EHR capabilities to track engaged OU populations across PPS primary care partners	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4. Identify resources, timing and expertise required to implement the patient registry plan.	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Implement plan across PPS primary care partners	Project		Not Started	06/01/2016	03/31/2017	06/01/2016	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										



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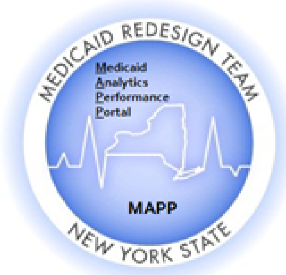
Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Establish appropriately sized and staffed observation (OBS) units in close proximity to ED services, unless the services required are better provided in another unit. When the latter occurs, care coordination must still be provided.										
Task Observation units established in proximity to PPS' ED departments.	0	0	0	0	0	0	0	0	0	6
Task Care coordination is in place for patients routed outside of ED or OBS services.										
Task Step 1. Determine preferred location for the NYU Lutheran OU and identify costs/timing to reconfigure and equip the OU.										
Task Step 2. Identify ED physician and nurse to lead NYU Lutheran OU										
Task Step 3. Identify preliminary set of conditions/diagnoses that will be evaluated & managed for Observation status, following best practice OU protocols										
Task Step 4. Establish agreements with key NYU Lutheran clinical and ancillary departments to support goals, protocols and workflows of the OU										
Task Step 5. Confirm OU workflow and documentation; install required OU workflow prompts & documentation templates to the NYU Lutheran EHR										
Task Step 6. Confirm OU staffing model										
Task Step 7. Recruit, train and assign staff to the OU										
Task Step 8. Roll out OU communication/outreach strategy for Lutheran physicians, staff and patients (leverage materials from NYU Langone)										
Task Step 9. Open the NYU Lutheran OU										
Task Step 10. Evaluate ramp-up success of placing patients into the OU and determine if any revisions, additional training, or communication interventions are needed.										
Milestone #2 Create clinical and financial model to support the need for the										



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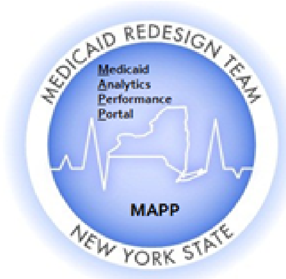
NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
unit.										
Task PPS has clinical and financial model, detailing: - number of beds - staffing requirements - services definition - admission protocols - discharge protocols - inpatient transfer protocols	0	0	0	0	0	0	0	0	0	6
Task Step 1. Establish the outcome metrics, benchmarks and goals the Lutheran OU team will use to measure its performance of the OU. Example of performance goals will include % of OU status patients admitted										
Task Step 2. Engage NYU Lutheran OU clinical work group and the Clinical Sub-Committee to review OU performance										
Task Step 3. Identify continuous quality improvement initiatives										
Task Step 4. Expand the number of conditions/diagnoses which OU protocols will be applied to										
Milestone #3 Utilize care coordination services to ensure safe discharge either to the community or a step down level of service, such as behavioral health or assisted living/SNF.										
Task Standard 30-day care coordination services for safe discharge to community or step-down level are implemented and specifically fitted to short-stay situations.										
Task Step 1. Identify case management needs for people being discharged from OU.										
Task Step 2. Develop case management protocols and train case management staff										
Task Step 3. Initiate case management for patients being discharged from OU										
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 Direct exchange (secure messaging),										



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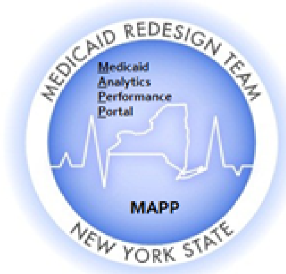
DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
alerts and patient record look up by the end of Demonstration Year (DY) 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 EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	16	164
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	1	5
Task Step 1. Complete current state assessment of interoperability and HIE requirements across the PPS safety net providers.										
Task Step 2. Identify gaps highlighting where PPS safety net members' EHRs fail to meet RHIO's HIE and SHIN-NY connectivity requirements.										
Task Step 3. Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network (see IT section of IDS project 2.a.i for details).										
Task Step 4. Identify resources and expertise required to implement HIE connectivity plan for PPS safety net provider partners.										
Task Step 5. Implement plan and achieve HIE connectivity across PPS safety net provider partners.										
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. Complete current state assessment of EHRs and patient registries in use across the PPS primary care provider network.										
Task Step 2. Identify gaps highlighting where a) current registries do not exist to meet PPS's clinical project requirements and target PPS populations; and, b) PPS primary care partners cannot easily upload appropriate EHR patient data to a patient registry										
Task										



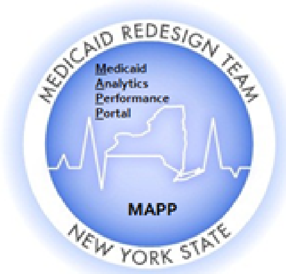
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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. Develop roadmap to achieving expansion and/or establishment of patient registries, ability to identify "high risk" OU patients, ability for the PNC to access provider organizations' appointment schedules and EHR capabilities to track engaged OU populations across PPS primary care partners										
Task Step 4. Identify resources, timing and expertise required to implement the patient registry plan.										
Task Step 5. Implement plan across PPS primary care partners										

Project 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 appropriately sized and staffed observation (OBS) units in close proximity to ED services, unless the services required are better provided in another unit. When the latter occurs, care coordination must still be provided.										
Task Observation units established in proximity to PPS' ED departments.	6	6	6	6	6	6	6	6	6	6
Task Care coordination is in place for patients routed outside of ED or OBS services.										
Task Step 1. Determine preferred location for the NYU Lutheran OU and identify costs/timing to reconfigure and equip the OU.										
Task Step 2. Identify ED physician and nurse to lead NYU Lutheran OU										
Task Step 3. Identify preliminary set of conditions/diagnoses that will be evaluated & managed for Observation status, following best practice OU protocols										
Task Step 4. Establish agreements with key NYU Lutheran clinical and ancillary departments to support goals, protocols and workflows of the OU										
Task Step 5. Confirm OU workflow and documentation; install required OU workflow prompts & documentation templates to the NYU Lutheran EHR										
Task Step 6. Confirm OU staffing model										

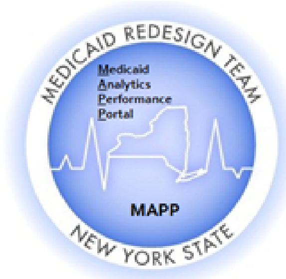


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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 7. Recruit, train and assign staff to the OU										
Task Step 8. Roll out OU communication/outreach strategy for Lutheran physicians, staff and patients (leverage materials from NYU Langone)										
Task Step 9. Open the NYU Lutheran OU										
Task Step 10. Evaluate ramp-up success of placing patients into the OU and determine if any revisions, additional training, or communication interventions are needed.										
Milestone #2 Create clinical and financial model to support the need for the unit.										
Task PPS has clinical and financial model, detailing: - number of beds - staffing requirements - services definition - admission protocols - discharge protocols - inpatient transfer protocols	6	6	6	6	6	6	6	6	6	6
Task Step 1. Establish the outcome metrics, benchmarks and goals the Lutheran OU team will use to measure its performance of the OU. Example of performance goals will include % of OU status patients admitted										
Task Step 2. Engage NYU Lutheran OU clinical work group and the Clinical Sub-Committee to review OU performance										
Task Step 3. Identify continuous quality improvement initiatives										
Task Step 4. Expand the number of conditions/diagnoses which OU protocols will be applied to										
Milestone #3 Utilize care coordination services to ensure safe discharge either to the community or a step down level of service, such as behavioral health or assisted living/SNF.										
Task Standard 30-day care coordination services for safe discharge to community or step-down level are implemented and specifically fitted to short-stay situations.										

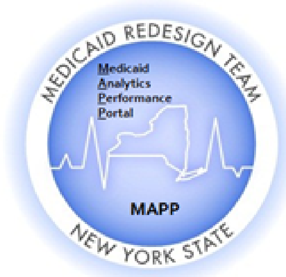


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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. Identify case management needs for people being discharged from OU.										
Task Step 2. Develop case management protocols and train case management staff										
Task Step 3. Initiate case management for patients being discharged from OU										
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 Direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 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 EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	164	164	164	164	164	164	164	164	164	164
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	5	5	5	5	5	5	5	5	5	5
Task Step 1. Complete current state assessment of interoperability and HIE requirements across the PPS safety net providers.										
Task Step 2. Identify gaps highlighting where PPS safety net members' EHRs fail to meet RHIO's HIE and SHIN-NY connectivity requirements.										
Task Step 3. Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network (see IT section of IDS project 2.a.i for details).										
Task Step 4. Identify resources and expertise required to implement HIE connectivity plan for PPS safety net provider partners.										
Task Step 5. Implement plan and achieve HIE connectivity across PPS safety net provider partners.										
Milestone #5 Use EHRs and other technical platforms to track all patients										



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

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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 in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1. Complete current state assessment of EHRs and patient registries in use across the PPS primary care provider network.										
Task Step 2. Identify gaps highlighting where a) current registries do not exist to meet PPS's clinical project requirements and target PPS populations; and, b) PPS primary care partners cannot easily upload appropriate EHR patient data to a patient registry										
Task Step 3. Develop roadmap to achieving expansion and/or establishment of patient registries, ability to identify "high risk" OU patients, ability for the PNC to access provider organizations' appointment schedules and EHR capabilities to track engaged OU populations across PPS primary care partners										
Task Step 4. Identify resources, timing and expertise required to implement the patient registry plan.										
Task Step 5. Implement plan across PPS primary care partners										

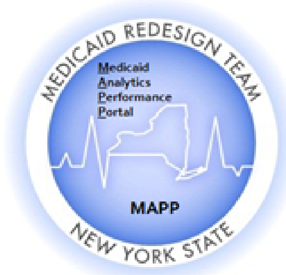
Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish appropriately sized and staffed observation (OBS) units in close proximity to ED services, unless the services required are better provided in another unit. When the latter occurs, care coordination must still be provided.	
Create clinical and financial model to support the need for the unit.	
Utilize care coordination services to ensure safe discharge either to the community or a step down level of service, such as behavioral	



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

DSRIP Implementation Plan Project

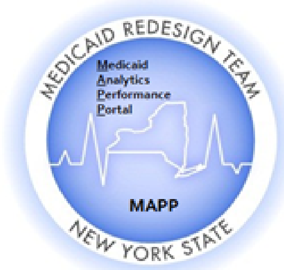
NYU Lutheran Medical Center (PPS ID:32)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
health or assisted living/SNF.	
Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including Direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.	
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

NYU Lutheran Medical Center (PPS ID:32)

IPQR Module 2.b.ix.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

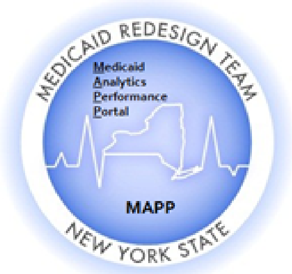
Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found



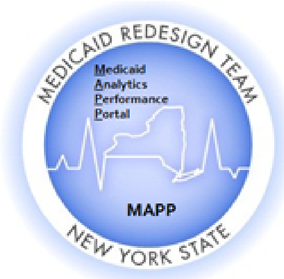
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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

Instructions :



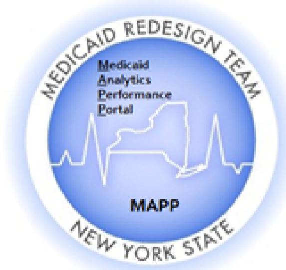
Project 2.c.i – Development of community-based health navigation services

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

Instructions :

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

1. Information Technology Adoption – EHRs & other technical platforms are extremely tricky to build and adopt, including ones to track all patients engaged in this project for proactive care management, and thus difficult or delayed milestone realization. Mitigation: PPS will conduct current state assessment and develop plans to advance partner implementation of EHRs/ HIE connectivity; PPS will provide technical assistance, data and analytics support to assist partners in meeting reporting requirements, and work with vendors who have successfully implemented relevant IT tools.
2. Patient Engagement- PPS may not meet patient engagement targets due to difficulty to engage patients or have them comply with care plan. Mitigation: During initial roll-out of the Patient Navigation Center (PNC), PPS will track patients' care plan compliance; identify hard to engage populations; analyze data to determine size, location, clinical needs and demographic profiling of these populations to identify reason for resistance; prioritize populations, based on scale, urgent need and potential impact of targeted, intensified intervention by PNC; develop culturally-specific care navigation strategies, expertise and tools with which to engage patients; deploy community health workers and embed care managers in PCMH sites for active patient engagement; staff will receive training and support to engage patients. PPS will track populations prioritized for targeted patient navigation resources to improve patient engagement performance and lessons learned can be applied to other populations. PPS will develop multilingual patient outreach and education materials to highlight importance of primary prevention, chronic disease management, and leverage community resources to support health and well-being; CHWs will support patients' clinical needs as well as their social and economic needs.
3. Provider Engagement- Providers may resist adoption of standardized PPS patient navigation and coordination protocols. Mitigation: PPS will identify clinical project leader(s) to serve as project champions and liaise with them to build support across the PPS provider network; create provider buy-in by engaging key partner providers in design and piloting standardized patient navigation protocols to meet project requirements. PPS will aim to refine and launch PNC tools, resources and protocols based on pilot feedback and develop a community care resource guide to assist the patients and ensure compliance with protocols. PPS will configure EMR/ HIE functionality to ensure system is user-friendly and provides information critical to meet goals; provide technical assistance, including IT and communications support, to providers who may struggle with implementing PNC requirements.
4. Workforce Risk- Supply for community health workers and navigators may not meet City-, State-, and Nation-wide demand. PPS may encounter challenges recruiting adequate numbers of case managers, care coordinators and CHWs to support centralized and community-based staffing needs. Mitigation: PPS will evaluate and identify project staffing needs; prioritize and identify voluntary redeployment opportunities to fill new/vacant positions and promote retraining opportunities for these positions. PPS will recruit CHWs from diverse communities within the PPS's target area to meet the needs of PPS patients. If access required services in target area seems unlikely to meet demand, PPS will implement strategies (likely in partnership with other Brooklyn PPSs) to increase access to these services via vendor contracts and/or expanding the capacity of these organizations already in the PPS.
5. Data- Significant risk in State not transmitting timely, accurate, valid, & meaningful recent patient-specific data on our attributable population required to measure PNC performance. Mitigation: None available.



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

Instructions :

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

Benchmarks	
100% Actively Engaged By	Expected Patient Engagement
DY4,Q4	27,148

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
1,629	2,968	109.32%	-253	10.93%

Current File Uploads

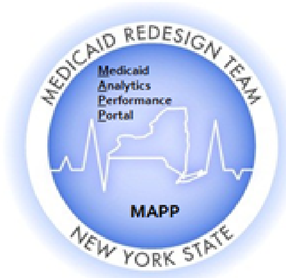
User ID	File Type	File Name	File Description	Upload Date
dbudman	Documentation/Certification	32_PMDL3415_1_3_20160115155753_2.c.i_-_DY1,_Q3.pdf	Patient Engagement - DY1, Q3 Project 2.c.i - Development of community-based health navigation services	01/15/2016 03:58 PM

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

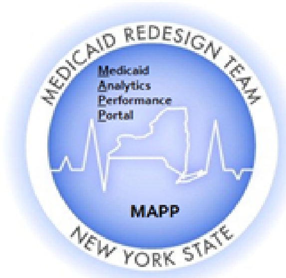
NYU Lutheran Medical Center (PPS ID:32)

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.	Project	N/A	In Progress	05/01/2015	09/30/2017	05/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Community-based health navigation services established.	Project		In Progress	05/01/2015	09/30/2017	05/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1. Conduct current state assessment to understand existing community-based health navigation services and CHW FTEs in place among PPS partners.	Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. Convene a community navigation project work group/program oversight group consisting of medical, behavioral health, community nursing, and social support service providers throughout the PPS network.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 3. Determine the scope of the PPS's community-based health navigation services.	Project		Completed	07/01/2015	10/30/2015	07/01/2015	10/30/2015	12/31/2015	DY1 Q3
Task Step 4. Determine staffing and resources needed to support community navigation services.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 5. Hire community-based navigators as necessary (phased growth).	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6. Train community navigator staff on the PPS's community navigation protocols and procedures (on-going).	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7. Design centralized Patient Navigation Center (PNC) and determine scope of services and required staffing.	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4

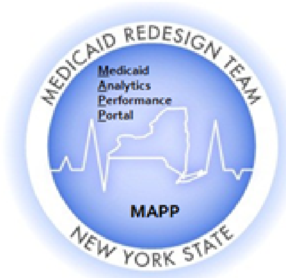


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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 8. Design the infrastructure and work streams of the PPS's Patient Navigation Center (PNC)									
Task Step 9. Determine best implementation approach for PNC (e.g. leverage services vendor or build capabilities)	Project		Not Started	03/31/2016	09/30/2016	03/31/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 10. Implement the initial PNC call center capabilities.	Project		Not Started	09/30/2016	12/31/2016	09/30/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 11. Conduct annual review of community-navigation services to determine whether the services are successfully assisting patients in accessing healthcare services and make revisions as necessary.	Project		Not Started	10/01/2016	09/30/2017	10/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #2 Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.	Project	N/A	In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Resource guide completed, detailing medical/behavioral/social community resources and care protocols developed by program oversight committee.	Project		In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Conduct current state assessment to understand the community care resource needs of PPS partners and available resources in the PPS.	Project		Completed	08/01/2015	09/30/2015	08/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. Identify industry best practices and develop resource requirements.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Develop a community care resource guide and enhance based on experience (phased development and implementation).	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Navigators recruited by residents in the targeted area, where possible.	Project		Not Started	10/01/2015	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

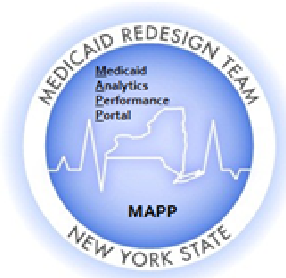


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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. Conduct an analysis of the PPS network and in collaboration with clinical workgroups to understand unique, culturally competent community staffing needs.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Engage with community partners to help identify community residents that can aid with community navigator recruitment (on-going).	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Hire and train community navigators.	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Resource appropriately for the community navigators, evaluating placement and service type.	Project	N/A	Not Started	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Navigator placement implemented based upon opportunity assessment.	Project		Not Started	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Telephonic and web-based health navigator services implemented by type.	Project		Not Started	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 1. Identify skillsets necessary for community navigators.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Establish standardized job description for community navigators.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Ensure that hired community navigators are trained and placed into positions based on geography, PPS programmatic need, navigator skill set and interested and cultural and linguistic match to the communities they will serve.	Project		Not Started	03/31/2016	09/30/2017	03/31/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #5 Provide community navigators with access to non-clinical resources, such as transportation and housing services.	Project	N/A	Not Started	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Navigators have partnerships with transportation, housing, and other social services benefitting target population.	Project		Not Started	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 1. Identify community-based organizations that can provide the PPS with access to non-clinical resources.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4

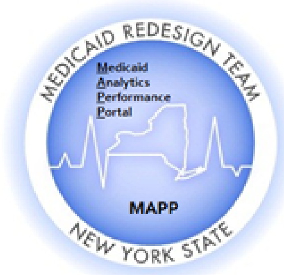


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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. Train navigators on use of the resource guide.									
Milestone #6 Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.	Project	N/A	Not Started	10/01/2015	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Case loads and discharge processes established for health navigators following patients longitudinally.	Project		Not Started	10/01/2015	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Conduct research on best practices in case load and discharge processes for community navigators.	Project		Not Started	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Develop a case load and discharge protocol for community navigators.	Project		Not Started	12/31/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Milestone #7 Market the availability of community-based navigation services.	Project	N/A	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Health navigator personnel and services marketed within designated communities.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Engage the PPS's Communications and Outreach team to develop pamphlet materials regarding available community-based navigation services.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Distribute pamphlets developed in Step 1 to all PPS providers to put on display for patients in waiting and exam rooms.	Project		Not Started	03/31/2016	06/30/2016	03/31/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. Conduct an online webinar to educate PPS providers on available community-based navigation services.	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	Not Started	10/01/2015	03/31/2017	01/01/2016	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		Not Started	10/01/2015	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Complete current state assessment of EHRs and patient registries in use across the PPS primary care provider network.	Project		Not Started	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4



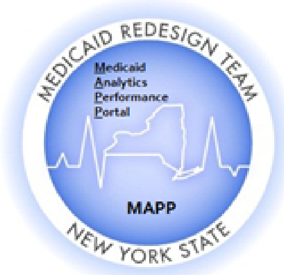
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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 gaps highlighting where a) current registries do not exist to meet PPS's clinical project requirements and target PPS populations; b) PPS primary care partners cannot easily upload appropriate EHR patient data to a patient registry; and c) PPS PCP partner organizations cannot make their schedules available to the PPS Patient Navigation Center for appointment scheduling.	Project		Not Started	12/31/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. Develop roadmap to achieving expansion and/or establishment of patient registries, ability to identify high risk, complex PPS patients, ability for the PNC to access provider organizations' appointment schedules and EHR capabilities to track engaged ED visit populations across PPS primary care partners.	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4. Identify resources, timing and expertise required to implement the patient registry plan for PPS primary care partners.	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Implement plan across PPS primary care partners.	Project		Not Started	06/01/2016	03/31/2017	06/01/2016	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 Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.										
Task Community-based health navigation services established.										
Task Step 1. Conduct current state assessment to understand existing community-based health navigation services and CHW FTEs in place among PPS partners.										
Task Step 2. Convene a community navigation project work group/program oversight group consisting of medical, behavioral health, community nursing, and social support service providers throughout the PPS network.										

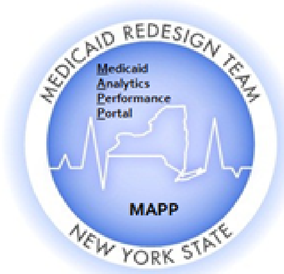


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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. Determine the scope of the PPS's community-based health navigation services.										
Task Step 4. Determine staffing and resources needed to support community navigation services.										
Task Step 5. Hire community-based navigators as necessary (phased growth).										
Task Step 6. Train community navigator staff on the PPS's community navigation protocols and procedures (on-going).										
Task Step 7. Design centralized Patient Navigation Center (PNC) and determine scope of services and required staffing.										
Task Step 8. Design the infrastructure and work streams of the PPS's Patient Navigation Center (PNC)										
Task Step 9. Determine best implementation approach for PNC (e.g. leverage services vendor or build capabilities)										
Task Step 10. Implement the initial PNC call center capabilities.										
Task Step 11. Conduct annual review of community-navigation services to determine whether the services are successfully assisting patients in accessing healthcare services and make revisions as necessary.										
Milestone #2 Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.										
Task Resource guide completed, detailing medical/behavioral/social community resources and care protocols developed by program oversight committee.										
Task Step 1. Conduct current state assessment to understand the community care resource needs of PPS partners and available resources in the PPS.										
Task Step 2. Identify industry best practices and develop resource requirements.										

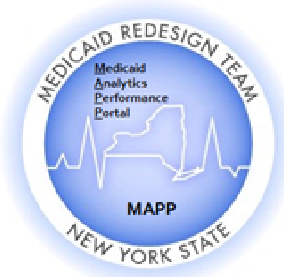


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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. Develop a community care resource guide and enhance based on experience (phased development and implementation).										
Milestone #3 Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.										
Task Navigators recruited by residents in the targeted area, where possible.										
Task Step 1. Conduct an analysis of the PPS network and in collaboration with clinical workgroups to understand unique, culturally competent community staffing needs.										
Task Step 2. Engage with community partners to help identify community residents that can aid with community navigator recruitment (on-going).										
Task Step 3. Hire and train community navigators.										
Milestone #4 Resource appropriately for the community navigators, evaluating placement and service type.										
Task Navigator placement implemented based upon opportunity assessment.										
Task Telephonic and web-based health navigator services implemented by type.										
Task Step 1. Identify skillsets necessary for community navigators.										
Task Step 2. Establish standardized job description for community navigators.										
Task Step 3. Ensure that hired community navigators are trained and placed into positions based on geography, PPS programmatic need, navigator skill set and interested and cultural and linguistic match to the communities they will serve.										
Milestone #5 Provide community navigators with access to non-clinical resources, such as transportation and housing services.										
Task Navigators have partnerships with transportation, housing, and other social services benefitting target population.										



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

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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 community-based organizations that can provide the PPS with access to non-clinical resources.										
Task Step 2. Train navigators on use of the resource guide.										
Milestone #6 Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.										
Task Case loads and discharge processes established for health navigators following patients longitudinally.										
Task Step 1. Conduct research on best practices in case load and discharge processes for community navigators.										
Task Step 2. Develop a case load and discharge protocol for community navigators.										
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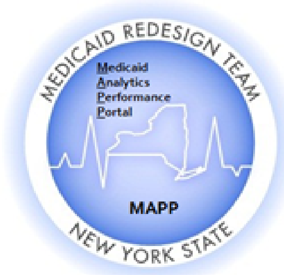
Task Health navigator personnel and services marketed within designated communities.										
Task Step 1. Engage the PPS's Communications and Outreach team to develop pamphlet materials regarding available community-based navigation services.										
Task Step 2. Distribute pamphlets developed in Step 1 to all PPS providers to put on display for patients in waiting and exam rooms.										
Task Step 3. Conduct an online webinar to educate PPS providers on available community-based navigation services.										
Milestone #8 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. Complete current state assessment of EHRs and patient registries in use across the PPS primary care provider network.										
Task										



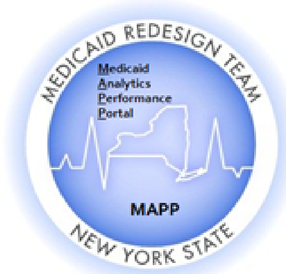
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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 2. Identify gaps highlighting where a) current registries do not exist to meet PPS's clinical project requirements and target PPS populations; b) PPS primary care partners cannot easily upload appropriate EHR patient data to a patient registry; and c) PPS PCP partner organizations cannot make their schedules available to the PPS Patient Navigation Center for appointment scheduling.										
Task Step 3. Develop roadmap to achieving expansion and/or establishment of patient registries, ability to identify high risk, complex PPS patients, ability for the PNC to access provider organizations' appointment schedules and EHR capabilities to track engaged ED visit populations across PPS primary care partners.										
Task Step 4. Identify resources, timing and expertise required to implement the patient registry plan for PPS primary care partners.										
Task Step 5. Implement plan across PPS primary care partners.										

Project 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 Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.										
Task Community-based health navigation services established.										
Task Step 1. Conduct current state assessment to understand existing community-based health navigation services and CHW FTEs in place among PPS partners.										
Task Step 2. Convene a community navigation project work group/program oversight group consisting of medical, behavioral health, community nursing, and social support service providers throughout the PPS network.										
Task Step 3. Determine the scope of the PPS's community-based health navigation services.										
Task Step 4. Determine staffing and resources needed to support community navigation services.										



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

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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. Hire community-based navigators as necessary (phased growth).										
Task Step 6. Train community navigator staff on the PPS's community navigation protocols and procedures (on-going).										
Task Step 7. Design centralized Patient Navigation Center (PNC) and determine scope of services and required staffing.										
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Task Step 10. Implement the initial PNC call center capabilities.										
Task Step 11. Conduct annual review of community-navigation services to determine whether the services are successfully assisting patients in accessing healthcare services and make revisions as necessary.										
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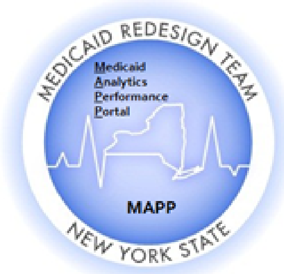
Task Resource guide completed, detailing medical/behavioral/social community resources and care protocols developed by program oversight committee.										
Task Step 1. Conduct current state assessment to understand the community care resource needs of PPS partners and available resources in the PPS.										
Task Step 2. Identify industry best practices and develop resource requirements.										
Task Step 3. Develop a community care resource guide and enhance based on experience (phased development and implementation).										
Milestone #3 Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.										



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

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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 Navigators recruited by residents in the targeted area, where possible.										
Task Step 1. Conduct an analysis of the PPS network and in collaboration with clinical workgroups to understand unique, culturally competent community staffing needs.										
Task Step 2. Engage with community partners to help identify community residents that can aid with community navigator recruitment (on-going).										
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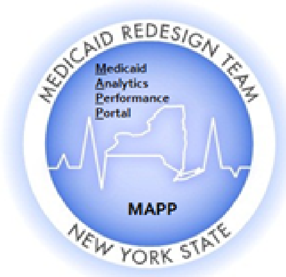
Task Step 3. Ensure that hired community navigators are trained and placed into positions based on geography, PPS programmatic need, navigator skill set and interested and cultural and linguistic match to the communities they will serve.										
Milestone #5 Provide community navigators with access to non-clinical resources, such as transportation and housing services.										
Task Navigators have partnerships with transportation, housing, and other social services benefitting target population.										
Task Step 1. Identify community-based organizations that can provide the PPS with access to non-clinical resources.										
Task Step 2. Train navigators on use of the resource guide.										
Milestone #6										



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

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.										
Task Case loads and discharge processes established for health navigators following patients longitudinally.										
Task Step 1. Conduct research on best practices in case load and discharge processes for community navigators.										
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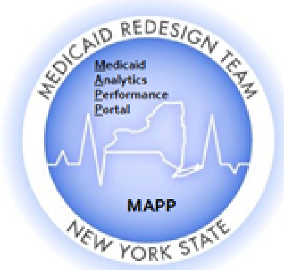
Task Health navigator personnel and services marketed within designated communities.										
Task Step 1. Engage the PPS's Communications and Outreach team to develop pamphlet materials regarding available community-based navigation services.										
Task Step 2. Distribute pamphlets developed in Step 1 to all PPS providers to put on display for patients in waiting and exam rooms.										
Task Step 3. Conduct an online webinar to educate PPS providers on available community-based navigation services.										
Milestone #8 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. Complete current state assessment of EHRs and patient registries in use across the PPS primary care provider network.										
Task Step 2. Identify gaps highlighting where a) current registries do not exist to meet PPS's clinical project requirements and target PPS populations; b) PPS primary care partners cannot easily upload appropriate EHR patient data to a patient registry; and c) PPS PCP partner organizations cannot make their schedules available to the PPS Patient Navigation Center for appointment scheduling.										



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

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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 roadmap to achieving expansion and/or establishment of patient registries, ability to identify high risk, complex PPS patients, ability for the PNC to access provider organizations' appointment schedules and EHR capabilities to track engaged ED visit populations across PPS primary care partners.										
Task Step 4. Identify resources, timing and expertise required to implement the patient registry plan for PPS primary care partners.										
Task Step 5. Implement plan across PPS primary care partners.										

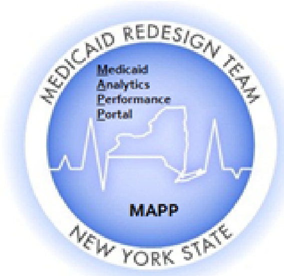
Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.	
Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.	
Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.	
Resource appropriately for the community navigators, evaluating placement and service type.	
Provide community navigators with access to non-clinical resources, such as transportation and housing services.	
Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.	
Market the availability of community-based navigation services.	



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

DSRIP Implementation Plan Project

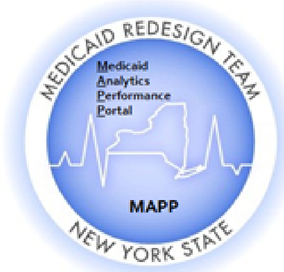
NYU Lutheran Medical Center (PPS ID:32)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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	
Milestone #8	Pass & Ongoing	



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

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

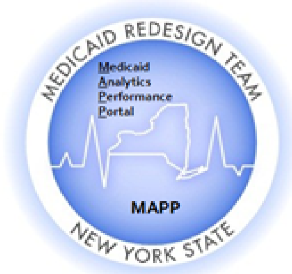
Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found



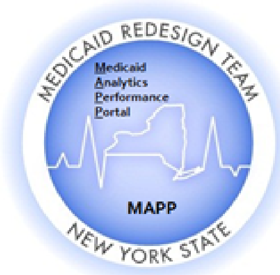
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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

Instructions :



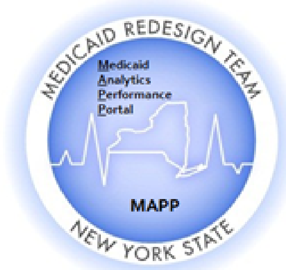
Project 3.a.i – Integration of primary care and behavioral health services

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

Instructions :

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

1. PCMH Status Risk- PPS partner support needed to achieve PCMH NCQA 2014 Level 3 status by DY 3 deadline may be greater than PPS's resources. Mitigation: The PPS will conduct a current state assessment and provide technical assistance to help eligible partners become PCMH 2014 NCQA Level 3 certified by end of DY 3. 2. Information Technology Adoption Risk- PPS partners may be unable to use EHRs & other technical platforms effectively to track all patients engaged in this project. EMRs may not integrate a patient's medical and Behavioral Health (BH) records within his/her patient record. Mitigation: PPS will conduct a current state assessment and develop a plan to support partner implementation of EHRs/HIE connectivity, and provide technical assistance to aid partners with meeting tracking and reporting requirements. 3. Patient Engagement Risk- Patients may not consent to share BH records. Patients may resist engagement due to social stigma associated with BH. Mitigation: PPS will use culturally competent care managers & navigators to educate patients about benefits of sharing information with their providers and management of BH disorders within their respective cultural frameworks. 4. Provider Engagement Risk- Providers resist adoption of standardized BH Integration and IMPACT project protocols. BH and PCP providers approach patients from different practice and clinical perspectives. The warm handoff means two patient visits on the same day, which we understand Medicaid won't pay for. Mitigation: PPS will identify clinical project leader(s) to serve as project champions and liaise with them to build support across the PPS provider network; create provider buy-in by engaging partner providers; configure EMR/HIE functionality to ensure system is user-friendly and provides information critical to meet project goals. PPS will engage providers in training to promote collaborative team-based care models and increase understanding of respective perspectives. If appropriate, PPS may consider incentive programs to support consistent protocol engagement. Discussions with MCOs and the State could help mitigate the financial risks associated with this project. 5. Workforce Risk- Given the psychiatry shortage in Brooklyn and PPSs competition for similar staff, the PPS may be unable to hire adequate BH specialists to provide care under this project. Mitigation: PPS will develop a comprehensive recruiting /training plan that includes identification of Depression care managers and child psychiatrists necessary to implement the IMPACT model. PPS will also explore use of telemedicine, in light of required fiscal sustainability and capital needs, to minimize need for on-site BH staff in light of staffing shortages and investigate the use of provider incentive programs. 6. Infrastructure Development Risk- Some sites may struggle to achieve co-location of BH services due to facility configuration/ space capacity issues and possible denial of capital funding requests. Some sites may not be successful because simply co-locating services doesn't automatically lead to effective integration of services. Reimbursement structure does not support this integration long term. Mitigation: PPS's project model allows sites to use the IMPACT model where co-location is not feasible in addition to employing Model 1 (co-located BH services at PCMH locations). PPS will engage providers to adopt best practice protocols to establish communication and clinical processes to effectively work together in a co-located model. 7. Data- Significant risk in State not transmitting timely, accurate, valid, & meaningful recent patient-specific data on our attributable population required to measure success of the initiative. Mitigation- None available.



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	28,192

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
6,689	10,019	177.70%	-4,381	35.54%

Current File Uploads

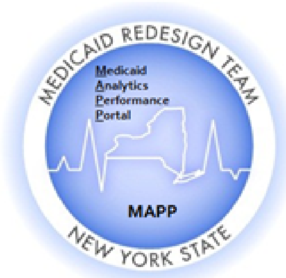
User ID	File Type	File Name	File Description	Upload Date
dbudman	Documentation/Certification	32_PMDL3715_1_3_20160115150518_3.a.i_-_DY1,_Q3.pdf	Patient Engagement - DY1, Q3 Project 3.a.i - Integration of primary care and behavioral health services	01/15/2016 03:06 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	



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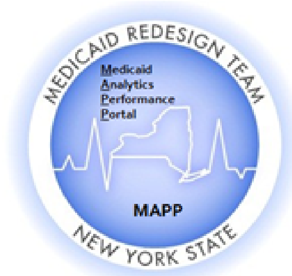
IPQR Module 3.a.i.3 - Prescribed Milestones

Instructions :

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

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Model 1	Project	N/A	In Progress	05/01/2015	03/31/2018	05/01/2015	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	05/01/2015	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	05/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Co-location Work Step 1. Assess current delivery of BH services in primary care provider network.		Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Co-location Work Step 2. Identify primary care partners that will be early adoption sites for BH co-location ("Phase 1 adopters").		Project		Completed	08/01/2015	09/30/2015	08/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Co-location Work Step 3. Develop site-specific plans for Phase 1 adopters.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Co-location Work Step 4. Identify site-specific financial sustainability challenges in current reimbursement environment and develop strategies for how to fill the gap.		Project		In Progress	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Co-location Work Step 5. Identify site-specific staffing needs and recruit, hire and train staff.		Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1



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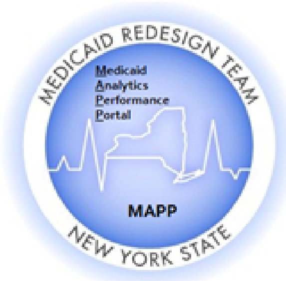
Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Co-location Work Step 6. Start BH screening and co-located services at Phase 1 adopter sites.										
Task Co-location Work Step 7. Document lessons learned to adjust strategies, workflows and practices.		Project		Not Started	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Co-location Work Step 8. Identify "Phase 2 adopter" sites.		Project		Not Started	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Co-location Work Step 9. Develop Phase 2 site-specific plans, integrating lessons learned.		Project		Not Started	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Co-location Work Step 10. Identify site-specific staffing needs and recruit, hire and train staff.		Project		Not Started	01/01/2017	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task Co-location Work Step 11. Start BH screening and co-located services at Phase 2 adopter sites.		Project		Not Started	04/01/2017	06/30/2017	04/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task PCMH Work Step 1. Complete current state assessment of primary care partners with BH co-location with respect to APCM and 2014 Level 3 PCMH standards.		Project		In Progress	10/01/2015	01/31/2016	10/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task PCMH Work Step 2. Identify gaps highlighting where PPS safety net members' fail to meet APCM and 2014 PCMH Level 3 certification requirements.		Project		In Progress	10/01/2015	03/01/2016	10/01/2015	03/01/2016	03/31/2016	DY1 Q4
Task PCMH Work Step 3. Develop roadmap to achieving 2014 PCMH Level 3 certification requirements across PPS safety net provider partners.		Project		Not Started	12/01/2015	04/30/2016	01/01/2016	04/30/2016	06/30/2016	DY2 Q1
Task PCMH Work Step 4. Work with Partners to identify resources and expertise required to implement 2014 PCMH Level 3 certification plan for PPS primary care partners implementing BH co-location.		Project		Not Started	01/01/2016	04/30/2016	01/01/2016	04/30/2016	06/30/2016	DY2 Q1
Task PCMH Work Step 5. Implement plan and support partners in completing 2014 PCMH Level 3 certification requirements.		Project		Not Started	05/01/2016	12/31/2017	05/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task		Project		Not Started	05/01/2016	03/31/2018	05/01/2016	03/31/2018	03/31/2018	DY3 Q4



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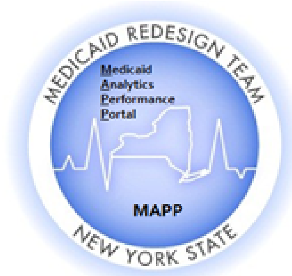
Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
PCMH Work Step 6. Confirm that all PPS primary care partner sites with BH co-location have met 2014 PCMH Level 3 or APCM standards by the end of DY3.										
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 1	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		Not Started	10/01/2015	03/31/2017	01/01/2016	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		Not Started	10/01/2015	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Develop PPS evidence-based practice guidelines, protocols and policies to implement evidence-based standards of care at partner primary care sites with BH co-location.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Establish regular meetings at implementing sites with BH clinicians and PCPs; ensure relevant staff attend these meetings.		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Develop and roll out training to providers at Phase 1 adoper sites for BH co-location.		Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 4. Monitor implementation at partner sites, capture lessons learned, and adapt practices based on lessons.		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5. Implement at additional Phase 2 adopter sites and monitor implementation.		Project		Not Started	01/01/2017	03/31/2017	01/01/2017	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	05/01/2015	03/31/2018	05/01/2015	03/31/2018	03/31/2018	DY3 Q4



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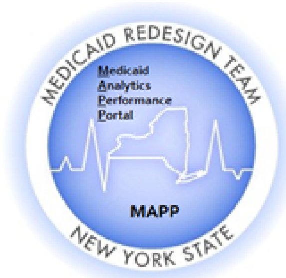
Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Policies and procedures are in place to facilitate and document completion of screenings.		Project		In Progress	05/01/2015	03/31/2018	05/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Screenings are documented in Electronic Health Record.		Project		In Progress	05/01/2015	03/31/2018	05/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		In Progress	05/01/2015	03/31/2018	05/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	05/01/2015	03/31/2018	05/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Identify appropriate PPS evidence-based preventive care screenings and administration protocols for patients ages 5 and older.		Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. Develop PPS screening protocols and work flows to facilitate implementation and documentation of screenings, including protocols for "warm transfers" to BH providers for patients who screen positive.		Project		In Progress	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Develop site-specific plans to roll-out preventive care screenings at Phase 1 adopter sites and implement plans.		Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 4. Monitor implementation at Phase 1 sites, capture lessons learned, and adapt practices based on lessons.		Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 5. Develop site-specific plans to roll-out preventive care screenings at Phase 2 adopter sites and implement plans.		Project		Not Started	01/01/2017	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task Step 6. Adapt EHR systems to ensure screenings can be captured electronically and provide training to staff.		Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #4	Model 1	Project	N/A	In Progress	01/01/2016	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4



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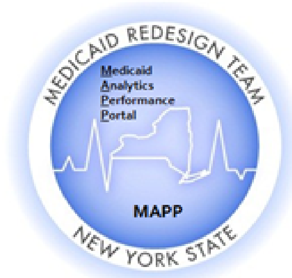
Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	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		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Complete current state assessment of EHRs in use across the PPS primary care provider network, including capacity to integrate medical and BH record for services delivered at primary care site.		Project		In Progress	01/01/2016	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Identify gaps highlighting where a) current EHRs do not document PPS's clinical project requirements (e.g., number of screenings completed) and target PPS populations, b) PPS primary care partners cannot easily upload appropriate EHR patient data to the PPS project reporting system, c) EHRs do not integrate medical and BH record.		Project		In Progress	01/01/2016	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. Develop roadmap to achieving expansion and/or establishment of EHR capabilities to track engaged patients across PPS primary care partners implementing project.		Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4. Identify resources, timing and expertise required to implement the patient tracking plan for PPS primary care partners.		Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Implement plan across PPS primary care partners implementing project.		Project		Not Started	06/01/2016	03/31/2017	06/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Co-locate primary care services at behavioral health sites.	Model 2	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH or		Provider	Practitioner - Primary Care Provider (PCP)	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4



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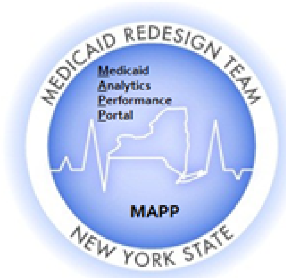
Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Advanced Primary Care Model Practices by the end of DY3.										
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Practitioner - Primary Care Provider (PCP)	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Mental Health	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 2	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 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	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Screenings are documented in Electronic Health Record.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in		Provider	Practitioner - Primary Care Provider (PCP)	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4



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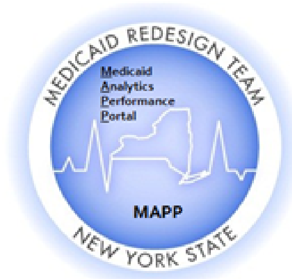
Electronic Health Record.										
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 2	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #9 Implement IMPACT Model at Primary Care Sites.	Model 3	Project	N/A	Not Started	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task PPS has implemented IMPACT Model at Primary Care Sites.		Provider	Practitioner - Primary Care Provider (PCP)	Not Started	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Identify primary care partners that will implement IMPACT.		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 2. Develop site-specific plans for phased implementation of program model.		Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 3. Identify site-specific financial sustainability challenges in current reimbursement environment and develop strategies for how to fill the gap.		Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4. Implement site-specific plans in a phased approach and document to ensure they are adequately staffed (e.g. depression care manager, consulting psychiatrist), required screenings/services are being offered, and other project requirements are being addressed.		Project		Not Started	01/01/2017	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task Step 5. Document lessons learned & challenges at early adopter sites with IMPACT & adapt strategy for later phases of roll-out.		Project		Not Started	01/01/2017	03/31/2018	01/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task Step 6. Monitor implementation and offer technical assistance as needed.		Project		Not Started	04/01/2017	03/31/2018	04/01/2017	03/31/2018	03/31/2018	DY3 Q4



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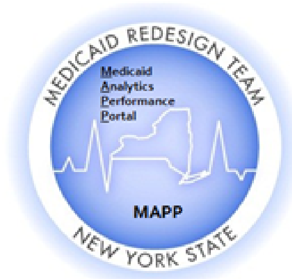
Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Model 3	Project	N/A	Not Started	01/01/2016	03/31/2017	01/01/2016	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		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures include process for consulting with Psychiatrist.		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Identify PPS partner collaborative care standards, policies and procedures for IMPACT care management.		Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Develop training & communication strategy, including materials to be rolled out across the PPS primary care provider network implementing IMPACT.		Project		Not Started	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 3. Roll out provider training and materials starting with early adopter PCPs in the network, tracking participation of PCPs in the training initiatives.		Project		Not Started	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 4. Monitor implementation at partner sites, capture lessons learned, and adapt practices based on lessons.		Project		Not Started	10/01/2016	03/31/2017	10/01/2016	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	Not Started	03/01/2016	03/31/2017	03/01/2016	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		Not Started	03/01/2016	03/31/2017	03/01/2016	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		Project		Not Started	03/01/2016	03/31/2017	03/01/2016	03/31/2017	03/31/2017	DY2 Q4



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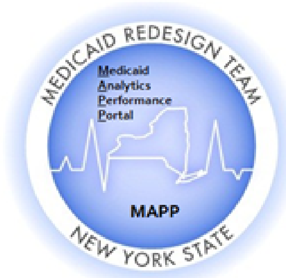
Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
symptoms for treatment response, and completing a relapse prevention plan.										
Task Step 1. Develop position requirements for Depression Care Manager (CM) per evidence-based model and NYS regulatory/reimbursement mandates.		Project		Not Started	03/01/2016	09/30/2016	03/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2. Implementing sites hire new staff members/identify current staff for CM role and PPS documents CM staffing per model.		Project		Not Started	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Training is provided to Depression Care Managers.		Project		Not Started	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	Model 3	Project	N/A	Not Started	03/01/2016	03/31/2017	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task All IMPACT participants in PPS have a designated Psychiatrist.		Project		Not Started	03/01/2016	03/31/2017	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Develop position requirements for Consulting Psychiatrist (PSY) per evidence-based model and NYS regulatory/reimbursement mandates.		Project		Not Started	03/01/2016	09/30/2016	03/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2. Implementing sites identify new clinician(s)/identify current clinician for PSY role and PPS documents site-specific PSY designation per model.		Project		Not Started	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Training is provided to consulting psychiatrists at implementing sites.		Project		Not Started	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #13 Measure outcomes as required in the IMPACT Model.	Model 3	Project	N/A	Not Started	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		Not Started	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Implement reporting mechanisms and roster		Project		Not Started	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4

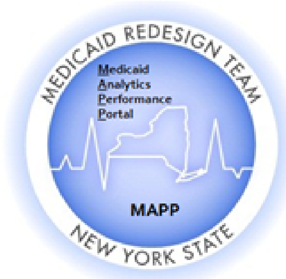


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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
system to measure numbers of patients and % receiving PHQ-2 and 9 screening for those screening positive, and SBIRT.										
Task Step 2. Monitor implementation, and develop/ implement as needed technical assistance plans to help participating partner sites achieve 90% target.		Project		Not Started	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #14 Provide "stepped care" as required by the IMPACT Model.	Model 3	Project	N/A	Not Started	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 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		Not Started	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Develop a treatment protocol and work flow for providing "stepped care" per IMPACT model.		Project		Not Started	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2. Train partners implementing IMPACT in stepped care and staff.		Project		Not Started	10/01/2016	06/30/2017	10/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task Step 3. Develop and implement site-specific plans.		Project		Not Started	10/01/2016	06/30/2017	10/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task Step 4. Monitor implementation, including adherence to 10-12 week evaluation, and offer technical assistance as needed.		Project		Not Started	07/01/2017	03/31/2018	07/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 3	Project	N/A	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	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		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Complete current state assessment of EHRs in use across the PPS primary care provider network, including		Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4



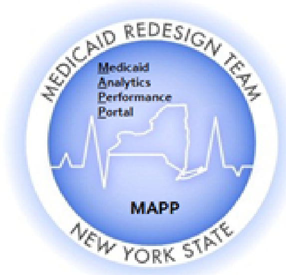
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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
capacity to integrate medical and BH record for services delivered at primary care site.										
Task Step 2. Identify gaps highlighting where a) current EHRs do not document PPS's clinical project requirements (e.g., number of screenings completed) and target PPS populations, b) PPS primary care partners cannot easily upload appropriate EHR patient data to the PPS project reporting system, c) EHRs do not integrate medical and BH record.		Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. Develop roadmap to achieving expansion and/or establishment of EHR capabilities to track engaged patients across PPS primary care partners implementing project.		Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4. Identify resources, timing and expertise required to implement the patient tracking plan for PPS primary care partners.		Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Implement plan across PPS primary care partners implementing project.		Project		Not Started	06/01/2016	03/31/2017	06/01/2016	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	5	10	29	58	87	146	204
Task Behavioral health services are co-located within PCMH/APC practices and are available.	0	0	0	0	2	3	4	5	6	10
Task Co-location Work Step 1. Assess current delivery of BH services										

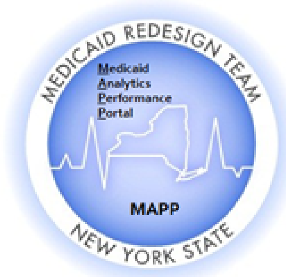


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
in primary care provider network.										
Task Co-location Work Step 2. Identify primary care partners that will be early adoption sites for BH co-location ("Phase 1 adopters").										
Task Co-location Work Step 3. Develop site-specific plans for Phase 1 adopters.										
Task Co-location Work Step 4. Identify site-specific financial sustainability challenges in current reimbursement environment and develop strategies for how to fill the gap.										
Task Co-location Work Step 5. Identify site-specific staffing needs and recruit, hire and train staff.										
Task Co-location Work Step 6. Start BH screening and co-located services at Phase 1 adopter sites.										
Task Co-location Work Step 7. Document lessons learned to adjust strategies, workflows and practices.										
Task Co-location Work Step 8. Identify "Phase 2 adopter" sites.										
Task Co-location Work Step 9. Develop Phase 2 site-specific plans, integrating lessons learned.										
Task Co-location Work Step 10. Identify site-specific staffing needs and recruit, hire and train staff.										
Task Co-location Work Step 11. Start BH screening and co-located services at Phase 2 adopter sites.										
Task PCMH Work Step 1. Complete current state assessment of primary care partners with BH co-location with respect to APCM and 2014 Level 3 PCMH standards.										
Task PCMH Work Step 2. Identify gaps highlighting where PPS safety net members' fail to meet APCM and 2014 PCMH Level 3 certification requirements.										
Task PCMH Work Step 3. Develop roadmap to achieving 2014 PCMH Level 3 certification requirements across PPS safety net provider partners.										

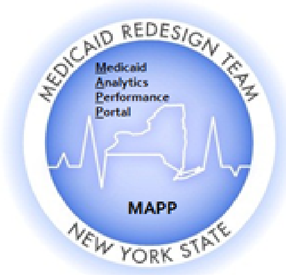


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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 PCMH Work Step 4. Work with Partners to identify resources and expertise required to implement 2014 PCMH Level 3 certification plan for PPS primary care partners implementing BH co-location.										
Task PCMH Work Step 5. Implement plan and support partners in completing 2014 PCMH Level 3 certification requirements.										
Task PCMH Work Step 6. Confirm that all PPS primary care partner sites with BH co-location have met 2014 PCMH Level 3 or APCM standards by the end of DY3.										
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. Develop PPS evidence-based practice guidelines, protocols and policies to implement evidence-based standards of care at partner primary care sites with BH co-location.										
Task Step 2. Establish regular meetings at implementing sites with BH clinicians and PCPs; ensure relevant staff attend these meetings.										
Task Step 3. Develop and roll out training to providers at Phase 1 adoper sites for BH co-location.										
Task Step 4. Monitor implementation at partner sites, capture lessons learned, and adapt practices based on lessons.										
Task Step 5. Implement at additional Phase 2 adopter sites and monitor implementation.										
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.										

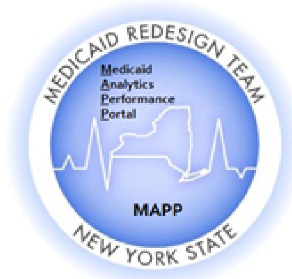


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	0	0	0	0	25	50	75	100	125	150
Task Step 1. Identify appropriate PPS evidence-based preventive care screenings and administration protocols for patients ages 5 and older.										
Task Step 2. Develop PPS screening protocols and work flows to facilitate implementation and documentation of screenings, including protocols for "warm transfers" to BH providers for patients who screen positive.										
Task Step 3. Develop site-specific plans to roll-out preventive care screenings at Phase 1 adopter sites and implement plans.										
Task Step 4. Monitor implementation at Phase 1 sites, capture lessons learned, and adapt practices based on lessons.										
Task Step 5. Develop site-specific plans to roll-out preventive care screenings at Phase 2 adopter sites and implement plans.										
Task Step 6. Adapt EHR systems to ensure screenings can be captured electronically and provide training to staff.										
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. Complete current state assessment of EHRs in use across the PPS primary care provider network, including capacity to integrate medical and BH record for services delivered at										

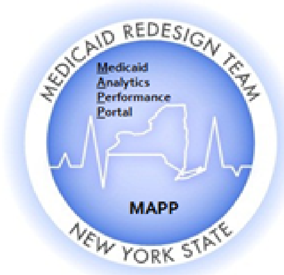


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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 site.										
Task Step 2. Identify gaps highlighting where a) current EHRs do not document PPS's clinical project requirements (e.g., number of screenings completed) and target PPS populations, b) PPS primary care partners cannot easily upload appropriate EHR patient data to the PPS project reporting system, c) EHRs do not integrate medical and BH record.										
Task Step 3. Develop roadmap to achieving expansion and/or establishment of EHR capabilities to track engaged patients across PPS primary care partners implementing project.										
Task Step 4. Identify resources, timing and expertise required to implement the patient tracking plan for PPS primary care partners.										
Task Step 5. Implement plan across PPS primary care partners implementing project.										
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
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.										
Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT)										

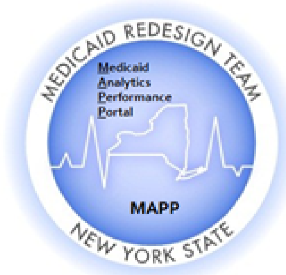


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
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
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.										
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	24	48
Task Step 1. Identify primary care partners that will implement IMPACT.										
Task Step 2. Develop site-specific plans for phased implementation of program model.										
Task Step 3. Identify site-specific financial sustainability challenges in current reimbursement environment and develop strategies for how to fill the gap.										
Task Step 4. Implement site-specific plans in a phased approach and document to ensure they are adequately staffed (e.g. depression care manager, consulting psychiatrist), required screenings/services are being offered, and other project										

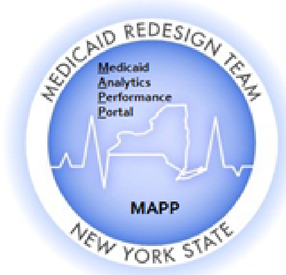


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
requirements are being addressed.										
Task Step 5. Document lessons learned & challenges at early adopter sites with IMPACT & adapt strategy for later phases of roll-out.										
Task Step 6. Monitor implementation and offer technical assistance 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. Identify PPS partner collaborative care standards, policies and procedures for IMPACT care management.										
Task Step 2. Develop training & communication strategy, including materials to be rolled out across the PPS primary care provider network implementing IMPACT.										
Task Step 3. Roll out provider training and materials starting with early adopter PCPs in the network, tracking participation of PCPs in the training initiatives.										
Task Step 4. Monitor implementation at partner sites, capture lessons learned, and adapt practices based on lessons.										
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.										
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.										
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms										



New York State Department Of Health
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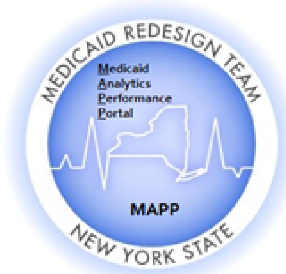
NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
for treatment response, and completing a relapse prevention plan.										
Task Step 1. Develop position requirements for Depression Care Manager (CM) per evidence-based model and NYS regulatory/reimbursement mandates.										
Task Step 2. Implementing sites hire new staff members/identify current staff for CM role and PPS documents CM staffing per model.										
Task Step 3. Training is provided to Depression Care Managers.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Task Step 1. Develop position requirements for Consulting Psychiatrist (PSY) per evidence-based model and NYS regulatory/reimbursement mandates.										
Task Step 2. Implementing sites identify new clinician(s)/identify current clinician for PSY role and PPS documents site-specific PSY designation per model.										
Task Step 3. Training is provided to consulting psychiatrists at implementing sites.										
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. Implement reporting mechanisms and roster system to measure numbers of patients and % receiving PHQ-2 and 9 screening for those screening positive, and SBIRT.										
Task Step 2. Monitor implementation, and develop/ implement as needed technical assistance plans to help participating partner sites achieve 90% target.										
Milestone #14										

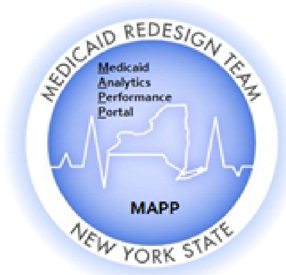


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Provide "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. Develop a treatment protocol and work flow for providing "stepped care" per IMPACT model.										
Task Step 2. Train partners implementing IMPACT in stepped care and staff.										
Task Step 3. Develop and implement site-specific plans.										
Task Step 4. Monitor implementation, including adherence to 10-12 week evaluation, and offer technical assistance as needed.										
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1. Complete current state assessment of EHRs in use across the PPS primary care provider network, including capacity to integrate medical and BH record for services delivered at primary care site.										
Task Step 2. Identify gaps highlighting where a) current EHRs do not document PPS's clinical project requirements (e.g., number of screenings completed) and target PPS populations, b) PPS primary care partners cannot easily upload appropriate EHR patient data to the PPS project reporting system, c) EHRs do not integrate medical and BH record.										
Task Step 3. Develop roadmap to achieving expansion and/or establishment of EHR capabilities to track engaged patients across PPS primary care partners implementing project.										
Task Step 4. Identify resources, timing and expertise required to implement the patient tracking plan for PPS primary care										



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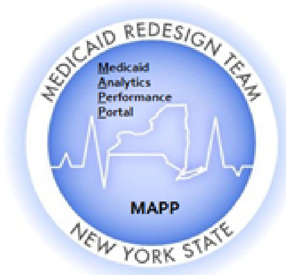
NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
partners.										
Task Step 5. Implement plan across PPS primary care partners implementing project.										

Project 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.	262	291	291	291	291	291	291	291	291	291
Task Behavioral health services are co-located within PCMH/APC practices and are available.	14	188	188	188	188	188	188	188	188	188
Task Co-location Work Step 1. Assess current delivery of BH services in primary care provider network.										
Task Co-location Work Step 2. Identify primary care partners that will be early adoption sites for BH co-location ("Phase 1 adopters").										
Task Co-location Work Step 3. Develop site-specific plans for Phase 1 adopters.										
Task Co-location Work Step 4. Identify site-specific financial sustainability challenges in current reimbursement environment and develop strategies for how to fill the gap.										
Task Co-location Work Step 5. Identify site-specific staffing needs and recruit, hire and train staff.										
Task Co-location Work Step 6. Start BH screening and co-located services at Phase 1 adopter sites.										
Task Co-location Work Step 7. Document lessons learned to adjust strategies, workflows and practices.										
Task Co-location Work Step 8. Identify "Phase 2 adopter" sites.										



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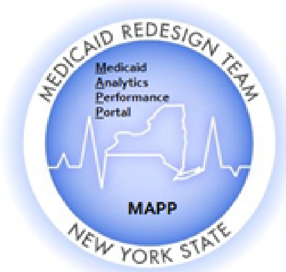
NYU Lutheran Medical Center (PPS ID:32)

Project 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 Co-location Work Step 9. Develop Phase 2 site-specific plans, integrating lessons learned.										
Task Co-location Work Step 10. Identify site-specific staffing needs and recruit, hire and train staff.										
Task Co-location Work Step 11. Start BH screening and co-located services at Phase 2 adopter sites.										
Task PCMH Work Step 1. Complete current state assessment of primary care partners with BH co-location with respect to APCM and 2014 Level 3 PCMH standards.										
Task PCMH Work Step 2. Identify gaps highlighting where PPS safety net members' fail to meet APCM and 2014 PCMH Level 3 certification requirements.										
Task PCMH Work Step 3. Develop roadmap to achieving 2014 PCMH Level 3 certification requirements across PPS safety net provider partners.										
Task PCMH Work Step 4. Work with Partners to identify resources and expertise required to implement 2014 PCMH Level 3 certification plan for PPS primary care partners implementing BH co-location.										
Task PCMH Work Step 5. Implement plan and support partners in completing 2014 PCMH Level 3 certification requirements.										
Task PCMH Work Step 6. Confirm that all PPS primary care partner sites with BH co-location have met 2014 PCMH Level 3 or APCM standards by the end of DY3.										
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. Develop PPS evidence-based practice guidelines,										

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
protocols and policies to implement evidence-based standards of care at partner primary care sites with BH co-location.										
Task Step 2. Establish regular meetings at implementing sites with BH clinicians and PCPs; ensure relevant staff attend these meetings.										
Task Step 3. Develop and roll out training to providers at Phase 1 adoper sites for BH co-location.										
Task Step 4. Monitor implementation at partner sites, capture lessons learned, and adapt practices based on lessons.										
Task Step 5. Implement at additional Phase 2 adopter sites and monitor implementation.										
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.	175	291	291	291	291	291	291	291	291	291
Task Step 1. Identify appropriate PPS evidence-based preventive care screenings and administration protocols for patients ages 5 and older.										
Task Step 2. Develop PPS screening protocols and work flows to facilitate implementation and documentation of screenings, including protocols for "warm transfers" to BH providers for patients who screen positive.										
Task Step 3. Develop site-specific plans to roll-out preventive care screenings at Phase 1 adopter sites and implement plans.										

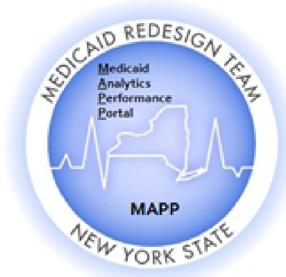


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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. Monitor implementation at Phase 1 sites, capture lessons learned, and adapt practices based on lessons.										
Task Step 5. Develop site-specific plans to roll-out preventive care screenings at Phase 2 adopter sites and implement plans.										
Task Step 6. Adapt EHR systems to ensure screenings can be captured electronically and provide training to staff.										
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. Complete current state assessment of EHRs in use across the PPS primary care provider network, including capacity to integrate medical and BH record for services delivered at primary care site.										
Task Step 2. Identify gaps highlighting where a) current EHRs do not document PPS's clinical project requirements (e.g., number of screenings completed) and target PPS populations, b) PPS primary care partners cannot easily upload appropriate EHR patient data to the PPS project reporting system, c) EHRs do not integrate medical and BH record.										
Task Step 3. Develop roadmap to achieving expansion and/or establishment of EHR capabilities to track engaged patients across PPS primary care partners implementing project.										
Task Step 4. Identify resources, timing and expertise required to implement the patient tracking plan for PPS primary care partners.										
Task Step 5. Implement plan across PPS primary care partners implementing project.										
Milestone #5 Co-locate primary care services at behavioral health sites.										
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced	0	0	0	0	0	0	0	0	0	0

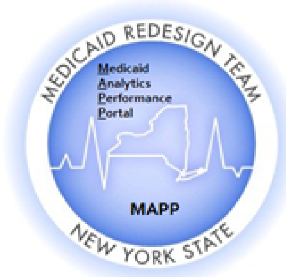


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Primary Care Model Practices by the end of DY3.										
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
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.										
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
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.										

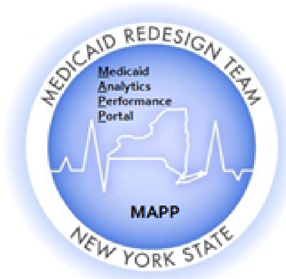


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Milestone #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	72	291	291	291	291	291	291	291	291	291
Task Step 1. Identify primary care partners that will implement IMPACT.										
Task Step 2. Develop site-specific plans for phased implementation of program model.										
Task Step 3. Identify site-specific financial sustainability challenges in current reimbursement environment and develop strategies for how to fill the gap.										
Task Step 4. Implement site-specific plans in a phased approach and document to ensure they are adequately staffed (e.g. depression care manager, consulting psychiatrist), required screenings/services are being offered, and other project requirements are being addressed.										
Task Step 5. Document lessons learned & challenges at early adopter sites with IMPACT & adapt strategy for later phases of roll-out.										
Task Step 6. Monitor implementation and offer technical assistance 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. Identify PPS partner collaborative care standards, policies and procedures for IMPACT care management.										



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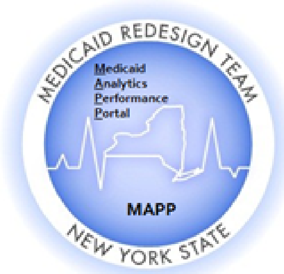
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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 training & communication strategy, including materials to be rolled out across the PPS primary care provider network implementing IMPACT.										
Task Step 3. Roll out provider training and materials starting with early adopter PCPs in the network, tracking participation of PCPs in the training initiatives.										
Task Step 4. Monitor implementation at partner sites, capture lessons learned, and adapt practices based on lessons.										
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.										
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.										
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.										
Task Step 1. Develop position requirements for Depression Care Manager (CM) per evidence-based model and NYS regulatory/reimbursement mandates.										
Task Step 2. Implementing sites hire new staff members/identify current staff for CM role and PPS documents CM staffing per model.										
Task Step 3. Training is provided to Depression Care Managers.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Task Step 1. Develop position requirements for Consulting Psychiatrist (PSY) per evidence-based model and NYS regulatory/reimbursement mandates.										
Task Step 2. Implementing sites identify new clinician(s)/identify										



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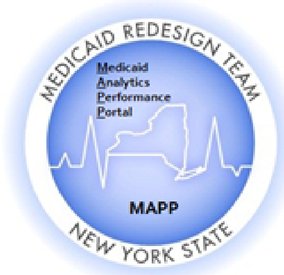
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
current clinician for PSY role and PPS documents site-specific PSY designation per model.										
Task Step 3. Training is provided to consulting psychiatrists at implementing sites.										
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. Implement reporting mechanisms and roster system to measure numbers of patients and % receiving PHQ-2 and 9 screening for those screening positive, and SBIRT.										
Task Step 2. Monitor implementation, and develop/ implement as needed technical assistance plans to help participating partner sites achieve 90% target.										
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. Develop a treatment protocol and work flow for providing "stepped care" per IMPACT model.										
Task Step 2. Train partners implementing IMPACT in stepped care and staff.										
Task Step 3. Develop and implement site-specific plans.										
Task Step 4. Monitor implementation, including adherence to 10-12 week evaluation, and offer technical assistance as needed.										
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										



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DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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 identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1. Complete current state assessment of EHRs in use across the PPS primary care provider network, including capacity to integrate medical and BH record for services delivered at primary care site.										
Task Step 2. Identify gaps highlighting where a) current EHRs do not document PPS's clinical project requirements (e.g., number of screenings completed) and target PPS populations, b) PPS primary care partners cannot easily upload appropriate EHR patient data to the PPS project reporting system, c) EHRs do not integrate medical and BH record.										
Task Step 3. Develop roadmap to achieving expansion and/or establishment of EHR capabilities to track engaged patients across PPS primary care partners implementing project.										
Task Step 4. Identify resources, timing and expertise required to implement the patient tracking plan for PPS primary care partners.										
Task Step 5. Implement plan across PPS primary care partners implementing project.										

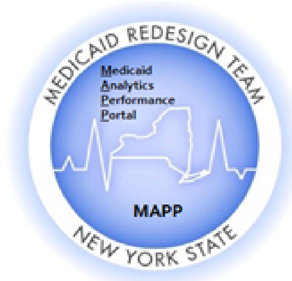
Prescribed Milestones Current File Uploads

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	



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

DSRIP Implementation Plan Project

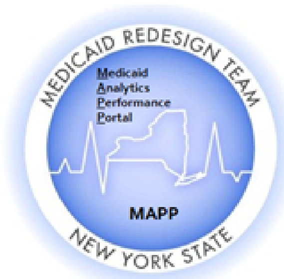
NYU Lutheran Medical Center (PPS ID:32)

Prescribed Milestones Narrative Text

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



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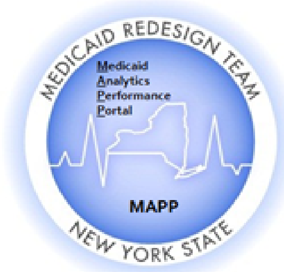
NYU Lutheran Medical Center (PPS ID:32)

Milestone Review Status

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



New York State Department Of Health
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DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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

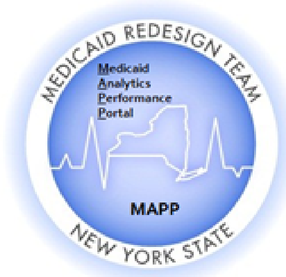
Milestone Name	Narrative Text

No Records Found

NYU Lutheran Medical Center (PPS ID:32)

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

Instructions :



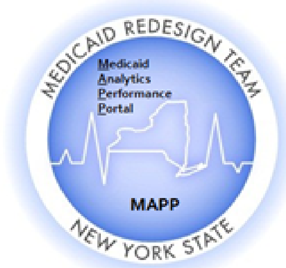
Project 3.c.i – Evidence-based strategies for disease management in high risk/affected populations (adults only)

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

Instructions :

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

1. PCMH Status - PPS partner support needed to achieve PCMH NCQA 2014 Level 3 status by DY 3 deadline may be greater than PPS's resources. Mitigation: The PPS will conduct a current state assessment, develop plans to support deployment of PCMH solutions to eligible providers across the PPS by DY 3 deadline; provide technical assistance to help eligible partners become PCMH 2014 NCQA Level 3 certified by end of DY 3.
2. Information Technology Adoption - PPS may be unable to use EHRs & other technical platforms effectively to track patients engaged in this project Mitigation: PPS will conduct a current state assessment and develop a plan to support partner implementation of EHRs /HIE connectivity; provide technical assistance, including data and analytic support, to assist partners with meeting tracking and reporting requirements.
3. Provider Engagement - PPS may not reach <80% of PCPs to engage in evidence-based best practices for diabetes management. Providers may resist adoption of standardized diabetes management project protocols. Mitigation: PPS will identify PCP partner project leaders to serve as project champions and liaise with them to build support across PPS provider network; establish provider buy-in; configure EMR/HIE functionality to ensure the system is user-friendly and provides critical information. PPS will educate on best practice protocols. PPS may consider incentive programs to support consistent protocol engagement.
4. MCO Contracting - PPS may struggle to negotiate agreements with MCOs related to coordination of services for high risk populations. Mitigation: PPS will leverage NYU's population health management expertise to structure and support implementation of care coordination strategies, reimbursement and incentive payment models for preventative screenings and services for high-risk populations. PPS leadership will work with MCOs to develop value-based payment models to identify data needs and proactively address issues impacting successful implementation of models. PPS will work with partners to identify and address readiness concerns and align incentive requirements where appropriate related to assuming financial risk and assist partners (e.g., FQHCs) where appropriate to develop structure and capacity to enter into risk-based contracts. PPS will ensure compliance with the Collaborative Contracting Model, antitrust requirements, and other laws and rules impacting MCO contracting initiative.
5. Patient Engagement - A proportion of the patients will be difficult to engage and may resist disease management efforts. Mitigation: PPS will utilize patient tracking and compliance tools to identify hard to engage populations and analyze data to determine size, location, clinical needs, reasons for resistance. PPS will leverage existing patient engagement data studies and prioritize populations based on scale, urgent need and potential impact, intensify intervention by patient navigation center; develop culturally-specific care navigation strategies, expertise and tools and deploy CHWs and embed CMs in PCMH sites to actively engage patients. PPS will target patient navigation strategies and train staff to discuss lifestyle changes to limit disease's impact and improve quality of life. PPS may incent patients to increase engagement and work in concert with Health Homes to support these patients. PPS will develop multilingual patient outreach and education materials around nutrition education, exercise, and other aspects of healthy living.
6. Data- Significant risk in State not transmitting timely, accurate, valid, & meaningful recent patient-specific data on our attributable population required to measure success of the initiative. Mitigation- None available.



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

Instructions :

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

Benchmarks	
100% Actively Engaged By	Expected Patient Engagement
DY3,Q4	5,075

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
2,088	3,339	131.61%	-802	65.79%

Current File Uploads

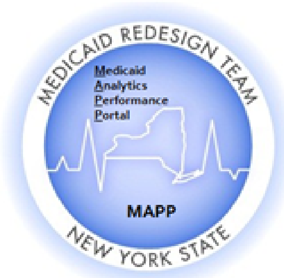
User ID	File Type	File Name	File Description	Upload Date
dbudman	Documentation/Certification	32_PMDL4415_1_3_20160115151410_3.c.i_-_DY1,_Q3.pdf	Patient Engagement - DY1, Q3 Project 3.c.i - Evidence-based strategies for disease management in high risk/affected populations (adults only)	01/15/2016 03:15 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	

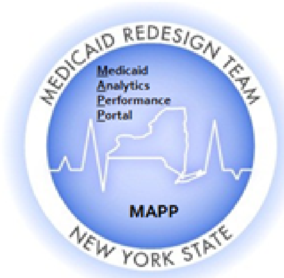


IPQR Module 3.c.i.3 - Prescribed Milestones

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.	Project	N/A	In Progress	05/01/2015	03/31/2018	05/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Evidence-based strategies for the management and control of diabetes in the PPS designated area are developed and implemented for all participating providers. Protocols for disease management are developed and training of staff is completed.	Project		In Progress	05/01/2015	03/31/2018	05/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Develop diabetes clinical protocols and to be used by providers across the PPS	Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. Develop a flexible diabetes workflow model that can be adapted for use by providers across the PPS	Project		Completed	10/01/2015	11/30/2015	10/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Step 3. Develop training & communication strategy, including diabetes best practice materials to be rolled out across the PPS provider network	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Roll out provider training and materials to primary care provider organizations in the network	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 5. Ensure ongoing access to PPS diabetes best practice protocols and other updated diabetes management resources via PPS provider portal	Project		Not Started	01/01/2017	03/31/2018	01/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task Step 6. Evaluate ramp-up success of providers utilizing the protocols and determine if any revisions and/or additional training/communication interventions are needed	Project		Not Started	07/01/2017	03/31/2018	07/01/2017	03/31/2018	03/31/2018	DY3 Q4



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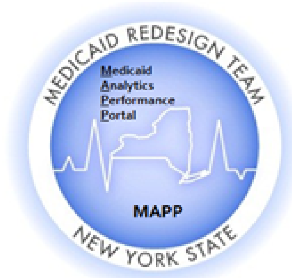
DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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 Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	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	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Review the PPS's diabetes disease management strategy and best practices with PCMH administrative & medical directors	Project		Completed	10/01/2015	11/30/2015	10/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Step 2. Develop training & communication strategy, including materials to be rolled out across the PPS provider network	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Roll out provider training and materials to primary care provider organizations in the network, tracking participation of PCPs in the training initiatives	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Confirm PCP use of the diabetes best practices via the PPS administrative & medical directors	Project		Not Started	04/01/2016	09/01/2016	04/01/2016	09/01/2016	09/30/2016	DY2 Q2
Task Step 5. Develop and implement strategy to engage PPS providers resistant to utilizing the PPS's diabetes disease management best practices	Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.	Project	N/A	In Progress	06/01/2015	03/31/2017	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	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	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination processes are established and implemented.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

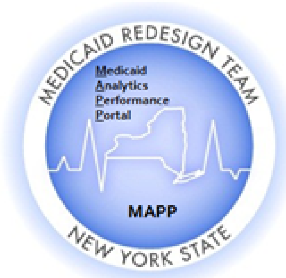


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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. Evaluate current diabetes care team models in place across PPS primary care settings, identifying care model strengths and gaps	Project		Completed	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. Establish definitions for: a) "high risk" diabetes patients to be referred to the Health Home for case management; b) "At Risk" diabetes patients who will require CHW support to supplement diabetes educator services; and c) "Not at risk" diabetes patients who will require a standard level of diabetes education and outreach from the PPS.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 3. Define diabetes care coordination services, CHW staff roles and virtual diabetes education program to be provided to PPS primary care partners.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4. Recruit/train new staffing roles. Determine deployment of diabetes education program services (both rotating in-person and virtual resources).	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 5. Pilot & evaluate the new diabetes care coordination resources and virtual diabetes education program across selected PPS primary care sites.	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 6. Expand access to diabetes care coordination resources across remaining PPS primary care provider organizations.	Project		Not Started	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7. Implement regular care coordination model evaluation and review process to assess & strengthen delivery of diabetes care coordination teams and resources	Project		Not Started	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task If applicable, PPS has Implemented collection of valid and	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4



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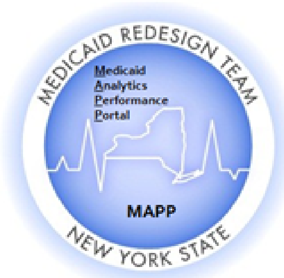
NYU Lutheran Medical Center (PPS ID:32)

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
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.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Complete current state assessment of diabetes patient registries active across the PPS primary care provider network and Brooklyn Health Home, focusing on the registries' abilities to collect valid and reliable REAL data (Race, Ethnicity and Language) to conduct hot-spotting analyses.	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Implement strategies to address any gaps in the collection of REAL data from patient registries. Strategies may include the use of retrospective SIMS data once patient-level SIMS data is made available by the State in December 2015.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Run PPS "hot-spotting" analyses to identify diabetes populations at the highest risk, evaluating the specific language & cultural requirements of those highest risk communities.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Launch collaborative planning among PPS diabetes project leaders & the Brooklyn Health Home leaders to develop patient diabetes education (e.g. Stanford model), & outreach models, tailored to the specific community requirements, as identified in the hot-spotting analyses.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 5. Provide Stanford model training for diabetes PCP, Health Home, PPS diabetes care coordination team members & CBO's, with approaches/content tailored to the local, high risk communities served	Project		Not Started	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 6. Pilot and evaluate diabetes Stanford model programs with diabetes populations at highest risk.	Project		Not Started	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4



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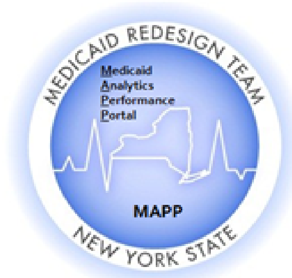
NYU Lutheran Medical Center (PPS ID:32)

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 roadmap to run future hot-spotting analyses and expand Stanford Model strategies across targeted communities in the PPS	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Ensure coordination with the Medicaid Managed Care organizations serving the target population.	Project	N/A	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.	Project		Not Started	10/01/2015	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Understand current MCO contracts in place and identify opportunities to engage PPS diabetes patients in value-based contracting arrangements across providers and target populations.	Project		Not Started	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Negotiate VBP contracts with at least one MCO (note - this will be part of the PPS's broader MCO strategy). Selected MCOs must be willing to support diabetes clinical project interventions, such as timely access to claims data for reporting and implementation of clinical care and coordination protocols.	Project		Not Started	09/01/2016	06/30/2017	09/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task Step 3. Implement value-based payment opportunities for diabetes populations and with new payers, as appropriate.	Project		Not Started	07/01/2017	03/31/2018	07/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Use EHRs or other technical platforms to track all patients engaged in this project.	Project	N/A	In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS uses a recall system that allows staff to report which patients are overdue for which preventive services and to track when and how patients were notified of needed services.	Project		Not Started	10/01/2015	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Complete current state assessment of EHRs and diabetes patient registries in use across the PPS primary care	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4



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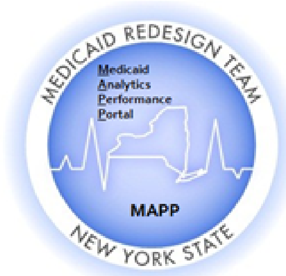
NYU Lutheran Medical Center (PPS ID:32)

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
provider network.									
Task Step 2. Identify gaps highlighting where a) current registries do not exist to meet PPS's clinical project requirements and target PPS populations, and, b) PPS primary care partners cannot easily upload appropriate EHR patient data to a patient registry.	Project		In Progress	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. Develop roadmap to achieving expansion and/or establishment of patient registries and EHR capabilities to track engaged diabetes populations across PPS primary care partners	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4. Identify resources, timing and expertise required to implement the patient registry plan for PPS primary care partners.	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Implement plan across PPS primary care partners	Project		Not Started	06/01/2016	03/31/2017	06/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.	Project	N/A	In Progress	10/01/2015	03/31/2018	10/01/2015	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	10/01/2015	03/31/2018	10/01/2015	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	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	Provider	Safety Net Mental Health	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Complete current state assessment of EHR systems' MU certification, APCM and 2014 Level 3 PCMH standards across primary PPS safety net providers.	Project		In Progress	10/01/2015	01/31/2016	10/01/2015	01/31/2016	03/31/2016	DY1 Q4



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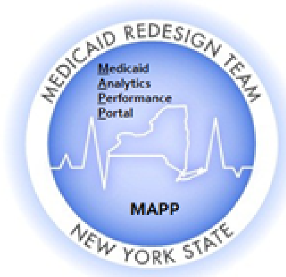
NYU Lutheran Medical Center (PPS ID:32)

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 gaps highlighting where PPS safety net members' fail to meet EHR MU, APCM and 2014 PCMH Level 3 certification requirements.	Project		In Progress	10/01/2015	03/01/2016	10/01/2015	03/01/2016	03/31/2016	DY1 Q4
Task Step 3. Develop roadmap to achieving EHR MU & 2014 PCMH Level 3 certification requirements across PPS safety net provider partners.	Project		Not Started	12/01/2015	04/30/2016	01/01/2016	04/30/2016	06/30/2016	DY2 Q1
Task Step 4. Work with Partners to identify resources and expertise required to implement EHR MU & 2014 PCMH Level 3 certification plan for PPS safety net provider partners.	Project		Not Started	01/01/2016	04/30/2016	01/01/2016	04/30/2016	06/30/2016	DY2 Q1
Task Step 5. Implement plan and support partners in completing EHR MU and 2014 PCMH Level 3 certification requirements.	Project		Not Started	05/01/2016	12/31/2017	05/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task Step 6. Confirm that all PPS safety net partners have met MU, PCMH Level 3 and/or APCM standards (by the end of DY3), and EHR connectivity requirements to RHIO SHIN-NY.	Project		Not Started	05/01/2016	03/31/2018	05/01/2016	03/31/2018	03/31/2018	DY3 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.										
Task Evidence-based strategies for the management and control of diabetes in the PPS designated area are developed and implemented for all participating providers. Protocols for disease management are developed and training of staff is completed.										
Task Step 1. Develop diabetes clinical protocols and to be used by providers across the PPS										
Task Step 2. Develop a flexible diabetes workflow model that can be adapted for use by providers across the PPS										
Task Step 3. Develop training & communication strategy, including diabetes best practice materials to be rolled out across the PPS										



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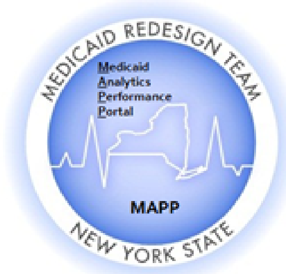
Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
provider network										
Task Step 4. Roll out provider training and materials to primary care provider organizations in the network										
Task Step 5. Ensure ongoing access to PPS diabetes best practice protocols and other updated diabetes management resources via PPS provider portal										
Task Step 6. Evaluate ramp-up success of providers utilizing the protocols and determine if any revisions and/or additional training/communication interventions are needed										
Milestone #2 Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.										
Task PPS has engaged at least 80% of their PCPs in this activity.	0	0	0	0	42	83	125	166	208	208
Task Step 1. Review the PPS's diabetes disease management strategy and best practices with PCMH administrative & medical directors										
Task Step 2. Develop training & communication strategy, including materials to be rolled out across the PPS provider network										
Task Step 3. Roll out provider training and materials to primary care provider organizations in the network, tracking participation of PCPs in the training initiatives										
Task Step 4. Confirm PCP use of the diabetes best practices via the PPS administrative & medical directors										
Task Step 5. Develop and implement strategy to engage PPS providers resistant to utilizing the PPS's diabetes disease management best practices										
Milestone #3 Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.										
Task Clinically Interoperable System is in place for all participating										



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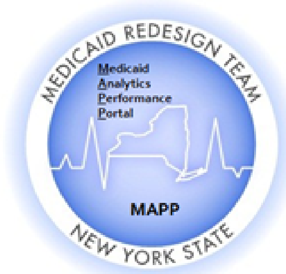
NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
providers.										
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.										
Task Care coordination processes are established and implemented.										
Task Step 1. Evaluate current diabetes care team models in place across PPS primary care settings, identifying care model strengths and gaps										
Task Step 2. Establish definitions for: a) "high risk" diabetes patients to be referred to the Health Home for case management; b) "At Risk" diabetes patients who will require CHW support to supplement diabetes educator services; and c) "Not at risk" diabetes patients who will require a standard level of diabetes education and outreach from the PPS.										
Task Step 3. Define diabetes care coordination services, CHW staff roles and virtual diabetes education program to be provided to PPS primary care partners.										
Task Step 4. Recruit/train new staffing roles. Determine deployment of diabetes education program services (both rotating in-person and virtual resources).										
Task Step 5. Pilot & evaluate the new diabetes care coordination resources and virtual diabetes education program across selected PPS primary care sites.										
Task Step 6. Expand access to diabetes care coordination resources across remaining PPS primary care provider organizations.										
Task Step 7. Implement regular care coordination model evaluation and review process to assess & strengthen delivery of diabetes care coordination teams and resources										
Milestone #4 Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.										



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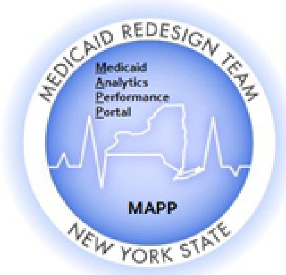
NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task If applicable, PPS has Implemented 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. Complete current state assessment of diabetes patient registries active across the PPS primary care provider network and Brooklyn Health Home, focusing on the registries' abilities to collect valid and reliable REAL data (Race, Ethnicity and Language) to conduct hot-spotting analyses.										
Task Step 2. Implement strategies to address any gaps in the collection of REAL data from patient registries. Strategies may include the use of retrospective SIMS data once patient-level SIMS data is made available by the State in December 2015.										
Task Step 3. Run PPS "hot-spotting" analyses to identify diabetes populations at the highest risk, evaluating the specific language & cultural requirements of those highest risk communities.										
Task Step 4. Launch collaborative planning among PPS diabetes project leaders & the Brooklyn Health Home leaders to develop patient diabetes education (e.g. Stanford model), & outreach models, tailored to the specific community requirements, as identified in the hot-spotting analyses.										
Task Step 5. Provide Stanford model training for diabetes PCP, Health Home, PPS diabetes care coordination team members & CBO's, with approaches/content tailored to the local, high risk communities served										
Task Step 6. Pilot and evaluate diabetes Stanford model programs with diabetes populations at highest risk.										
Task Step 7. Develop roadmap to run future hot-spotting analyses and expand Stanford Model strategies across targeted communities in the PPS										



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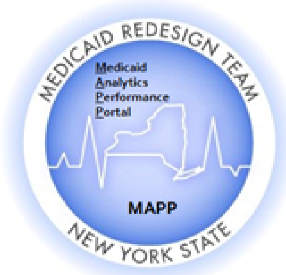
NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #5 Ensure coordination with the Medicaid Managed Care organizations serving the target population.										
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.										
Task Step 1. Understand current MCO contracts in place and identify opportunities to engage PPS diabetes patients in value-based contracting arrangements across providers and target populations.										
Task Step 2. Negotiate VBP contracts with at least one MCO (note - this will be part of the PPS's broader MCO strategy). Selected MCOs must be willing to support diabetes clinical project interventions, such as timely access to claims data for reporting and implementation of clinical care and coordination protocols.										
Task Step 3. Implement value-based payment opportunities for diabetes populations and with new payers, as appropriate.										
Milestone #6 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task PPS uses a recall system that allows staff to report which patients are overdue for which preventive services and to track when and how patients were notified of needed services.										
Task Step 1. Complete current state assessment of EHRs and diabetes patient registries in use across the PPS primary care provider network.										
Task Step 2. Identify gaps highlighting where a) current registries do not exist to meet PPS's clinical project requirements and target PPS populations, and, b) PPS primary care partners cannot easily upload appropriate EHR patient data to a patient registry.										
Task Step 3. Develop roadmap to achieving expansion and/or establishment of patient registries and EHR capabilities to track engaged diabetes populations across PPS primary care partners										



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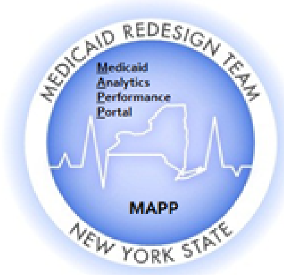
Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Step 4. Identify resources, timing and expertise required to implement the patient registry plan for PPS primary care partners.										
Task Step 5. Implement plan across PPS primary care partners										
Milestone #7 Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	0	0	5	21	42	62	83	104	146
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	0	0	0	0	0	0	0	0	11	29
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	0	0	0	0	0	0	0	0	9	23
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	0	0	0	0	0	0	0	0	6	16
Task Step 1. Complete current state assessment of EHR systems' MU certification, APCM and 2014 Level 3 PCMH standards across primary PPS safety net providers.										
Task Step 2. Identify gaps highlighting where PPS safety net members' fail to meet EHR MU, APCM and 2014 PCMH Level 3 certification requirements.										
Task Step 3. Develop roadmap to achieving EHR MU & 2014 PCMH Level 3 certification requirements across PPS safety net provider partners.										
Task Step 4. Work with Partners to identify resources and expertise required to implement EHR MU & 2014 PCMH Level 3 certification plan for PPS safety net provider partners.										
Task Step 5. Implement plan and support partners in completing EHR MU and 2014 PCMH Level 3 certification requirements.										
Task Step 6. Confirm that all PPS safety net partners have met MU,										



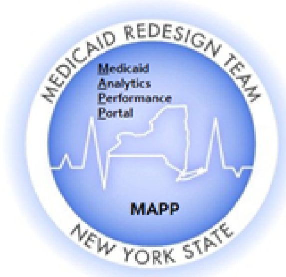
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
PCMH Level 3 and/or APCM standards (by the end of DY3), and EHR connectivity requirements to RHIO SHIN-NY.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.										
Task Evidence-based strategies for the management and control of diabetes in the PPS designated area are developed and implemented for all participating providers. Protocols for disease management are developed and training of staff is completed.										
Task Step 1. Develop diabetes clinical protocols and to be used by providers across the PPS										
Task Step 2. Develop a flexible diabetes workflow model that can be adapted for use by providers across the PPS										
Task Step 3. Develop training & communication strategy, including diabetes best practice materials to be rolled out across the PPS provider network										
Task Step 4. Roll out provider training and materials to primary care provider organizations in the network										
Task Step 5. Ensure ongoing access to PPS diabetes best practice protocols and other updated diabetes management resources via PPS provider portal										
Task Step 6. Evaluate ramp-up success of providers utilizing the protocols and determine if any revisions and/or additional training/communication interventions are needed										
Milestone #2 Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.										
Task PPS has engaged at least 80% of their PCPs in this activity.	208	208	208	208	208	208	208	208	208	208
Task Step 1. Review the PPS's diabetes disease management strategy and best practices with PCMH administrative & medical										

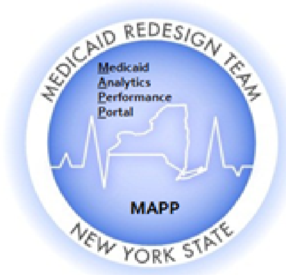


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
directors										
Task Step 2. Develop training & communication strategy, including materials to be rolled out across the PPS provider network										
Task Step 3. Roll out provider training and materials to primary care provider organizations in the network, tracking participation of PCPs in the training initiatives										
Task Step 4. Confirm PCP use of the diabetes best practices via the PPS administrative & medical directors										
Task Step 5. Develop and implement strategy to engage PPS providers resistant to utilizing the PPS's diabetes disease management best practices										
Milestone #3 Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.										
Task Clinically Interoperable System is in place for all participating providers.										
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.										
Task Care coordination processes are established and implemented.										
Task Step 1. Evaluate current diabetes care team models in place across PPS primary care settings, identifying care model strengths and gaps										
Task Step 2. Establish definitions for: a) "high risk" diabetes patients to be referred to the Health Home for case management; b) "At Risk" diabetes patients who will require CHW support to supplement diabetes educator services; and c) "Not at risk" diabetes patients who will require a standard level of diabetes education and outreach from the PPS.										
Task Step 3. Define diabetes care coordination services, CHW staff roles and virtual diabetes education program to be provided to										

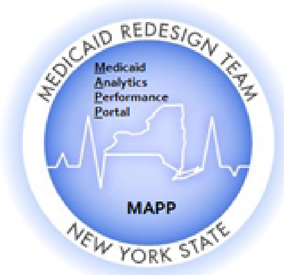


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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 primary care partners.										
Task Step 4. Recruit/train new staffing roles. Determine deployment of diabetes education program services (both rotating in-person and virtual resources).										
Task Step 5. Pilot & evaluate the new diabetes care coordination resources and virtual diabetes education program across selected PPS primary care sites.										
Task Step 6. Expand access to diabetes care coordination resources across remaining PPS primary care provider organizations.										
Task Step 7. Implement regular care coordination model evaluation and review process to assess & strengthen delivery of diabetes care coordination teams and resources										
Milestone #4 Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.										
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.										
Task If applicable, PPS has established linkages to health homes for targeted patient populations.										
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.										
Task Step 1. Complete current state assessment of diabetes patient registries active across the PPS primary care provider network and Brooklyn Health Home, focusing on the registries' abilities to collect valid and reliable REAL data (Race, Ethnicity and Language) to conduct hot-spotting analyses.										
Task Step 2. Implement strategies to address any gaps in the collection of REAL data from patient registries. Strategies may include the use of retrospective SIMS data once patient-level SIMS data is made available by the State in December 2015.										

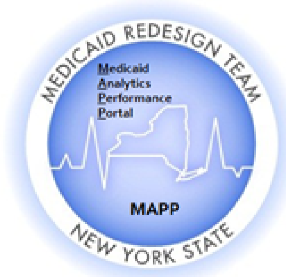


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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. Run PPS "hot-spotting" analyses to identify diabetes populations at the highest risk, evaluating the specific language & cultural requirements of those highest risk communities.										
Task Step 4. Launch collaborative planning among PPS diabetes project leaders & the Brooklyn Health Home leaders to develop patient diabetes education (e.g. Stanford model), & outreach models, tailored to the specific community requirements, as identified in the hot-spotting analyses.										
Task Step 5. Provide Stanford model training for diabetes PCP, Health Home, PPS diabetes care coordination team members & CBO's, with approaches/content tailored to the local, high risk communities served										
Task Step 6. Pilot and evaluate diabetes Stanford model programs with diabetes populations at highest risk.										
Task Step 7. Develop roadmap to run future hot-spotting analyses and expand Stanford Model strategies across targeted communities in the PPS										
Milestone #5 Ensure coordination with the Medicaid Managed Care organizations serving the target population.										
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.										
Task Step 1. Understand current MCO contracts in place and identify opportunities to engage PPS diabetes patients in value-based contracting arrangements across providers and target populations.										
Task Step 2. Negotiate VBP contracts with at least one MCO (note - this will be part of the PPS's broader MCO strategy). Selected MCOs must be willing to support diabetes clinical project interventions, such as timely access to claims data for reporting and implementation of clinical care and coordination protocols.										
Task Step 3. Implement value-based payment opportunities for diabetes populations and with new payers, as appropriate.										

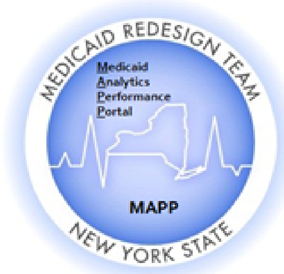


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #6 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task PPS uses a recall system that allows staff to report which patients are overdue for which preventive services and to track when and how patients were notified of needed services.										
Task Step 1. Complete current state assessment of EHRs and diabetes patient registries in use across the PPS primary care provider network.										
Task Step 2. Identify gaps highlighting where a) current registries do not exist to meet PPS's clinical project requirements and target PPS populations, and, b) PPS primary care partners cannot easily upload appropriate EHR patient data to a patient registry.										
Task Step 3. Develop roadmap to achieving expansion and/or establishment of patient registries and EHR capabilities to track engaged diabetes populations across PPS primary care partners										
Task Step 4. Identify resources, timing and expertise required to implement the patient registry plan for PPS primary care partners.										
Task Step 5. Implement plan across PPS primary care partners										
Milestone #7 Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	166	208	208	208	208	208	208	208	208	208
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	57	114	114	114	114	114	114	114	114	114
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	46	92	92	92	92	92	92	92	92	92



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

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	32	63	63	63	63	63	63	63	63	63
Task Step 1. Complete current state assessment of EHR systems' MU certification, APCM and 2014 Level 3 PCMH standards across primary PPS safety net providers.										
Task Step 2. Identify gaps highlighting where PPS safety net members' fail to meet EHR MU, APCM and 2014 PCMH Level 3 certification requirements.										
Task Step 3. Develop roadmap to achieving EHR MU & 2014 PCMH Level 3 certification requirements across PPS safety net provider partners.										
Task Step 4. Work with Partners to identify resources and expertise required to implement EHR MU & 2014 PCMH Level 3 certification plan for PPS safety net provider partners.										
Task Step 5. Implement plan and support partners in completing EHR MU and 2014 PCMH Level 3 certification requirements.										
Task Step 6. Confirm that all PPS safety net partners have met MU, PCMH Level 3 and/or APCM standards (by the end of DY3), and EHR connectivity requirements to RHIO SHIN-NY.										

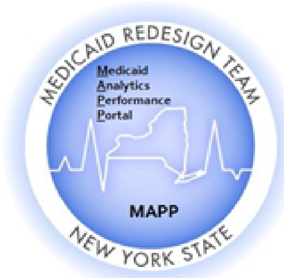
Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.	
Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.	



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

DSRIP Implementation Plan Project

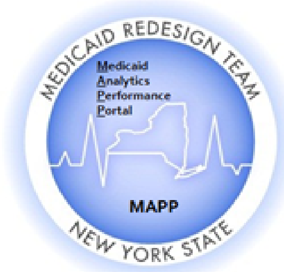
NYU Lutheran Medical Center (PPS ID:32)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.	
Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.	
Ensure coordination with the Medicaid Managed Care organizations serving the target population.	
Use EHRs or other technical platforms to track all patients engaged in this project.	
Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.	

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

NYU Lutheran Medical Center (PPS ID:32)

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

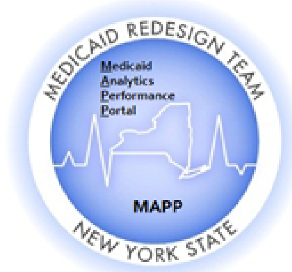
Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

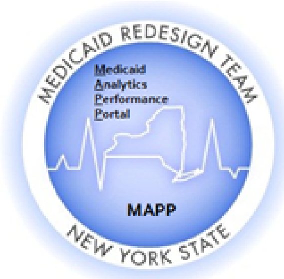
Milestone Name	Narrative Text

No Records Found



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

Instructions :



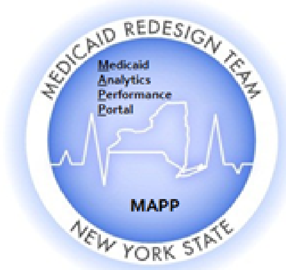
Project 3.d.ii – Expansion of asthma home-based self-management program

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.

1. IT Adoption- PPS may be unable to effectively use EHRs & other technical platforms to track patients engaged in this project for proactive care management and milestone reporting. Mitigation: PPS will conduct current state assessment and develop a plan to support partner implementation of EHRs /HIE connectivity; provide technical assistance to partners.
2. IT Connectivity- PPS partner support required to meet EHR, data sharing and HIE connectivity requirements may be greater than the PPS's resources. Mitigation: PPS will conduct current state assessment to develop a work plan and determine the best approach, resources required and timing to support partner's implementation of EHRs/HIE connectivity; leverage NYU's HIE platform and help establish connectivity to HIE and the RHIO/SHIN-NY.
3. Provider Engagement- Providers resist adoption of standardized asthma home-based interventions project protocols. Mitigation: PPS will identify clinical project leader(s) to serve as project champions and liaise with partner champions to build support across PPS network; establish buy-in by engaging them to design and agree upon standardized evidence-based best practice protocols; configure EMR /HIE functionality to ensure system is user-friendly and provides information critical to meet goals. PPS will provide education on the protocols and consider incentive programs to support consistent protocol engagement.
4. MCO Contracting- PPS may struggle to negotiate agreements with MCOs related to coordination of services for high risk populations. Mitigation: PPS will leverage NYULMC's Population Health Management expertise to structure and support implementation of care coordination strategies, reimbursement and incentive payment models. PPS leadership will work with MCOs to develop VBP models to identify data needs and address issues impacting successful implementation. PPS will work with partners where appropriate to identify and address readiness concerns; align incentive requirements related to assuming financial risk and assist partners in developing the structure and capacity to enter into risk-based contracts.
5. Patient Engagement - A portion of PPS's lives may be hard to engage and may resist disease management interventions or unable to combat environmental triggers at home. Mitigation: PPS will track patient compliance, identifying populations and analyze data to determine demographic profile, size, location, clinical needs, reasons for resistance; leverage existing patient engagement studies and prioritize populations based on scale, urgent need and potential impact; intensify intervention by PNC; develop culturally-specific care navigation strategies, expertise and tools; deploy CHWs and embed CMs in PCMH sites to discuss cultural barriers to interventions; work with airNYC to identify best practices for patient engagement and removal of environmental triggers. PPS will collaborate with DOHMH and other PPSs to leverage available city resources.
6. Workforce- PPS encounters challenges recruiting adequate numbers of CHWs to support home-based visiting program. Mitigation: PPS will identify project staffing needs and prioritize voluntary redeployment opportunities to fill vacant positions and promote retraining opportunities. PPS will coordinate efforts with workforce vendor on recruitment and training on best practices/protocols. Recruit diverse CHWs to meet needs of patients.
7. Data- Significant risk in State not transmitting timely, accurate, valid, & meaningful recent patient-specific data on our attributable population required to measure success of the initiative. Mitigation- None available.



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

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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	2,339

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%	234	0.00%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (234)

Current File Uploads

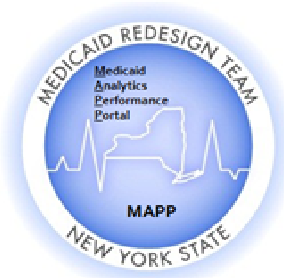
User ID	File Type	File Name	File Description	Upload Date
dbudman	Documentation/Certification	32_PMDL4715_1_3_20160115152707_3.d.ii_-_DY1,_Q3.pdf	Patient Engagement - DY1, Q3 Project 3.d.ii - Expansion of asthma home-based self-management program	01/15/2016 03:27 PM

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

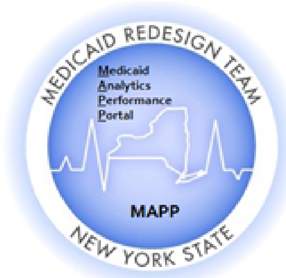
NYU Lutheran Medical Center (PPS ID:32)

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	05/01/2015	03/31/2018	05/01/2015	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	05/01/2015	03/31/2018	05/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Understand current asthma clinical and home-based self-management programs in use across PPS primary care providers.	Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. Review and adopt best practice asthma self-management guidelines, including referral criteria to home environmental assessment, home environment trigger reduction, medication and self-management protocols.	Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 3. Contract with vendor to provide asthma home-based self-management program.	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Work with vendor to develop referral flows from PPS PCPs, relevant specialists and ERs.	Project		Not Started	10/01/2015	12/31/2015	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 5. Roll out provider training and materials to NYU Lutheran emergency department staff and primary care provider organizations in the network.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 6. Ensure ongoing access to PPS asthma home-based self-management protocols via the PPS website and patient	Project		Not Started	01/01/2017	03/31/2018	01/01/2017	03/31/2018	03/31/2018	DY3 Q4

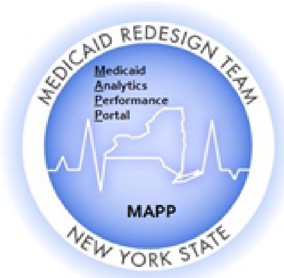


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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
portal.									
Task Step 7. Evaluate ramp-up success of patients utilizing the home-based self-management program and determine if any revisions, additional training, or communication interventions are needed.	Project		Not Started	07/01/2017	03/31/2018	07/01/2017	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	08/01/2015	03/31/2017	08/01/2015	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	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Collaborate with vendor to understand their program offerings related to indoor home environment assessments and criteria for referring patients to appropriate resources.	Project		Completed	08/01/2015	09/30/2015	08/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. Adopt vendor procedures to link asthma patients with poor indoor environment triggers to appropriate resources.	Project		Not Started	10/01/2015	12/31/2015	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. Engage vendor to conduct a pilot program employing PPS procedures adopted in Step 2 across several PPS PCP sites and NYU Lutheran emergency department.	Project		Not Started	10/01/2015	06/30/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4. Engage vendor and start referring PPS patients for home-based trigger reduction interventions.	Project		Not Started	10/01/2015	06/30/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 5. Evaluate data to determine success of vendor program. If successful, expand contract with vendor to scale for the whole PPS network. If not successful, reassess options with PPS's Care Management services.	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Develop and implement evidence-based asthma management guidelines.	Project	N/A	In Progress	06/01/2015	03/31/2017	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS incorporates evidence-based guidelines that are	Project		In Progress	06/01/2015	03/31/2017	06/01/2015	03/31/2017	03/31/2017	DY2 Q4

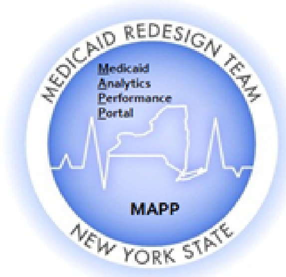


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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
periodically evaluated and revised, if necessary, in the design and implementation of asthma management.									
Task Step 1. Adopt comprehensive evidence-based asthma management clinical guidelines to be used across PPS.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. Develop training & communication strategy, including materials to be rolled out across the PPS provider network.	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Roll out provider training and materials to primary care provider organizations in the network.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Ensure ongoing access to PPS asthma best practice guidelines and other updated asthma management resources via PPS provider portal.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Step 5. Evaluate ramp-up success of providers utilizing the guidelines and determine if any revisions and/or additional training/communication interventions are needed.	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	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	10/01/2015	03/31/2017	10/01/2015	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	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Review and align PPS asthma self-management education materials used by PCPs in network and by selected home-based asthma care vendor. Select materials. Translate materials to meet specific cultural needs across communities served.	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

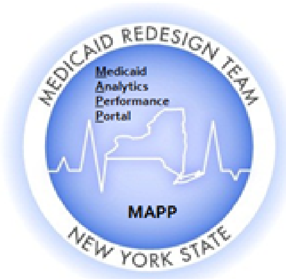


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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. Develop training and communication strategy to be rolled out across the PPS provider network.	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Roll out provider training and materials to primary care provider organizations in the network.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 4. Ensure ongoing access to PPS provider training and asthma self-education services via the PPS website/patient and provider portals.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Step 5. Evaluate ramp-up success of providers utilizing the guidelines and determine if any revisions and/or additional training/communication interventions are needed.	Project		Not Started	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	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has developed and conducted training of all providers, including social services and support.	Project		Not Started	10/01/2015	03/31/2018	02/01/2016	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	10/01/2015	03/31/2018	10/01/2015	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		Not Started	10/01/2015	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Coordinate social services and supports (i.e. access to legal services, pest control, etc.) in collaboration with vendor for patients referred to home visits.	Project		Not Started	10/01/2015	10/30/2015	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 2. Determine how the BB PPS Patient Navigation Center (PNC) & Care Management strategy - in concert with vendor's role as PPS asthma home environmental provider - can provide social service supports.	Project		Not Started	11/01/2016	12/31/2016	11/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task	Project		Not Started	02/15/2016	03/31/2018	02/15/2016	03/31/2018	03/31/2018	DY3 Q4

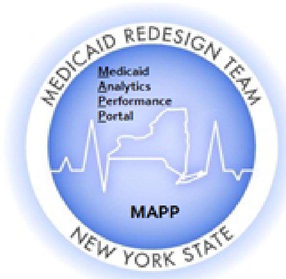


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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 3. Implement coordinated care model for asthma patients and continue monitoring and reviewing practices to ensure continued success.									
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	10/01/2015	03/31/2017	10/01/2015	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	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Determine current post-ED/hospital follow-up services provided to patients admitted due to asthma.	Project		In Progress	10/01/2015	10/30/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Engage the ED Care Triage program to understand how best to integrate and implement the post-ED/hospital protocols for asthmatics into the ED Care Triage project's ED discharge program.	Project		Completed	11/01/2015	12/31/2015	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3 Develop protocols for post-ED/hospital follow-up services for patients admitted due to asthma in coordination with ED care triage group.	Project		In Progress	11/01/2015	12/31/2015	11/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Engage vendor to conduct follow-up services with asthmatic patients who are admitted to the emergency department.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
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	10/01/2015	03/31/2018	10/01/2015	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	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Determine current communication and asthma care coordination models in place across PPS providers, Medicaid	Project		In Progress	10/01/2015	10/30/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

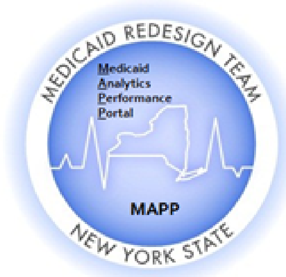


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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
Managed Care plans, and Health Home managers.									
Task Step 2. Identify gaps in current communication and care coordination models.	Project		In Progress	10/01/2015	10/30/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Engage the BB PPS Patient Navigation Center (PNC) & Care Management Strategy to enable and ensure communication, coordination, and continuity of asthma care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	Project		Not Started	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	10/01/2015	03/31/2017	10/01/2015	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		Not Started	10/01/2015	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Complete current state assessment of EHRs and asthma patient registries in use across the PPS primary care provider network.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Identify gaps highlighting where a) current registries do not exist to meet PPS's clinical project requirements and target PPS populations, and, b) PPS primary care partners cannot easily upload appropriate EHR patient data to a patient registry.	Project		In Progress	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. Develop roadmap to achieving expansion and/or establishment of patient registries and EHR capabilities to track engaged asthma populations across PPS primary care partners	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4. Identify resources, timing and expertise required to implement the patient registry plan for PPS primary care partners.	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Implement plan across PPS primary care partners	Project		Not Started	06/01/2016	03/31/2017	06/01/2016	03/31/2017	03/31/2017	DY2 Q4



New York State Department Of Health
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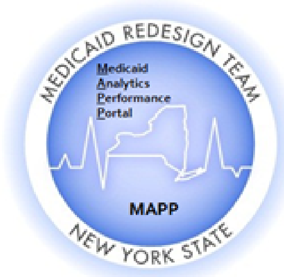
DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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 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. Understand current asthma clinical and home-based self-management programs in use across PPS primary care providers.										
Task Step 2. Review and adopt best practice asthma self-management guidelines, including referral criteria to home environmental assessment, home environment trigger reduction, medication and self-management protocols.										
Task Step 3. Contract with vendor to provide asthma home-based self-management program.										
Task Step 4. Work with vendor to develop referral flows from PPS PCPs, relevant specialists and ERs.										
Task Step 5. Roll out provider training and materials to NYU Lutheran emergency department staff and primary care provider organizations in the network.										
Task Step 6. Ensure ongoing access to PPS asthma home-based self-management protocols via the PPS website and patient portal.										
Task Step 7. Evaluate ramp-up success of patients utilizing the home-based self-management program and determine if any revisions, additional training, or communication interventions are needed.										
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.										

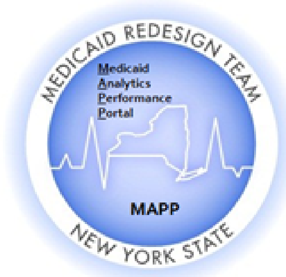


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project 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. Collaborate with vendor to understand their program offerings related to indoor home environment assessments and criteria for referring patients to appropriate resources.										
Task Step 2. Adopt vendor procedures to link asthma patients with poor indoor environment triggers to appropriate resources.										
Task Step 3. Engage vendor to conduct a pilot program employing PPS procedures adopted in Step 2 across several PPS PCP sites and NYU Lutheran emergency department.										
Task Step 4. Engage vendor and start referring PPS patients for home-based trigger reduction interventions.										
Task Step 5. Evaluate data to determine success of vendor program. If successful, expand contract with vendor to scale for the whole PPS network. If not successful, reassess options with PPS's Care Management services.										
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. Adopt comprehensive evidence-based asthma management clinical guidelines to be used across PPS.										
Task Step 2. Develop training & communication strategy, including materials to be rolled out across the PPS provider network.										
Task Step 3. Roll out provider training and materials to primary care provider organizations in the network.										
Task Step 4. Ensure ongoing access to PPS asthma best practice guidelines and other updated asthma management resources via PPS provider portal.										
Task Step 5. Evaluate ramp-up success of providers utilizing the guidelines and determine if any revisions and/or additional training/communication interventions are needed.										
Milestone #4 Implement training and asthma self-management education										

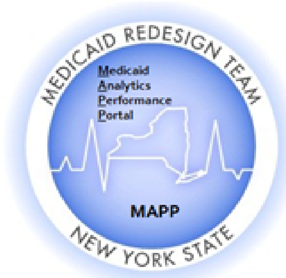


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
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. Review and align PPS asthma self-management education materials used by PCPs in network and by selected home-based asthma care vendor. Select materials. Translate materials to meet specific cultural needs across communities served.										
Task Step 2. Develop training and communication strategy to be rolled out across the PPS provider network.										
Task Step 3. Roll out provider training and materials to primary care provider organizations in the network.										
Task Step 4. Ensure ongoing access to PPS provider training and asthma self-education services via the PPS website/patient and provider portals.										
Task Step 5. Evaluate ramp-up success of providers utilizing the guidelines and determine if any revisions and/or additional training/communication interventions are needed.										
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										



New York State Department Of Health
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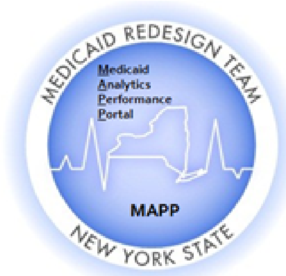
DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
self-management.										
Task Step 1. Coordinate social services and supports (i.e. access to legal services, pest control, etc.) in collaboration with vendor for patients referred to home visits.										
Task Step 2. Determine how the BB PPS Patient Navigation Center (PNC) & Care Management strategy - in concert with vendor's role as PPS asthma home environmental provider - can provide social service supports.										
Task Step 3. Implement coordinated care model for asthma patients and continue monitoring and reviewing practices to ensure continued success.										
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. Determine current post-ED/hospital follow-up services provided to patients admitted due to asthma.										
Task Step 2. Engage the ED Care Triage program to understand how best to integrate and implement the post-ED/hospital protocols for asthmatics into the ED Care Triage project's ED discharge program.										
Task Step 3 Develop protocols for post-ED/hospital follow-up services for patients admitted due to asthma in coordination with ED care triage group.										
Task Step 4. Engage vendor to conduct follow-up services with asthmatic patients who are admitted to the emergency department.										
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										



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

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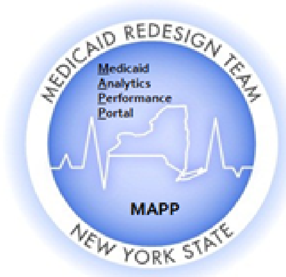
NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers.										
Task Step 1. Determine current communication and asthma care coordination models in place across PPS providers, Medicaid Managed Care plans, and Health Home managers.										
Task Step 2. Identify gaps in current communication and care coordination models.										
Task Step 3. Engage the BB PPS Patient Navigation Center (PNC) & Care Management Strategy to enable and ensure communication, coordination, and continuity of asthma care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.										
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. Complete current state assessment of EHRs and asthma patient registries in use across the PPS primary care provider network.										
Task Step 2. Identify gaps highlighting where a) current registries do not exist to meet PPS's clinical project requirements and target PPS populations, and, b) PPS primary care partners cannot easily upload appropriate EHR patient data to a patient registry.										
Task Step 3. Develop roadmap to achieving expansion and/or establishment of patient registries and EHR capabilities to track engaged asthma populations across PPS primary care partners										
Task Step 4. Identify resources, timing and expertise required to implement the patient registry plan for PPS primary care partners.										
Task Step 5. Implement plan across PPS primary care partners										



New York State Department Of Health
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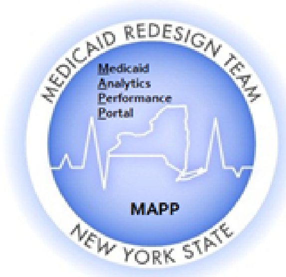
NYU Lutheran Medical Center (PPS ID:32)

Project 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. Understand current asthma clinical and home-based self-management programs in use across PPS primary care providers.										
Task Step 2. Review and adopt best practice asthma self-management guidelines, including referral criteria to home environmental assessment, home environment trigger reduction, medication and self-management protocols.										
Task Step 3. Contract with vendor to provide asthma home-based self-management program.										
Task Step 4. Work with vendor to develop referral flows from PPS PCPs, relevant specialists and ERs.										
Task Step 5. Roll out provider training and materials to NYU Lutheran emergency department staff and primary care provider organizations in the network.										
Task Step 6. Ensure ongoing access to PPS asthma home-based self-management protocols via the PPS website and patient portal.										
Task Step 7. Evaluate ramp-up success of patients utilizing the home-based self-management program and determine if any revisions, additional training, or communication interventions are needed.										
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.										



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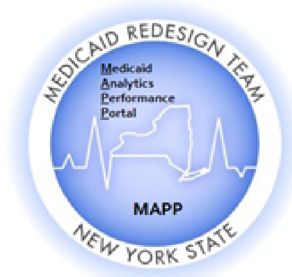
NYU Lutheran Medical Center (PPS ID:32)

Project 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. Collaborate with vendor to understand their program offerings related to indoor home environment assessments and criteria for referring patients to appropriate resources.										
Task Step 2. Adopt vendor procedures to link asthma patients with poor indoor environment triggers to appropriate resources.										
Task Step 3. Engage vendor to conduct a pilot program employing PPS procedures adopted in Step 2 across several PPS PCP sites and NYU Lutheran emergency department.										
Task Step 4. Engage vendor and start referring PPS patients for home-based trigger reduction interventions.										
Task Step 5. Evaluate data to determine success of vendor program. If successful, expand contract with vendor to scale for the whole PPS network. If not successful, reassess options with PPS's Care Management services.										
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. Adopt comprehensive evidence-based asthma management clinical guidelines to be used across PPS.										
Task Step 2. Develop training & communication strategy, including materials to be rolled out across the PPS provider network.										
Task Step 3. Roll out provider training and materials to primary care provider organizations in the network.										
Task Step 4. Ensure ongoing access to PPS asthma best practice guidelines and other updated asthma management resources via PPS provider portal.										
Task Step 5. Evaluate ramp-up success of providers utilizing the guidelines and determine if any revisions and/or additional training/communication interventions are needed.										
Milestone #4 Implement training and asthma self-management education										



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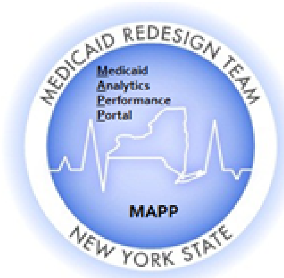
NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
services, including 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. Review and align PPS asthma self-management education materials used by PCPs in network and by selected home-based asthma care vendor. Select materials. Translate materials to meet specific cultural needs across communities served.										
Task Step 2. Develop training and communication strategy to be rolled out across the PPS provider network.										
Task Step 3. Roll out provider training and materials to primary care provider organizations in the network.										
Task Step 4. Ensure ongoing access to PPS provider training and asthma self-education services via the PPS website/patient and provider portals.										
Task Step 5. Evaluate ramp-up success of providers utilizing the guidelines and determine if any revisions and/or additional training/communication interventions are needed.										
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										

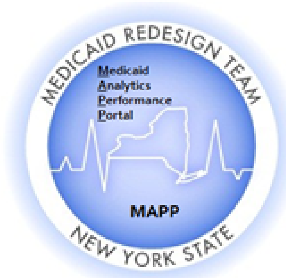


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
self-management.										
Task Step 1. Coordinate social services and supports (i.e. access to legal services, pest control, etc.) in collaboration with vendor for patients referred to home visits.										
Task Step 2. Determine how the BB PPS Patient Navigation Center (PNC) & Care Management strategy - in concert with vendor's role as PPS asthma home environmental provider - can provide social service supports.										
Task Step 3. Implement coordinated care model for asthma patients and continue monitoring and reviewing practices to ensure continued success.										
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. Determine current post-ED/hospital follow-up services provided to patients admitted due to asthma.										
Task Step 2. Engage the ED Care Triage program to understand how best to integrate and implement the post-ED/hospital protocols for asthmatics into the ED Care Triage project's ED discharge program.										
Task Step 3 Develop protocols for post-ED/hospital follow-up services for patients admitted due to asthma in coordination with ED care triage group.										
Task Step 4. Engage vendor to conduct follow-up services with asthmatic patients who are admitted to the emergency department.										
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										

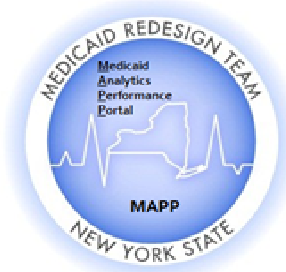


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers.										
Task Step 1. Determine current communication and asthma care coordination models in place across PPS providers, Medicaid Managed Care plans, and Health Home managers.										
Task Step 2. Identify gaps in current communication and care coordination models.										
Task Step 3. Engage the BB PPS Patient Navigation Center (PNC) & Care Management Strategy to enable and ensure communication, coordination, and continuity of asthma care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.										
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. Complete current state assessment of EHRs and asthma patient registries in use across the PPS primary care provider network.										
Task Step 2. Identify gaps highlighting where a) current registries do not exist to meet PPS's clinical project requirements and target PPS populations, and, b) PPS primary care partners cannot easily upload appropriate EHR patient data to a patient registry.										
Task Step 3. Develop roadmap to achieving expansion and/or establishment of patient registries and EHR capabilities to track engaged asthma populations across PPS primary care partners										
Task Step 4. Identify resources, timing and expertise required to implement the patient registry plan for PPS primary care partners.										
Task Step 5. Implement plan across PPS primary care partners										



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

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

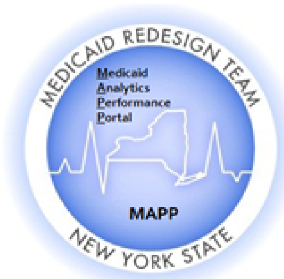
No Records Found

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.	The Brooklyn Bridges PPS is in active negotiations with a home-based asthma assessment vendor. We will provide updates as the DSRIP Program continues.
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.	
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	



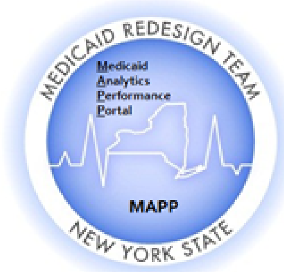
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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	



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

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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

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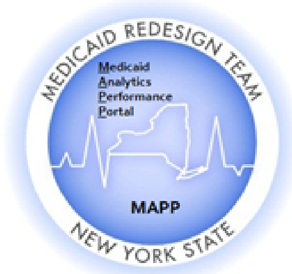
PPS Defined Milestones Narrative Text

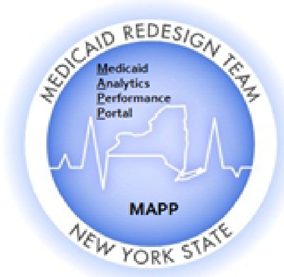
Milestone Name	Narrative Text

No Records Found



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

NYU Lutheran Medical Center (PPS ID:32)

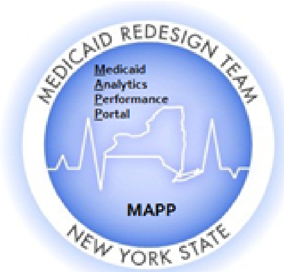
Project 4.b.i – Promote tobacco use cessation, especially among low SES populations and those with poor mental health.

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

Instructions :

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

1. Information Technology Adoption Risk
PPS struggles to effectively use EHRs/other technical platforms to track all patients engaged in this project for proactive care management and for milestone reporting. Mitigation: PPS will conduct a current state assessment and develop a plan to support partner implementation of EHRs/HIE connectivity; provide technical assistance, including data and analytic support, to assist partners with meeting tracking and reporting requirements.
2. Patient Engagement Risk- PPS may encounter difficulties actively engaging "hard to reach" patients, particularly those where tobacco use remains a cultural norm which may lead to low patient participation. Mitigation: PPS will leverage NYU's expertise in engaging the Chinese-American community in tobacco use cessation. Facilitate culturally-competent tobacco patient interventions and counseling and recruit providers to make referrals to the NY Quitline and Asian Quitline, as appropriate. Work with partners to develop culturally-competent outreach and engagement strategies for reaching Arab, Latino and other identified communities. Work with BH partners to engage behavioral health patients in a clinically appropriate manner. Facilitate culturally-competent tobacco patient interventions and counseling; and recruit providers to make referrals to the NY Quitline and Asian Quitline, as appropriate. PPS will develop multilingual patient education materials that identify the risks of smoking and available support to help patients quit and engage its providers to assess patient tobacco use status and train them on the risks of smoking and benefits of quitting. PPS will provide technical assistance, such as data and analytic support, to assist partners with meeting tracking and reporting requirements.
3. CBO Engagement Risk:
a. Demographic and socio-economic factors may impede uptake of this initiative across the PPS's population base. The PPS may struggle to sustain provider commitment in the project, as the project does not have scale and speed commitments. Mitigation: The PPS will partner with numerous CBOs that are embedded and trusted in the community and whose missions include addressing poverty, education, and cultural barriers. These partnerships will help PPS target not only the specific issue of tobacco use but also broader socio-economic and demographic factors to improve overall health and well-being. The PPS will consider the use of provider incentives for providers that successfully engage patients in tobacco use cessation conversations and make referrals to the Quitline.
b. The PPS may struggle to sustain provider commitment in the project, as the project does not have scale and speed commitments. Mitigation: The PPS will discuss the project's outcome measures and the importance of meeting those measures in order to receive funding. Collaborating with other PPSs and the DOHMH will help to sustain momentum and efficient allocation of project resources to maintain communication and outreach with PPS providers across Brooklyn.
c. Brooklyn-based CBOs are likely to be partnering with multiple PPSs and already face many competing demands for their expertise, time and resources; PPS may be stretched to provide support to CBOs to deploy community-based interventions. Mitigation: The PPS will partner with the DOHMH and other PPSs implementing this project to leverage existing resources and minimize duplication of effort. The PPS will leverage the MIX to share best practices with other PPSs and partner organizations.



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

DSRIP Implementation Plan Project

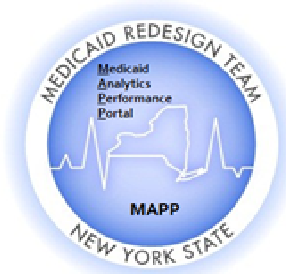
NYU Lutheran Medical Center (PPS ID:32)

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Milestone #1	Not Started	Convene a collaborative of CBOs to plan, set milestones, and implement a community campaign.	01/01/2016	03/31/2020	01/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task Step 1	Not Started	Convene an initial planning workgroup with PPS partners to develop a framework for community collaboration.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 2	Not Started	Develop a communication strategy to let community partners know that the PPS is pursuing the project and invite collaboration.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 3	Not Started	Convene CBOs to plan and set milestones for culturally-specific community campaigns, including: (1) the enhancement of tobacco cessation education and counseling at CBOs and, (2) the development and promotion of tobacco-free environments across the PPS.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4	Not Started	Implement community campaign and develop a forum for continuing community dialogue to exchange best practices and opportunities for collaboration on tobacco cessation programs.	04/01/2016	03/31/2020	04/01/2016	03/31/2020	03/31/2020	DY5 Q4
Milestone Milestone #2	In Progress	Convene a collaborative of PPSs undertaking the tobacco cessation project and partnering with NYC DOHMH.	01/01/2016	03/31/2020	10/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 1	Not Started	Convene an initial planning workgroup with PPS partners to develop a framework for community and cross-PPS collaboration.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 2	Not Started	Schedule and hold meetings with the other NYC PPSs pursuing the project (contingent on the PPSs' willingness to collaborate) and NYC DOHMH to discuss planning and collaboration.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 3	Not Started	Plan and set milestones for cross-PPS initiatives, including a payer strategy to enhance coverage of tobacco cessation treatment and medication and the identification of value-based models of reimbursement.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 4	Not Started	Implement cross-PPS tobacco cessation plan and develop forum for ongoing communication with NYC DOHMH and the other NYC PPSs pursuing the project.	04/01/2016	03/31/2020	04/01/2016	03/31/2020	03/31/2020	DY5 Q4
Milestone	In Progress	Agree upon shared resources across partners to implement the 5A	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

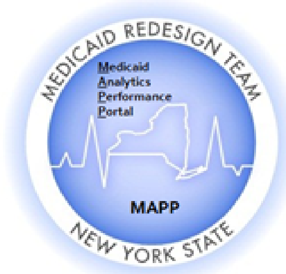


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #3		tobacco cessation protocol in primary care settings.						
Task Step 1	Completed	Develop 5A tobacco cessation clinical protocols to be used by providers in the PPS.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2	Not Started	Develop flexible 5A workflow model that can be adapted for use by providers across the PPS.	10/01/2015	12/31/2015	02/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 3	Not Started	Develop training and communication strategy, including tobacco cessation best practice materials to be rolled out across the PPS provider network.	10/01/2015	12/31/2015	02/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 4	Not Started	Agree upon staffing resources (e.g., Tobacco Cessation Educator) to serve the PPS and recruit the identified position(s).	11/01/2015	03/31/2016	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 5	Not Started	Roll out provider training and materials to primary care provider organizations in the network implementing the project.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6	Not Started	Evaluate ramp-up success of providers utilizing the 5A protocol and determine if any revisions and/or additional training/communication interventions are needed.	07/01/2017	03/31/2018	07/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone Milestone #4	Not Started	Agree upon a data sharing system to address reporting and implementation needs.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1	Not Started	Complete current state assessment of EHRs and tobacco cessation patient registries in use across the PPS primary care provider network.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 2	Not Started	Identify gaps highlighting where a) current registries do not exist to meet PPS's clinical project requirements and target PPS populations, and, b) PPS primary care partners cannot easily upload appropriate EHR patient data to a patient registry.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 3	Not Started	Develop roadmap to achieving expansion and/or establishment of patient registries and EHR capabilities to track engaged tobacco cessation populations across PPS primary care partners.	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4	Not Started	Identify resources, timing and expertise required to implement the patient registry plan for PPS primary care partners.	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5	Not Started	Implement plan across PPS primary care partners	06/01/2016	03/31/2017	06/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone Milestone #5	In Progress	Repurpose and/or develop outdoor media campaign.	07/01/2015	06/30/2017	07/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 1	Completed	Collaborate with NYC DOHMH and community partners to review inventory of existing media campaigns.	07/01/2015	07/31/2015	07/01/2015	07/31/2015	09/30/2015	DY1 Q2
Task	Completed	Review Community Needs Assessment and community data to	07/31/2015	09/30/2015	07/31/2015	09/30/2015	09/30/2015	DY1 Q2



New York State Department Of Health
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NYU Lutheran Medical Center (PPS ID:32)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 2		identify high-risk neighborhoods and evaluate the specific language and cultural requirements of those highest risk communities with regard to effective messaging.						
Task Step 3	In Progress	Develop media campaign materials either by repurposing and rebranding previous ads or developing new materials.	10/01/2015	01/31/2016	10/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task Step 4	Not Started	Perform consumer-testing of media campaigns.	02/01/2016	03/31/2016	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 5	Not Started	Launch outdoor media campaigns in the community.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6	Not Started	Develop a set of metrics to evaluate the success of the campaigns and perform an annual review.	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Step 7	Not Started	Revise and update media campaigns as needed based on feedback from the community and the results of the annual review.	04/01/2017	06/30/2017	04/01/2017	06/30/2017	06/30/2017	DY3 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

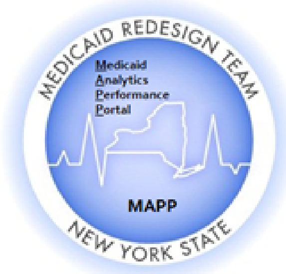
No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Milestone #1	
Milestone #2	The PPS lead has been working with NYS DOH on smoking cessation initiatives. Note that the lead is not currently working directly with the NYC DOHMH.
Milestone #3	
Milestone #4	
Milestone #5	

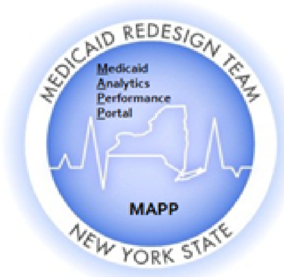
Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	



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

Instructions :



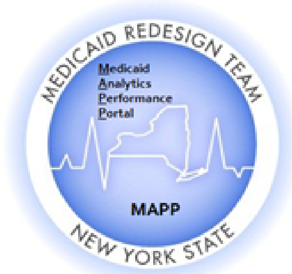
Project 4.c.ii – Increase early access to, and retention in, HIV care

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.

1. Patient Engagement Risk:
a. PPS may encounter difficulties actively engaging "hard to reach" patients. Mitigation: The PPS will utilize PNC resources and strategies to engage patients in care and provide assistance with care coordination and education about self-management and PrEP strategies. PPS will coordinate, train, equip and deploy community health workers and embed care managers in PCMH sites to actively engage difficult-to-reach patients through the PNC. CHWs and care managers will be trained to address social stigma that often accompanies HIV. PPS will utilize CHWs and CBOs, with an emphasis on organizations that have trusted relationships with high-risk communities, to support outreach and education on self-management care strategies and navigation activities.
b. Demographic and socio-economic factors may impede uptake of this initiative across the PPS's population base. Mitigation: Due to demographic and socio-economic factors the PPS will partner with numerous CBOs that are embedded and trusted in the community and whose missions include addressing poverty, education, and cultural barriers. These partnerships will help the PPS target not only the specific issue of HIV but support culturally competent approaches to reaching the community, for promotion of appropriate use primary care use for all clinical areas, and when to use the ER.
2. Provider Engagement Risk- Providers resist adoption of project protocols (including the use of PrEP) and given that the project does not have scale and speed commitments the PPS may struggle to sustain provider commitment in the project. Mitigation: PPS will identify clinical project leader(s) to serve as project champions and liaise with partner champions to build support across the PPS provider network; establish provider buy-in by engaging providers in design and agree upon standardized evidence-based best practice protocols; configure EMR/HIE functionality to ensure the system is user-friendly and provides information critical to meet goals. The PPS will develop multilingual patient outreach and education materials on HIV prevention and practicing safe behaviors. PPS will provide education on best practice protocols and consider incentive programs to support consistent protocol engagement. To sustain provider commitment the PPS will discuss the project's outcome measures and the importance of meeting those measures in order to receive funding. Collaborating with other PPSs and the DOHMH will help to sustain momentum and efficient allocation of project resources to maintain communication and outreach with PPS providers across Brooklyn.
3. CBO and Cross-PPS Engagement Risk- Brooklyn-based CBOs are likely to be partnering with multiple PPSs and already face many competing demands for their expertise, time and resources; PPS may be stretched to provide support to CBOs to deploy community-based interventions. HIV Collaborative struggles to implement a governance model that supports timely decision-making, budgeting and implementation of shared PPS projects initiatives and resources (e.g. protocols, access to data and reporting tools). Mitigation: CBO engagement across multiple PPSs the PPS will identify HIV Collaborative members, who will also serve on the PPS's HIV Work Group and work both across PPSs and within the Brooklyn Bridges network to implement the HIV project. The PPS will leverage the MIX to share best practices with other PPSs and partner organizations.



New York State Department Of Health
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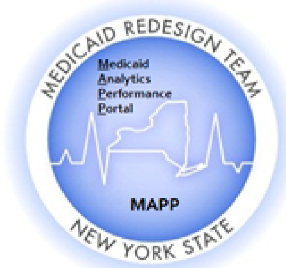
NYU Lutheran Medical Center (PPS ID:32)

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 Milestone #1	In Progress	Convening the PPS HIV Collaborative	07/01/2015	03/31/2020	07/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 1	Completed	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	In Progress	Contract with DOHMH to convene and support the HIV Collaborative.	01/01/2016	01/31/2016	10/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task Step 3	Not Started	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 Milestone #2	Not Started	Establishing a work plan and timeline for project implementation.	10/01/2015	03/31/2017	02/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1	Not Started	Develop work plan and timeline for projects being implemented jointly across multiple PPSs.	10/01/2015	09/30/2016	02/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2	Not Started	Develop work plan and timeline for additional projects being implemented by the Brooklyn Bridges PPS.	10/01/2015	09/30/2016	02/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 3	Not Started	Validate work plans and timelines with PPS governance bodies and relevant stakeholders, as needed.	01/01/2016	03/31/2017	02/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone Milestone #3	Not Started	Developing agreed upon milestones for project implementation.	10/01/2015	03/31/2017	02/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1	Not Started	Develop milestones for projects being implemented jointly across multiple PPSs.	10/01/2015	09/30/2016	02/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2	Not Started	Develop milestones for additional projects being implemented by the Brooklyn Bridges PPS.	10/01/2015	09/30/2016	02/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 3	Not Started	Validate milestones with PPS governance bodies and relevant stakeholders, as needed.	01/01/2016	03/31/2017	02/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone Milestone #4	Not Started	Agreeing upon project commonalities and shared resources.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1	Not Started	Determine 4.c.ii projects that are common across most/all PPSs in the Collaborative and structure for sharing resources needed for implementation.	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

NYU Lutheran Medical Center (PPS ID:32)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 2	Not Started	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 Milestone #5	Not Started	Agreeing upon 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
Task Step 1	Not Started	Determine system for sharing information across PPSs 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	Not Started	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

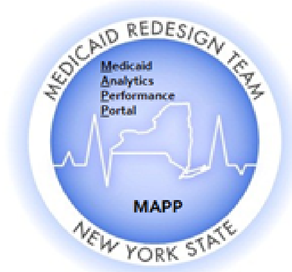
No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Milestone #1	
Milestone #2	
Milestone #3	
Milestone #4	
Milestone #5	

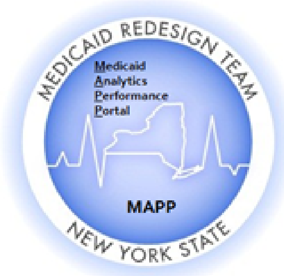
Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	



IPQR Module 4.c.ii.3 - IA Monitoring

Instructions :



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.

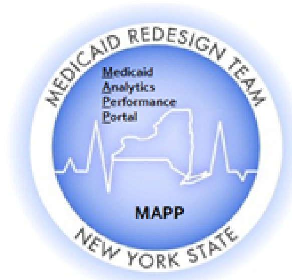
The Lead Representative of the Performing Provider System (PPS) must complete this attestation form in order for the project application to be accepted by the NYS Department of Health. Once the attestation is complete, the Quarterly Report will be locked down from any further editing. Do not complete 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 'NYU Lutheran Medical Center', 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:	LUTHERAN MEDICAL CENTER
Secondary Lead PPS Provider:	
Lead Representative:	Hilton Marcus
Submission Date:	03/16/2016 01:09 PM
Comments:	

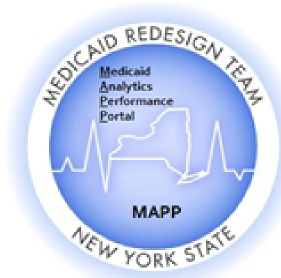


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Status Log				
Quarterly Report (DY,Q)	**Status**	**Lead Representative Name**	**User ID**	**Date Timestamp**
DY1, Q3	Adjudicated	Hilton Marcus	emcgill	03/31/2016 05:17 PM
DY1, Q3	Submitted	Hilton Marcus	hiltonm	03/16/2016 01:09 PM
DY1, Q3	Returned	Hilton Marcus	emcgill	03/01/2016 05:15 PM
DY1, Q3	Submitted	Hilton Marcus	hiltonm	02/03/2016 03:39 PM
DY1, Q3	In Process		ETL	01/03/2016 08:01 PM

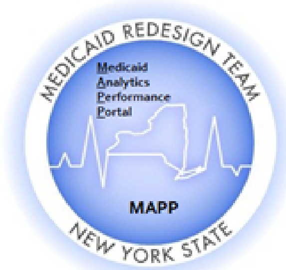


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Comments Log			
Status	**Comments**	**User ID**	**Date Timestamp**
Adjudicated	The IA has adjudicated the DY1 Q3 Quarterly Report.	emcgill	03/31/2016 05:17 PM
Submitted	Larry McReynolds will send via email a separate attestation to Peggy Chan and Logan Tierney with the same.	hiltonm	03/16/2016 01:09 PM
Returned	The IA is returning the DY1Q3 Quarterly Report to the PPS for Remediation.	emcgill	03/01/2016 05:15 PM



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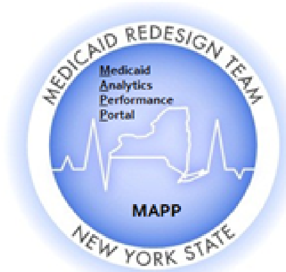
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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

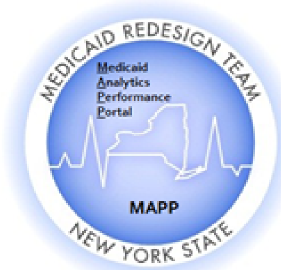


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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

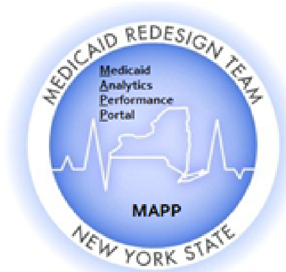


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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

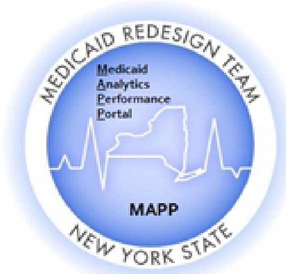


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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	

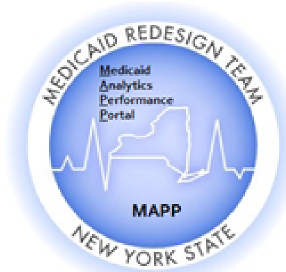


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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

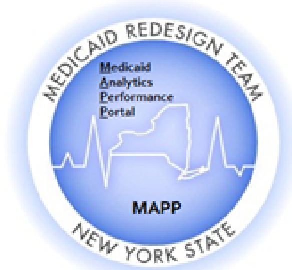


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project ID	Module Name	Status
	IPQR Module 3.c.i.4 - PPS Defined Milestones	Completed
	IPQR Module 3.c.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	
4.b.i	IPQR Module 4.b.i.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 4.b.i.2 - PPS Defined Milestones	Completed
	IPQR Module 4.b.i.3 - IA Monitoring	
4.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	

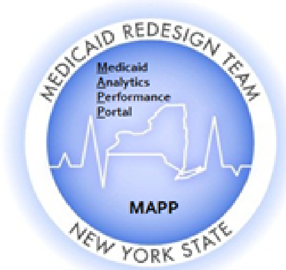


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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 latest	Pass & Ongoing	

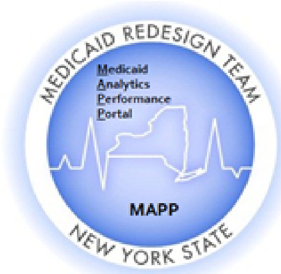


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Section	Module Name / Milestone #	Review Status	
	Milestone #6 Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	Pass & Ongoing	
	Milestone #7 Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	Pass & Ongoing	
	Milestone #8 >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	Pass & Ongoing	
Section 04	Module 4.1 - Prescribed Milestones		
	Milestone #1 Finalize cultural competency / health literacy strategy.	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	
	Milestone #2 Develop a Clinical Integration strategy.	Pass & Ongoing	

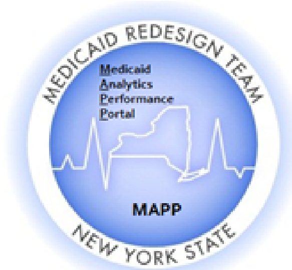


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Section	Module Name / Milestone #	Review Status	
Section 11	Module 11.2 - Prescribed Milestones		
	Milestone #1 Define target workforce state (in line with DSRIP program's goals).	Pass & Ongoing	
	Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	Pass & Ongoing	
	Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	Pass & Ongoing	
	Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	Pass & Ongoing	
	Milestone #5 Develop training strategy.	Pass & Ongoing	

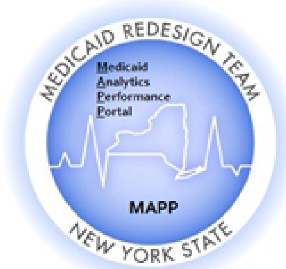


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project ID	Module Name / Milestone #	Review Status	
2.a.i	Module 2.a.i.2 - Prescribed Milestones		
	Milestone #1 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.	Pass & Ongoing	
	Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	Pass & Ongoing	
	Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	Pass & Ongoing	
	Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	Pass & Ongoing	
	Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Pass & Ongoing	
	Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Pass & Ongoing	
	Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	Pass & Ongoing	
	Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	Pass & Ongoing	
	Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	Pass & Ongoing	
	Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	Pass & Ongoing	
	Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	Pass & Ongoing	
2.b.iii	Module 2.b.iii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.b.iii.3 - Prescribed Milestones		
	Milestone #1 Establish ED care triage program for at-risk populations	Pass & Ongoing	
	Milestone #2 Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary	Pass & Ongoing	



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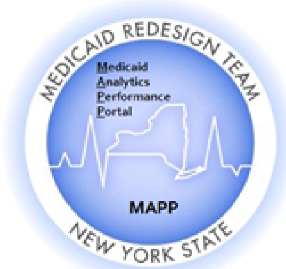
	care providers. c. Ensure real time notification to a Health Home care manager as applicable		
	Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	Pass & Ongoing	
	Milestone #4 Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)	Pass & Ongoing	
	Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
2.b.ix	Module 2.b.ix.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.b.ix.3 - Prescribed Milestones		
	Milestone #1 Establish appropriately sized and staffed observation (OBS) units in close proximity to ED services, unless the services required are better provided in another unit. When the latter occurs, care coordination must still be provided.	Pass & Ongoing	
	Milestone #2 Create clinical and financial model to support the need for the unit.	Pass & Ongoing	
	Milestone #3 Utilize care coordination services to ensure safe discharge either to the community or a step down level of service, such as behavioral health or assisted living/SNF.	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 Direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.	Pass & Ongoing	
	Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
2.c.i	Module 2.c.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.c.i.3 - Prescribed Milestones		
	Milestone #1 Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.	Pass & Ongoing	
	Milestone #2 Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.	Pass & Ongoing	
	Milestone #3 Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.	Pass & Ongoing	
	Milestone #4 Resource appropriately for the community navigators, evaluating placement and service type.	Pass & Ongoing	
	Milestone #5 Provide community navigators with access to non-clinical resources, such as transportation and housing	Pass & Ongoing	



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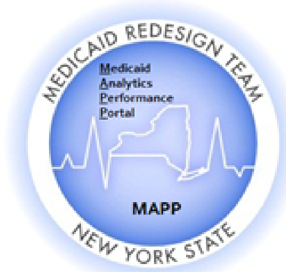
	services.		
	Milestone #6 Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.	Pass & Ongoing	
	Milestone #7 Market the availability of community-based navigation services.	Pass & Ongoing	
	Milestone #8 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
3.a.i	Module 3.a.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.a.i.3 - Prescribed Milestones		
	Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Pass & Ongoing	
	Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Pass & Ongoing	
	Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Pass & Ongoing	
	Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #5 Co-locate primary care services at behavioral health sites.	Pass & Ongoing	
	Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Pass & Ongoing	
	Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Pass & Ongoing	
	Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #9 Implement IMPACT Model at Primary Care Sites.	Pass & Ongoing	
	Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Pass & Ongoing	
	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.c.i	Module 3.c.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.c.i.3 - Prescribed Milestones		



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Project ID	Module Name / Milestone #	Review Status	
	Milestone #1 Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.	Pass & Ongoing	
	Milestone #2 Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.	Pass & Ongoing	
	Milestone #3 Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.	Pass & Ongoing	
	Milestone #4 Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.	Pass & Ongoing	
	Milestone #5 Ensure coordination with the Medicaid Managed Care organizations serving the target population.	Pass & Ongoing	
	Milestone #6 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #7 Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.	Pass & Ongoing	
3.d.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	
	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	
4.b.i	Module 4.b.i.2 - PPS Defined Milestones	Pass & Ongoing	
4.c.ii	Module 4.c.ii.2 - PPS Defined Milestones	Pass & Ongoing	