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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Quarterly Report - Implementation Plan for NYU Lutheran Medical Center

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

Status By Section

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

Status By Project

Project ID	Project Title	Status
2.a.i	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management	☑ Completed
2.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

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Section 01 – Budget

☑ **IPQR Module 1.1 - PPS Budget Report**

Instructions :

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

Budget Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	10,948,848	11,667,873	18,868,415	16,707,909	10,948,848	69,141,893
Cost of Project Implementation & Administration	7,554,705	5,133,864	5,283,156	3,090,963	2,737,212	23,799,900
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

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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✅ **IPQR Module 1.2 - PPS Flow of Funds**

Instructions :

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

Funds Flow Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	10,948,848	11,667,873	18,868,415	16,707,909	10,948,848	69,141,893
Primary Care Physicians	1,888,676	1,370,975	1,650,986	1,106,899	908,755	6,926,291
Non-PCP Practitioners	0	52,506	198,119	200,495	134,671	585,791
Hospitals	1,057,659	3,664,879	4,985,035	5,465,992	3,432,464	18,606,029
Clinics	1,510,941	1,201,791	1,717,026	1,286,509	996,345	6,712,612
Health Home / Care Management	656,931	700,072	1,320,789	1,169,554	985,396	4,832,742
Behavioral 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
Skilled Nursing Facilities / Nursing Homes	0	320,867	849,079	898,050	585,763	2,653,759
Pharmacies	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	5,230,265	3,561,035	6,271,861	4,862,837	2,698,891	22,624,889
Total Funds Distributed	**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

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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☑ **IPQR Module 1.3 - Prescribed Milestones**

Instructions :

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

Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Complete funds flow budget and distribution plan and communicate with network	In Progress	Funds Flow Budget and Distribution Plan, signed off by your Finance Committee, including details of your approach to funds flow on a whole-PPS and project-by-project basis; evidence of involvement of provider network in developing funds flow methodology.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task Step 1	In Progress	Review final PPS attribution and valuation.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2	In Progress	Define PPS baseline funding schedule.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3	In Progress	Define PPS project-specific funding schedule.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4	In Progress	Negotiate and finalize individual funding schedules with PPS partners.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5	In Progress	Create mechanism for generating quarterly reports of earned waiver revenue and partner payments.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6	In Progress	Create processes to review and update PPS budget and flow of funds estimates on a quarterly basis.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7	In Progress	Engage PPS Committees and stakeholders to develop criteria and processes for administering DSRIP internal PPS provider bonus payments and revenue loss funds.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Complete funds flow budget and distribution plan and communicate with network	The Finance Sub-Committee of the NYU Lutheran Medical Center PPS is reviewing the final PPS attribution and valuation. Budget and funding methodology is being drafted on a whole-PPS and a project-by-project bases. Actual flow of funds to support central services and activities of the various partners is dependent on funds actually provided by the State.

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✅ **IPQR Module 1.4 - PPS Defined Milestones**

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 1.5 - IA Monitoring

Instructions :

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Section 02 – Governance

☑ IPQR Module 2.1 - Prescribed Milestones

Instructions :

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.

Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation. Note some milestones include minimum expected completion dates.

Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize governance structure and sub-committee structure	In Progress	This milestone must be completed by 9/30/2015. Governance and committee structure, signed off by PPS Board.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task Step 1	In Progress	Identify size and number of standing committees.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2	In Progress	Solicit and appoint members of the Executive Committee.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3	In Progress	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	09/30/2015	DY1 Q2	
Task Step 4	In Progress	Obtain Executive approval of final governance structure.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	In Progress	This milestone must be completed by 12/31/2015. Clinical Quality Committee charter and committee structure chart	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1	In Progress	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	09/30/2015	DY1 Q2	
Task Step 2	In Progress	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 based organizations.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task	In Progress	Draft and obtain Clinical Sub-Committee approval of initial clinical operational	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 3		plans for each project (with consensus-based decision-making process set forth in charter).					
Task Step 4	In Progress	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	12/31/2015	DY1 Q3	
Task Step 5	In Progress	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	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6	In Progress	Develop and adopt initial reports for clinical workgroups.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	In Progress	This milestone must be completed by 9/30/2015. Upload of bylaws and policies document or committee guidelines.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task Step 1	In Progress	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	09/30/2015	DY1 Q2	
Task Step 2	In Progress	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	09/30/2015	DY1 Q2	
Task Step 3	In Progress	Draft, and obtain approval from Executive Committee on, process for addressing underperformance of partners.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4	In Progress	Appoint PPS compliance officer.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #4 Establish governance structure reporting and monitoring processes	In Progress	This milestone must be completed by 12/31/2015. Governance and committee structure document, including description of two-way reporting processes and governance monitoring processes	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1	In Progress	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	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		partner.					
Task Step 2	In Progress	Include Reporting Process in charters to be finalized per milestones described above.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3	In Progress	Monitor committee and sub-committee performance through review of minutes and other means.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	In Progress	Community engagement plan, including plans for two-way communication with stakeholders.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1	In Progress	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.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2	In Progress	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.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3	In Progress	Revise plan to reflect input from key stakeholders.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4	In Progress	Obtain Executive Committee approval of draft community engagement plan.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #6 Finalize partnership agreements or contracts with CBOs	In Progress	Signed CBO partnership agreements or contracts.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1	In Progress	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").	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2	In Progress	Obtain feedback from CBOs on Base Agreement and revise based on feedback received.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task	In Progress	Send Base Agreement to each CBO.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 3							
Task Step 4	In Progress	Finalize Base Agreement; execute with each CBO.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
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	12/31/2015	DY1 Q3	
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	03/31/2016	DY1 Q4	
Milestone #7 Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	In Progress	Agency Coordination Plan.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1	In Progress	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.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2	In Progress	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.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3	In Progress	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.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #8 Inclusion of CBOs in PPS Implementation.	In Progress	Explain your plans for contracting with CBOs and their continuing role as your PPS develops over time; detail how many CBOs you will be contracting with and by when; explain how they will be included in project delivery and in the development of your PPS network.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1	In Progress	Solicit and appoint CBOs to standing committees and sub-committees	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2	In Progress	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	09/30/2015	DY1 Q2	
Task Step 3	In Progress	Assign PPS Lead for on-going CBO engagement and communication	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 4	In Progress	Solicit input from CBOs on Masters Service Agreement	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 5	In Progress	Execute Masters Service Agreement with 20 CBOs	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
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.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7	In Progress	Finalize schedules, as appropriate to date, to Base Agreement and attach to Base Agreement.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 8	In Progress	Conduct CBO surveys to assess strengths/gaps and to further implementation of all workstreams; surveys will include IT, workforce and clinical project planning	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 9	In Progress	Engage CBOs in clinical project planning and implementation	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #9 Finalize workforce communication and engagement plan	In Progress	Workforce communication & engagement plan, including plans for two-way communication with all levels of the workforce, signed off by PPS workforce governance body (e.g. workforce transformation committee).	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task Step 1	In Progress	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.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2	In Progress	Develop input/revise workforce communication and engagement plan from 1199 and Clinical Sub-Committee members.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3	In Progress	Obtain Executive Committee approval of workforce communication and engagement plan.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

NYS Confidentiality – **High**

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize governance structure and sub-committee structure	NYU Lutheran Medical Center PPS has conducted initial meetings this quarter to begin formalizing the governance and sub-committee structure. We will continue developing our committee and sub-committee structure during the second quarter of DY1 and obtain Executive Committee approval of final governance structure by 9/30/2015.
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	The process of establishing a clinical governance structure has commenced at NYU Lutheran Medical Center PPS. The charters for the clinical sub-committee and each clinical work group, which oversees each clinical project by project, are being drafted and proper approval will be obtained. Each clinical work group focuses on that project"s implementation plan, including budgeting and quality oversight. The appointment of clinical work group members is in process and will continue during the second quarter of DY 1.
Finalize bylaws and policies or Committee Guidelines where applicable	The Governance Charters (i.e., charters for the Executive Committee and each subcommittee) and PPS Policies and Procedures are in the drafting stage for the NYU Lutheran Medical Center PPS. Processes to address the under performance of partners, conflicts of interest policy, compliance plan, data sharing policies, antitrust policies, and appointing a PPS Compliance Officer, has been initiated and will be completed by 9/30/2015.
Establish governance structure reporting and monitoring processes	Procedures regarding the Reporting Process are being drafted by NYU Lutheran Medical Center PPS. Committee and sub-committee minutes are currently being recorded. The procedures by which the Executive Committee and Committees receive and keep the minutes and make them available to partners will include limitations on availability of Executive Committee minutes to partners for security and confidentiality purposes.
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	NYU Lutheran Medical Center PPS is in the initial stage of drafting the preliminary community engagement plan. We will continue to develop the plan, reflect input from key stakeholders and assure that bi-directional communication with community partners is achieved.
Finalize partnership agreements or contracts with CBOs	The Master Services Agreement (MSA) has been drafted and reviewed; the MSA draft for feedback was sent to all PPS partners, including CBOs, on 6/8/2015 . NYU Lutheran Medical Center PPS is awaiting partner feedback and will finalize the MSA once feedback and input is received.
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.)	NYU Lutheran Medical Center PPS has already begun to work with the local health agency -- the New York City Department of Health and Mental Hygiene -- to coordinate the PPS"s efforts with other PPSs through that agency, and therefore has engaged in preliminary talks pertaining to the Agency Coordination Plan. In the coming months, we intend to include additional information on what agencies the PPS will work with, how agencies will be conducted and recruited to help, and how specific roles and responsibilities of agencies in DSRIP will be established and maintained.
Finalize workforce communication and engagement plan	NYU Lutheran Medical Center PPS has engaged in internal and broader discussions pertaining to the workforce and engagement plan, including with a potential training vendor. A communication plan will incorporate two-way communication either directly with the PPS or with the training vendor.
Inclusion of CBOs in PPS Implementation.	An initial CBO engagement plan has been drafted by NYU Lutheran Medical Center PPS. Meetings are being scheduled to establish a CBO communication infrastructure for bi-directional communication and feedback. An e-mail listserv has been created for ongoing CBO engagement and communication.

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☑ **IPQR Module 2.2 - PPS Defined Milestones**

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

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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.

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☑ **IPQR Module 2.5 - Roles and Responsibilities**

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Lead 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
Brooklyn Bridges PPS Advisors, Consultants	Manatt	Support drafting of governance documents, bylaws, Committee guidelines, etc.
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

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☑ **IPQR Module 2.7 - IT Expectations**

Instructions :

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

The 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 :

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Section 03 – Financial Stability

☑ IPQR Module 3.1 - Prescribed Milestones

Instructions :

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.

Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation. Note some milestones include minimum expected completion dates.

Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize PPS finance structure, including reporting structure	In Progress	This milestone must be completed by 12/31/2015. PPS finance structure chart / document, signed off by PPS Board.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1	In Progress	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	09/30/2015	DY1 Q2	
Task Step 2	In Progress	Revise Finance Subcommittee membership as necessary.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3	In Progress	Convene regular Finance Subcommittee meetings.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4	In Progress	Document Finance Subcommittee actions and minutes and provide regular reports to PPS Executive Committee.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5	In Progress	Review PPS finance and reporting structure.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6	In Progress	Obtain Executive Committee sign off of PPS finance structure, policies and procedures.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	In Progress	This milestone must be completed by 3/31/2016. Network financial health current state assessment (to be performed at least annually). The PPS must: - identify those providers in their network that are financially fragile, including those that have qualified as IAAF providers; -- define their approach for monitoring those financially fragile providers, which must include an analysis of provider performance on the following financial indicators: days cash on hand, debt ratio, operating margin and current ratio; -- include any additional financial indicators that they deem necessary for monitoring the financial sustainability of their network providers	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 1	In Progress	Conduct financial health current state assessment of new PPS partners by utilizing assessment tool developed during the DSRIP planning phase.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2	In Progress	Review all results of financial health current state assessment and, if applicable, identify financially fragile partners.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3	In Progress	Develop process for monitoring and assisting financially fragile partners including the involvement of the Finance Subcommittee.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4	In Progress	Develop Financial Stability Plan – including metrics and ongoing monitoring – and obtain approval from Finance Subcommittee.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5	In Progress	Establish an annual schedule to monitor partner financial status and a quarterly schedule for those deemed financially fragile.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	In Progress	This milestone must be completed by 12/31/2015. Finalized Compliance Plan (for PPS Lead).	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1	In Progress	Determine how to fill the need to staff PPS Compliance function in accordance with the DSRIP Compliance Program.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2	In Progress	Establish PPS chain-of-command for compliance enforcement.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3	In Progress	Incorporate NYS Social Services Law 363-d requirements such as training, education and disciplinary policies into lead PPS's existing compliance plan.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4	In Progress	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.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5	In Progress	Conduct first quarterly PPS compliance workgroup meeting.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6	In Progress	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.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	In Progress	This milestone must be completed by 3/31/2016. Value-based payment plan, signed off by PPS board	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task Step 1	In Progress	Review final State value-based payment roadmap upon release.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2	In Progress	Develop value-based payment assessment and partner value-based payment reporting framework.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 3	In Progress	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).	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4	In Progress	Develop preferred compensation and MCO strategy framework (including a regular schedule of meetings with MCOs) through Finance subcommittee.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5	In Progress	Develop provider education and engagement strategy, and conduct education sessions with PPS provider partners, focused on value-based payment concepts and potential contracting arrangements.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6	In Progress	Incorporate findings from assessments into a baseline PPS value-based payment plan.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	In Progress	This milestone must be completed by 12/31/2016. Value-based payment plan, signed off by PPS board	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	YES
Task Step 1	In Progress	Review final State value-based payment roadmap upon release.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2	In Progress	Review baseline assessment of PPS partners' value-based payment revenue to inform development of PPS value-based payment plan.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3	In Progress	Conduct gap assessment between current volume of value-based revenue across the PPS network and State target of 90%.	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4	In Progress	Establish annual targets for volume of value-based revenue across the PPS network (To be completed on an ongoing basis).	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 5	In Progress	Finalize PPS value-based payment plan and present to Executive Committee for approval.	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 6	In Progress	Establish partner value-based payment reporting requirements and procedures to enable ongoing monitoring of PPS value-based payment revenue.	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 7	In Progress	Provide quarterly updates to Executive Committee on progress toward value-based payment and revise PPS plan as needed.	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 8	In Progress	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.	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 9	In Progress	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	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		assisting with value-based payment transition for its provider partners, etc.).					
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	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	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	03/31/2020	DY5 Q4	YES

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize PPS finance structure, including reporting structure	NYU Lutheran Medical Center PPS is in the process of finalizing the Finance Subcommittee charter and membership. Finance Subcommittee meetings are currently being conducted with minutes being recorded.
Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	The financial health current state assessment of new PPS partners will be conducted using an assesment tool currently being developed. NYU Lutheran Medical Center PPS is collaborating with other PPSs to make the assessment process as efficient as possible and reduce the burden of responding to the assessment for overlapping partners.
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	In its general compliance plan, the PPS will set forth policies and procedures to ensure compliance with New York State Social Services Law section 363-d.
Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	In its general assessment tool, the PPS will determine the various partners' approaches to value based payments, and will develop recommendations to advance the State-wide value based payment initiative as part of the DSRIP Program.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	The PPS is awaiting further guidance from the State regarding the Value Based Payment road map, which will inform the plan toward reaching 90 percent value based payments by DSRIP Year 5.
Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	
Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	
>=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	

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✅ **IPQR Module 3.2 - PPS Defined Milestones**

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

• 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.

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• 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.

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☑ **IPQR Module 3.5 - Roles and Responsibilities**

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
PPS Executive Committee	Claudia Caine, Chair, NYU Lutheran	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, Chair, NYU Lutheran	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

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☑ IPQR Module 3.7 - IT Expectations

Instructions :

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

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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize cultural competency / health literacy strategy.	In Progress	This milestone must be completed by 12/31/2015. Cultural competency / health literacy strategy signed off by PPS Board. The strategy should: -- Identify priority groups experiencing health disparities (based on your CNA and other analyses); -- Identify key factors to improve access to quality primary, behavioral health, and preventive health care -- Define plans for two-way communication with the population and community groups through specific community forums -- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors); and -- Identify community-based interventions to reduce health disparities and improve outcomes.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1	In Progress	Identify oversight staff and process for Cultural Competency/Health Literacy Strategy.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2	In Progress	Based on Community Needs Assessment, identify priority populations experiencing health disparities.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3	In Progress	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).	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4	In Progress	Research and identify PPS best practices/centers of excellence in achieving provider Cultural Competency; research industry best practices on health literacy enhancement strategies (including assessments and tools to assist patients with self-management of conditions).	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5	In Progress	Consult with Partners, providers and CBOs to inform the strategy.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task	In Progress	Develop a written Cultural Competency/Health Literacy strategy, action plan	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 6		and monitoring process to address the prioritized areas, signed off by the PPS Executive Committee.					
Milestone #2 Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	In Progress	This milestone must be completed by 6/30/2016. Cultural competency training strategy, signed off by PPS Board. The strategy should include: -- Training plans for clinicians, focused on available evidence-based research addressing health disparities for particular groups identified in your cultural competency strategy -- Training plans for other segments of your workforce (and others as appropriate) regarding specific population needs and effective patient engagement approaches	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES
Task Step 1	In Progress	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).	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2	In Progress	Collaborate with training vendor on cultural competency training development and delivery options.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3	In Progress	Identify champions (including clinicians and community based organizations) that will support training strategies addressing the drivers of health disparities	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4	In Progress	Develop strategy for encouraging partner participation in health disparities training	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5	In Progress	Determine scope, scale, audience, format and content for training programs, focused on targeted populations and health disparities identified in Milestone 1 strengths/gaps analysis.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6	In Progress	Develop a written Cultural Competency Training Strategy (signed off by PPS Executive Committee).	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 7	In Progress	Establish process for on-going assessments to identify gaps and needs	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize cultural competency / health literacy strategy.	NYU Lutheran Medical Center PPS has started to develop the DSRIP Cultural Competency and Health Literacy plan and strategy, which will include, but will not be limited to: the identification of oversight staff, addressing the needs and deficits regarding cultural competency and health literacy as set forth in the Community Needs Assessment, performing a gap analysis across partners, build upon the cultural competency expertise at NYU Lutheran (as recognized by the American Hospital Association), and developing a promulgation and training process for DSRIP Cultural Competency & Health Literacy plan within our PPS.
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	Once the overall Cultural Competency & Health Literacy strategy is finalized, NYU Lutheran Medical Center PPS will focus on and develop training strategies and programs associated with this milestone and matter.

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☑ **IPQR Module 4.2 - PPS Defined Milestones**

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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.

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☑ **IPQR Module 4.5 - Roles and Responsibilities**

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
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	Claudia Caine, Chair of Executive Committee, NYU Lutheran	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.

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☑ IPQR Module 4.7 - IT Expectations

Instructions :

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

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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	In Progress	Detailed IT current state assessment. Relevant QEs (RHIOs/HIEs) should be involved in performing this assessment.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1	In Progress	Identify/validate contacts at each partner organization.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2	In Progress	Develop data sharing & interoperability requirements and plan for using existing external resources (e.g., RHIOs).	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3	In Progress	Develop, distribute and collect detailed survey to determine current state.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4	In Progress	Establish process for partners to conduct IT self-assessment and to validate those assessments.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5	In Progress	Establish process for periodic data reporting on IT capabilities.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6	In Progress	Conduct gap identification and analysis.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 7	In Progress	Develop mitigation strategies to resolve IT interoperability and data sharing gaps.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #2 Develop an IT Change Management Strategy.	In Progress	IT change management strategy, signed off by PPS Board. The strategy should include: -- Your approach to governance of the change process; -- A communication plan to manage communication and involvement of all stakeholders, including users; -- An education and training plan;	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO

NYS Confidentiality – **High**

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		-- An impact / risk assessment for the entire IT change process; and -- Defined workflows for authorizing and implementing IT changes					
Task Step 1	In Progress	Meet to determine general governance approach to IT Change Management, including accountabilities and deliverables.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2	In Progress	Design communication plan to partner end-users as part of overall DSRIP communications strategy.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3	In Progress	Use survey tool to help identify user education and training requirements.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4	In Progress	Develop education and training plan.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5	In Progress	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.).	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6	In Progress	Conduct initial risk assessment & risk mitigation approach.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 7	In Progress	Finalize change management plan at the PPS and obtain Executive Board authorization on IT change management strategy.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 8	In Progress	Develop plan for how central PPS IT services will be made available to providers.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 9	In Progress	Communicate IT change management model to partners.	04/01/2015	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 between all providers within the PPS, including care management records (completed subcontractor DEAAs with all Medicaid providers within the PPS; contracts with all relevant CBOs including a BAA documenting the level of PHI to be shared and the purpose of this sharing).	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task	In Progress	Engage with SHIN-NY & RHIOs on pre-planning.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

NYS Confidentiality – High

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 1							
Task Step 2	In Progress	Identify PPS leadership who will be responsible for developing roadmap.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3	In Progress	Develop strategies for connectivity based on interoperability requirements and current state assessment, including setting technical standards for sharing and using common clinical data sets.	04/01/2015	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.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5	In Progress	Draft and execute all legally binding agreements related to data exchange, including subcontractor Data Exchange Applications & Agreements and HIPAA Business Associate Agreements.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6	In Progress	Estimate and identify resource requirements, in addition to those provided in gap analysis.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 7	In Progress	Develop training plan.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 8	In Progress	Develop phased implementation roadmap.	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	In Progress	PPS plan for engaging attributed members in Qualifying Entities, signed off by PPS Board. The plan should include your approach to outreach into culturally and linguistically isolated communities.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1	In Progress	Engage and ready all partners to gain consent from patients for use of data.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2	In Progress	Assess communication channel options and establish communications approach (e.g. portals, email, etc.).	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3	In Progress	Identify process for working with front office provider staff on patient engagement. Assess RHIO use across PPS for Medicaid beneficiaries and MU adoption.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4	In Progress	Develop and obtain approval on plan for outreach to patients actively engaged in clinical projects including culturally and linguistically isolated patient populations.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Milestone #5 Develop a data security and confidentiality plan.	In Progress	Data security and confidentiality plan, signed off by PPS Board, including: -- Analysis of information security risks and design of controls to mitigate risks -- Plans for ongoing security testing and controls to be rolled out throughout network.	04/01/2015	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.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 2	In Progress	Assess risks and design mitigation approaches that are tailored to the risk type and include monitoring and oversight.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3	In Progress	Obtain Executive Board approval for final plan.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

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).	Working with the subject matter experts, the PPS is developing a detailed IT current state assessment. The subject matter experts are in frequent contact with the local RHIO, HealthIx, to ensure interoperability, and is evaluating whether additional HIE resources are required to buttress the systems provided by that RHIO.
Develop an IT Change Management Strategy.	The PPS is developing an IT change management strategy, which will be approved by the IT Sub-Committee of the Executive Committee. This strategy may include governance processes and procedures as they relate to IT change management, a communications plan to ensure buy-in and understanding from the various PPS partners, an education and training plan, an impact assessment for the entire IT change process, and a defined workflow process to implement these changes.
Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	The PPS will develop a robust roadmap to advance effective clinical data sharing and interoperable systems. This roadmap will include a governance framework, an education plan, and technical guidance for sharing clinical data, including plans for establishing data exchange agreements between all providers within the PPS.
Develop a specific plan for engaging attributed members in Qualifying Entities	The PPS will develop a culturally and linguistically sensitive plan to engage attributed members in HIE, which will be approved by the IT Sub-Committee of the Executive Committee.
Develop a data security and confidentiality plan.	Using the existing expertise of the lead organizations and institutions, the PPS will develop a data security and confidentiality plan which will be approved by the IT Sub-Committee of the Executive Committee. The plan will include the analysis of information security risks and design of controls to mitigate risks and address the need for ongoing security testing and controls across the PPS network.

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☑ **IPQR Module 5.2 - PPS Defined Milestones**

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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.

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• 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.

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☑ **IPQR Module 5.5 - Roles and Responsibilities**

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
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.

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☑ IPQR Module 5.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
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.

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☑ **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 :

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Section 06 – Performance Reporting

✅ IPQR Module 6.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Establish reporting structure for PPS-wide performance reporting and communication.	In Progress	Performance reporting and communications strategy, signed off by PPS Board. This should include: -- The identification of individuals responsible for clinical and financial outcomes of specific patient pathways; -- Your plans for the creation and use of clinical quality & performance dashboards -- Your approach to Rapid Cycle Evaluation	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1	In Progress	Identify PPS members with responsibility for outcomes/impacting performance measurements.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2	In Progress	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.).	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3	In Progress	Design reports & dashboards.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4	In Progress	Work with MCOs to get more timely data than the State provides.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5	In Progress	Develop communication plan – including frequency of communication and process for rapid cycle evaluation.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6	In Progress	Draft Performance Reporting and Communications strategy (e.g. who receives which performance reports/dashboards, how often, etc.).	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 7	In Progress	Obtain Executive Board approval for Performance Reporting and Communications strategy.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #2 Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	In Progress	Finalized performance reporting training program.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 1	In Progress	Identify PPS members requiring training.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2	In Progress	Identify scope of training (e.g., quality/process improvement strategies and monitoring, performance reporting, and pay for performance and pay for reporting)	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3	In Progress	Identify PPS team and develop a comprehensive strategy to lead and provide oversight over training	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4	In Progress	Design training content tailored for user communities.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5	In Progress	Develop model and tools to track/manage the training program.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6	In Progress	Communicate training program including access, goals, benefits, etc.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 7	In Progress	Implement program, track participation, continuously improve program based on feedback.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish reporting structure for PPS-wide performance reporting and communication.	The PPS is developing its performance reporting and communications strategy. This will be reviewed and approved by the PPS Executive Committee. This strategy will include the naming of clinical and financial leads, the development of clinical quality & performance dashboards, and process-improvement methodologies.
Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	The PPS is developing a performance reporting training program and evaluation process thereof. The PPS will determine which training tools, such as in-person meetings or webinars, are most effective and cost efficient.

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☑ **IPQR Module 6.2 - PPS Defined Milestones**

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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☑ **IPQR Module 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.

NYS Confidentiality – **High**

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☑ IPQR Module 6.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Reporting Leader	Priya Gopinath, 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.

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✅ **IPQR Module 6.6 - Key Stakeholders**

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
IT	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.

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☑ **IPQR Module 6.7 - IT Expectations**

Instructions :

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

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 :

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Section 07 – Practitioner Engagement

☑ IPQR Module 7.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop Practitioners communication and engagement plan.	In Progress	Practitioner communication and engagement plan. This should include: -- Your plans for creating PPS-wide professional groups / communities and their role in the PPS structure -- The development of standard performance reports to professional groups --The identification of profession / peer-group representatives for relevant governing bodies, including (but not limited to) Clinical Quality Committee	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1	In Progress	Establish practitioner engagement and communication infrastructure for overseeing outreach, education and engagement of practitioners; strategy to be coordinated with partner communication and engagement strategy.	04/01/2015	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.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3	In Progress	Engage professional practicer organizations including MSSNY, county associations, ACP chapters or AAFP affiliations.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4	In Progress	Assign practitioner representatives to PPS committees including Governance, Clinical Project Planning, IT, and Finance.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5	In Progress	Conduct outreach with practitioners, through face-to-face meetings and webinars, to develop better understanding of PPS goals, metrics and clinical project plans.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Milestone #2 Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	In Progress	Practitioner training / education plan.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task	In Progress	Identify needed training capacity for practitioners through engagement of	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 1		Clinical Sub-Committee and partner surveys.					
Task Step 2	In Progress	Identify vendor/internal resources for practitioner training/education development.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3	In Progress	Set up training/education curriculum that is specifically designed for practitioners.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4	In Progress	Establish plan for evaluating on-going training needs.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5	In Progress	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.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop Practitioners communication and engagement plan.	The PPS is developing a practitioner communication and engagement plan, which will include a professional group-oriented strategy to engage the professional practitioner community in clinical quality development.
Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	The PPS is developing a practitioner training and education plan tailored to the needs and resources of the community that the PPS serves, with considerations that include cultural competency and health literacy, information technology resources, and existing clinical practices.

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✅ **IPQR Module 7.2 - PPS Defined Milestones**

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

> 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.

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☑ **IPQR Module 7.5 - Roles and Responsibilities**

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Practitioner Engagement Oversight	Dr. 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.

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☑ **IPQR Module 7.6 - Key Stakeholders**

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
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.

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☑ IPQR Module 7.7 - IT Expectations

Instructions :

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

> 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 :

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Section 08 – Population Health Management

☑ IPQR Module 8.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop population health management roadmap.	In Progress	Population health roadmap, signed off by PPS Board, including: -- The IT infrastructure required to support a population health management approach -- Your overarching plans for achieving PCMH 2014 Level 3 certification in relevant provider organizations --Defined priority target populations and define plans for addressing their health disparities.	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Step 1	In Progress	Identify those responsible for population health management roadmap development, monitoring and reporting.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2	In Progress	Conduct current state IT assessment, including those elements needed to support population health management.	04/01/2015	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.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4	In Progress	Conduct workforce assessment that includes functions needed for population health management.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5	In Progress	Analyze data from IT, PCMH and workforce assessments.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6	In Progress	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.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 7	In Progress	Draft and finalize population health management roadmap.	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 8	In Progress	Obtain approval of population health management roadmap from Brooklyn Bridges PPS Leadership.	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Milestone #2 Finalize PPS-wide bed reduction plan.	In Progress	PPS Bed Reduction plan, signed off by PPS Board. This should set out your plan for bed reductions across your network, including behavioral health	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		units/facilities, in line with planned reductions in avoidable admissions and the shift of activity from inpatient to outpatient settings.					
Task Step 1	In Progress	Identify staff responsible for developing and reporting on bed reduction plan.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2	In Progress	Develop implementation plans for the ED Triage and Observation Unit projects.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3	In Progress	Develop method to monitor the impact of DSRIP and care activities on utilization.	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4	In Progress	Draft and finalize bed reduction plan.	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop population health management roadmap.	The PPS is developing a population health roadmap, which will be approved by the PPS Executive Committee. The roadmap will be designed to address the IT infrastructure to advance the population health management approach designed by the PPS. The roadmap will also set forth resources needed for the PPS and its comprising partners to achieve PCMH 2014 Level 3 certification in relevant provider organizations, and will address ways to overcome existing health disparities in the PPS population.
Finalize PPS-wide bed reduction plan.	The PPS will provide a recommendation for bed reductions that each affected institution or organization within the PPS may review and implement at its discretion. This plan will set forth bed reduction recommendations across the PPS.

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☑ **IPQR Module 8.2 - PPS Defined Milestones**

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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.

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☑ **IPQR Module 8.5 - Roles and Responsibilities**

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
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	Hilton Marcus, Chief of Staff, NYU Lutheran	Ensuring modeling of impact of clinical projects on hospital/community care utilization.

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☑ **IPQR Module 8.6 - Key Stakeholders**

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
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.

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☑ **IPQR Module 8.7 - IT Expectations**

Instructions :

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

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 :

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Section 09 – Clinical Integration

☑ IPQR Module 9.1 - Prescribed Milestones

Instructions :

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.

Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation.

Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform a clinical integration 'needs assessment'.	In Progress	Clinical integration 'needs assessment' document, signed off by the Clinical Quality Committee, including: -- Mapping the providers in the network and their requirements for clinical integration (including clinical providers, care management and other providers impacting on social determinants of health) -- Identifying key data points for shared access and the key interfaces that will have an impact on clinical integration -- Identify other potential mechanisms to be used for driving clinical integration	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1	In Progress	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).	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2	In Progress	Map the provider landscape participating in each clinical project.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
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).	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4	In Progress	Finalize clinical integration needs assessment.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5	In Progress	Obtain approval of clinical integration needs assessment by Clinical Sub Committee.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #2 Develop a Clinical Integration strategy.	In Progress	Clinical Integration Strategy, signed off by Clinical Quality Committee, including: -- Clinical and other info for sharing -- Data sharing systems and interoperability -- A specific Care Transitions Strategy, including: hospital admission and discharge coordination; and care transitions and coordination and	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		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	In Progress	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.).	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2	In Progress	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.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3	In Progress	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.	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform a clinical integration 'needs assessment'.	The PPS will develop a clinical integration plan, which will be approved by the Clinical Sub-Committee. The information that will inform this plan will be derived from the general provider assessment.
Develop a Clinical Integration strategy.	The PPS will develop a Clinical Integration Strategy, to include requirements for data sharing, interoperabilty, and training on these tools and strategies for providers and operations staff.

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☑ **IPQR Module 9.2 - PPS Defined Milestones**

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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.

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☑ **IPQR Module 9.5 - Roles and Responsibilities**

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Oversight 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.

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☑ **IPQR Module 9.6 - Key Stakeholders**

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
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 :

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Section 10 – General Project Reporting

☑ IPQR Module 10.1 - Overall approach to implementation

Instructions :

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

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

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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.

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☑ **IPQR Module 10.3 - Project Roles and Responsibilities**

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
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.

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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.

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Run Date : 09/25/2015

IPQR Module 10.5 - IA Monitoring

Instructions :

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

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

Instructions :

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

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

Instructions :

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

Benchmarks
100% Total Committed By
DY4,Q2

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	**DY1,Q2**	**DY1,Q3**	**DY1,Q4**	**DY2,Q1**	**DY2,Q2**	**DY2,Q3**	**DY2,Q4**	**DY3,Q1**	**DY3,Q2**
Primary Care Physicians	392	0	0	0	0	0	0	0	0	39	98
Non-PCP Practitioners	1,262	0	0	0	0	0	0	0	0	126	316
Hospitals	6	0	0	0	0	0	0	0	0	1	2
Clinics	38	0	0	0	0	0	0	0	0	4	10
Health Home / Care Management	8	0	0	0	0	0	0	0	0	1	2
Behavioral Health	188	0	0	0	0	0	0	0	0	19	47
Substance Abuse	22	0	0	0	0	0	0	0	0	2	6
Skilled Nursing Facilities / Nursing Homes	34	0	0	0	0	0	0	0	0	3	9
Pharmacies	0	0	0	0	0	0	0	0	0	0	0
Hospice	3	0	0	0	0	0	0	0	0	0	1
Community Based Organizations	18	0	0	0	0	0	0	0	0	2	5
All Other	894	0	0	0	0	0	0	0	0	89	224
Total Committed Providers	**2,865**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**286**	**720**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**9.98**	**25.13**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	**DY3,Q4**	**DY4,Q1**	**DY4,Q2**	**DY4,Q3**	**DY4,Q4**	**DY5,Q1**	**DY5,Q2**	**DY5,Q3**	**DY5,Q4**
Primary Care Physicians	392	196	274	353	392	392	392	392	392	392	392
Non-PCP Practitioners	1,262	631	883	1,136	1,262	1,262	1,262	1,262	1,262	1,262	1,262

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Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Hospitals	6	3	4	5	6	6	6	6	6	6	6
Clinics	38	19	27	34	38	38	38	38	38	38	38
Health Home / Care Management	8	4	6	7	8	8	8	8	8	8	8
Behavioral Health	188	94	132	169	188	188	188	188	188	188	188
Substance Abuse	22	11	15	20	22	22	22	22	22	22	22
Skilled Nursing Facilities / Nursing Homes	34	17	24	31	34	34	34	34	34	34	34
Pharmacies	0	0	0	0	0	0	0	0	0	0	0
Hospice	3	2	2	3	3	3	3	3	3	3	3
Community Based Organizations	18	9	13	16	18	18	18	18	18	18	18
All Other	894	447	626	805	894	894	894	894	894	894	894
Total Committed Providers	**2,865**	**1,433**	**2,006**	**2,579**	**2,865**	**2,865**	**2,865**	**2,865**	**2,865**	**2,865**	**2,865**
Percent Committed Providers(%)		**50.02**	**70.02**	**90.02**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Current File Uploads

User ID	File Name	File Description	Upload Date
pg558102	32_PMDL2014_1_1_20150723173016_lutheran_medical_center_org_app Page 28.pdf	NYU Lutheran Medical Center Organizational Application - Section 3.2 Healthcare Provider Infrastructure Table	07/23/2015 05:30 PM

Narrative Text :

Provider ramp up: While these figures represent the PPS's best estimate as of August 7 2015, these estimates may need to be modified for reasons including, but not limited to unforeseeable changes to the PPS partners relationships following MSA and schedule A execution.; Partner movement in between PPS's; Changes to provider classification and General changes in provider marketplace. Provider ramp up dependent on accurate and timely data provided by the State.

Whereas this MAPP tool is based on the speed and scale estimates submitted in January 2015, which states that the NYU Lutheran Medical Center PPS has 6 hospitals in its network, the PPS in fact has 2 hospitals in its network as described in the attached Section 3.2 Healthcare Provider Infrastructure table.

Patient Ramp up: While these figures represent the PPS's best estimate as of August 7, 2015, PPS may need to modify these estimates for reasons including, but not limited to Results form the State's "Opt out" process and significant changes in attributed population (including movement to and from Medicaid, and changes in the provider and partner marketplace).

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.	Project	N/A	In Progress	04/01/2015	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		In Progress	04/01/2015	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		In Progress	04/01/2015	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		In Progress	04/01/2015	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	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS produces a list of participating HHs and ACOs.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Continue to contract with the Brooklyn Health Home (BHH) for those	Project		In Progress	04/01/2015	09/30/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
patients who are HH-eligible.							
Task Step 2. Conduct regular coordination meetings between the BHH and Brooklyn Bridges PPS.	Project		In Progress	04/01/2015	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	04/01/2015	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	04/01/2015	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		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.	Project		In Progress	04/01/2015	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	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS trains staff on IDS protocols and processes.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 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		In Progress	04/01/2015	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		In Progress	04/01/2015	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	Project		In Progress	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project		In Progress	04/01/2015	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		In Progress	04/01/2015	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		In Progress	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 7. Communicate expectations and timeframes for achieving PPS-wide connectivity.	Project		In Progress	04/01/2015	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	04/01/2015	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		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	Project	N/A	In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Primary Care Physicians	In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Non-PCP Practitioners	In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Hospitals	In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Behavioral Health	In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Skilled Nursing Facilities / Nursing Homes	In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task	Project		In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project		In Progress	04/01/2015	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	04/01/2015	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		In Progress	04/01/2015	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		In Progress	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Implement plan and achieve HIE connectivity across PPS safety net provider partners.	Project		In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Project	N/A	In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Project		In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Safety Net Primary Care Physicians	In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Complete current state assessment of EHR systems' MU certification and PCMH Level 3 standards across the PPS.	Provider	Safety Net Primary Care Physicians	In Progress	04/01/2015	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.	Provider	Safety Net Primary Care Physicians	In Progress	04/01/2015	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.	Provider	Safety Net Primary Care Physicians	In Progress	04/01/2015	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.	Provider	Safety Net Primary Care Physicians	In Progress	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

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

DSRIP Implementation Plan Project
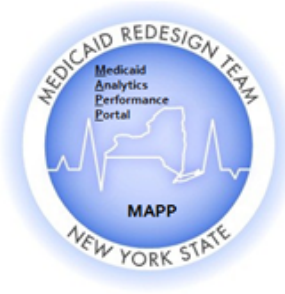
NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 5. Implement plan and support partners in completing their EHR MU & PCMH certification requirements.	Provider	Safety Net Primary Care Physicians	In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
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.	Project		In Progress	04/01/2015	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 safety net partners cannot easily upload appropriate patient data to a patient registry.	Project		In Progress	04/01/2015	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		In Progress	04/01/2015	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		In Progress	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Implement plan across PPS safety net partners.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	Project	N/A	In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.	Project		In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.	Provider	Primary Care Physicians	In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task	Project		In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	Project		In Progress	04/01/2015	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 requirements.	Project		In Progress	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Develop roadmap to achieving EHR MU & 2014 PCMH Level 3 certification requirements across PPS provider partners.	Project		In Progress	04/01/2015	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		In Progress	04/01/2015	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		In Progress	04/01/2015	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	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	Project	N/A	In Progress	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Medicaid Managed Care contract(s) are in place that include value-based payments.	Project		In Progress	04/01/2015	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		In Progress	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Develop initial plan to expand MCO value-based contracts across the system, identifying priority opportunities, needed infrastructure, reporting requirements and negotiation strategies.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Determine structure of legal entity (or entities) to be created for	Project		In Progress	04/01/2015	09/30/2017	09/30/2017	DY3 Q2

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

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project		In Progress	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 5. Implement expanded value-based payment opportunities for new target populations and with new payers, as appropriate.	Project		In Progress	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Identify MCOs with which to schedule regular progress meetings.	Project		In Progress	04/01/2015	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	04/01/2015	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	04/01/2015	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	In Progress	04/01/2015	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		In Progress	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.	Project		In Progress	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 1. Identify current models being used in the PPS.	Project		In Progress	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

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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)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 2. Identify stakeholders who should be involved in each step of value based payment reform.	Project		In Progress	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
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.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4. Pilot and evaluate new incentive-based compensation models.	Project		In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 5. Expand implementation of provider incentive-based compensation models.	Project		In Progress	04/01/2015	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	In Progress	04/01/2015	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		In Progress	04/01/2015	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		In Progress	04/01/2015	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		In Progress	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. Implement the community outreach plan.	Project		In Progress	04/01/2015	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		In Progress	04/01/2015	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		In Progress	04/01/2015	09/30/2018	09/30/2018	DY4 Q2

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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 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 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.										

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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 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.										
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										

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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
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.										
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										

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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
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.										
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										

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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
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.										
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										

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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 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 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,										

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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
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 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.										

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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
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 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										

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
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.										
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.										

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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 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 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.										

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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
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.	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.										

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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 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.	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										

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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
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.	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.										

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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 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 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.										

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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 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.										
Task Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.										

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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. 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										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	The Master Services Agreement (MSA) has been drafted and reviewed; the MSA draft for feedback was sent to all PPS partners, including CBOs, on 6/8/2015. Clinical workgroups have been founded and meeting periodically to meet objectives of chosen DSRIP projects, including 2.a.i. Topics discussed include, but have not been limited to: care coordination protocols, clinical pathways, training requirements, budgets, communication strategies and IT needs. The PPS plans to determine the various partners' approaches to value based payments, and will develop recommendations to advance the Statewide value based payment initiative as part of the DSRIP Program.
Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	The Master Services Agreement (MSA) has been drafted and reviewed; the MSA draft for feedback was sent to all PPS partners, including CBOs, on 6/8/2015. Clinical workgroups have been founded and meeting periodically to meet objectives of chosen DSRIP projects, including 2.a.i. Topics discussed include, but have not been limited to: care coordination protocols, clinical pathways, training requirements, budgets, communication strategies and IT needs. The PPS plans to determine the various partners' approaches to value based payments, and will develop recommendations to advance the Statewide value based payment initiative as part of the DSRIP Program.
Ensure patients receive appropriate health care and community support, including medical and	The Master Services Agreement (MSA) has been drafted and reviewed; the MSA draft for feedback was sent to all PPS partners, including CBOs, on 6/8/2015. Clinical workgroups have been founded and meeting periodically to meet objectives of chosen DSRIP projects, including 2.a.i. Topics discussed include, but have not been

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
behavioral health, post-acute care, long term care and public health services.	limited to: care coordination protocols, clinical pathways, training requirements, budgets, communication strategies and IT needs. The PPS plans to determine the various partners' approaches to value based payments, and will develop recommendations to advance the Statewide value based payment initiative as part of the DSRIP Program.
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.	The Master Services Agreement (MSA) has been drafted and reviewed; the MSA draft for feedback was sent to all PPS partners, including CBOs, on 6/8/2015. Clinical workgroups have been founded and meeting periodically to meet objectives of chosen DSRIP projects, including 2.a.i. Topics discussed include, but have not been limited to: care coordination protocols, clinical pathways, training requirements, budgets, communication strategies and IT needs. The PPS plans to determine the various partners' approaches to value based payments, and will develop recommendations to advance the Statewide value based payment initiative as part of the DSRIP Program.
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.	The Master Services Agreement (MSA) has been drafted and reviewed; the MSA draft for feedback was sent to all PPS partners, including CBOs, on 6/8/2015. Clinical workgroups have been founded and meeting periodically to meet objectives of chosen DSRIP projects, including 2.a.i. Topics discussed include, but have not been limited to: care coordination protocols, clinical pathways, training requirements, budgets, communication strategies and IT needs. The PPS plans to determine the various partners' approaches to value based payments, and will develop recommendations to advance the Statewide value based payment initiative as part of the DSRIP Program.
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	The Master Services Agreement (MSA) has been drafted and reviewed; the MSA draft for feedback was sent to all PPS partners, including CBOs, on 6/8/2015. Clinical workgroups have been founded and meeting periodically to meet objectives of chosen DSRIP projects, including 2.a.i. Topics discussed include, but have not been limited to: care coordination protocols, clinical pathways, training requirements, budgets, communication strategies and IT needs. The PPS plans to determine the various partners' approaches to value based payments, and will develop recommendations to advance the Statewide value based payment initiative as part of the DSRIP Program.
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.	The Master Services Agreement (MSA) has been drafted and reviewed; the MSA draft for feedback was sent to all PPS partners, including CBOs, on 6/8/2015. Clinical workgroups have been founded and meeting periodically to meet objectives of chosen DSRIP projects, including 2.a.i. Topics discussed include, but have not been limited to: care coordination protocols, clinical pathways, training requirements, budgets, communication strategies and IT needs. The PPS plans to determine the various partners' approaches to value based payments, and will develop recommendations to advance the Statewide value based payment initiative as part of the DSRIP Program.
Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	The Master Services Agreement (MSA) has been drafted and reviewed; the MSA draft for feedback was sent to all PPS partners, including CBOs, on 6/8/2015. Clinical workgroups have been founded and meeting periodically to meet objectives of chosen DSRIP projects, including 2.a.i. Topics discussed include, but have not been limited to: care coordination protocols, clinical pathways, training requirements, budgets, communication strategies and IT needs. The PPS plans to determine the various partners' approaches to value based payments, and will develop recommendations to advance the Statewide value based payment initiative as part of the DSRIP Program.
Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	The Master Services Agreement (MSA) has been drafted and reviewed; the MSA draft for feedback was sent to all PPS partners, including CBOs, on 6/8/2015. Clinical workgroups have been founded and meeting periodically to meet objectives of chosen DSRIP projects, including 2.a.i. Topics discussed include, but have not been limited to: care coordination protocols, clinical pathways, training requirements, budgets, communication strategies and IT needs. The PPS plans to determine the various partners' approaches to value based payments, and will develop recommendations to advance the Statewide value based payment initiative as part of the DSRIP Program.
Re-enforce the transition towards value-based payment reform by aligning provider compensation	The Master Services Agreement (MSA) has been drafted and reviewed; the MSA draft for feedback was sent to all PPS partners, including CBOs, on 6/8/2015. Clinical workgroups have been founded and meeting periodically to meet objectives of chosen DSRIP projects, including 2.a.i. Topics discussed include, but have not been

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
to patient outcomes.	limited to: care coordination protocols, clinical pathways, training requirements, budgets, communication strategies and IT needs. The PPS plans to determine the various partners' approaches to value based payments, and will develop recommendations to advance the Statewide value based payment initiative as part of the DSRIP Program.
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.	The Master Services Agreement (MSA) has been drafted and reviewed; the MSA draft for feedback was sent to all PPS partners, including CBOs, on 6/8/2015. Clinical workgroups have been founded and meeting periodically to meet objectives of chosen DSRIP projects, including 2.a.i. Topics discussed include, but have not been limited to: care coordination protocols, clinical pathways, training requirements, budgets, communication strategies and IT needs. The PPS plans to determine the various partners' approaches to value based payments, and will develop recommendations to advance the Statewide value based payment initiative as part of the DSRIP Program.

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

Milestone 3: PPS should collaborate with MCOs, HHs, OPDs PEER advocacy organizations and residential providers that serve SMI individuals to expand access to clientele to educate and engage.

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

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

Instructions :

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

1. 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.

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

Instructions :

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

Benchmarks
100% Total Committed By
DY3,Q4

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	**DY1,Q2**	**DY1,Q3**	**DY1,Q4**	**DY2,Q1**	**DY2,Q2**	**DY2,Q3**	**DY2,Q4**	**DY3,Q1**	**DY3,Q2**
Emergency Departments with Care Triage	2	0	0	0	0	0	0	0	0	1	1
Total Committed Providers	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**1**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**50.00**	**50.00**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	**DY3,Q4**	**DY4,Q1**	**DY4,Q2**	**DY4,Q3**	**DY4,Q4**	**DY5,Q1**	**DY5,Q2**	**DY5,Q3**	**DY5,Q4**
Emergency Departments with Care Triage	2	2	2	2	2	2	2	2	2	2	2
Total Committed Providers	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**
Percent Committed Providers(%)		**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Current File Uploads

User ID	File Name	File Description	Upload Date

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Narrative Text :

Provider ramp up: While these figures represent the PPS's best estimate as of August 7, 2015, these estimates may need to be modified for reasons including, but not limited to unforeseeable changes to the PPS partners relationships following MSA and schedule A execution.; Partner movement in between PPS's; Changes to provider classification and General changes in provider marketplace. Provider ramp up dependent on accurate and timely data provided by the State.

Whereas this MAPP tool is based on the speed and scale estimates submitted in January 2015, which states that the NYU Lutheran Medical

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Center PPS has 6 hospitals in its network, the PPS in fact has 2 hospitals in its network as described in the attached Section 3.2 Healthcare Provider Infrastructure table.

Patient Ramp up: While these figures represent the PPS's best estimate as of August 7, 2015, PPS may need to modify these estimates for reasons including, but not limited to Results form the State's "Opt out" process and significant changes in attributed population (including movement to and from Medicaid, and changes in the provider and partner marketplace).

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	6,056

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	379	455	2,120	303	1,211	1,453	3,028	757	3,028
Percent of Expected Patient Engagement(%)	**0.00**	**6.26**	**7.51**	**35.01**	**5.00**	**20.00**	**23.99**	**50.00**	**12.50**	**50.00**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	3,634	6,056	757	3,028	3,634	6,056	0	0	0	0
Percent of Expected Patient Engagement(%)	**60.01**	**100.00**	**12.50**	**50.00**	**60.01**	**100.00**	**0.00**	**0.00**	**0.00**	**0.00**

Current File Uploads

User ID	File Name	File Description	Upload Date
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Narrative Text :

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Establish ED care triage program for at-risk populations	Project	N/A	In Progress	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	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		In Progress	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		In Progress	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		In Progress	09/01/2015	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		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 5. Roll out patient education strategies with community partners	Project		In Progress	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 3. Enroll all eligible patients into health home 4. SBIRT screening to identify potential ED "frequent fliers" appropriate for referral to substance abuse care.	Project		In Progress	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 7. Identify ED discharge program lead	Project		In Progress	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 8. Determine resource needs to successfully implement the discharge	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
program.							
Task Step 9. Recruit, train and assign staff to discharge unit	Project		In Progress	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		In Progress	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 11. Begin conducting ED care triage services at LMC	Project		In Progress	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 12. Begin conducting ED care triage services at Cobble Hill	Project		In Progress	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		In Progress	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		In Progress	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 15. Identify continuous quality improvement initiatives	Project		In Progress	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	06/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	Provider	Safety Net Primary Care Physicians	In Progress	06/01/2015	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	06/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	Provider	Safety Net Primary Care Physicians	In Progress	06/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	Provider	Safety Net Hospitals	In Progress	06/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Conduct a current state assessment to determine which community	Provider	Hospitals	In Progress	06/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Provider	Hospitals	In Progress	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.	Provider	Hospitals	In Progress	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.	Provider	Hospitals	In Progress	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 accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	Project	N/A	In Progress	06/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task A defined process for triage of patients from patient navigators to non-emergency PCP and needed community support resources is in place.	Project		In Progress	06/01/2015	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		In Progress	08/01/2015	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)	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project		In Progress	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		In Progress	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 optional.)	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has protocols and operations in place to transport non-acute patients to appropriate care site. (Optional).	Provider	Safety Net Hospitals	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	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	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	09/01/2015	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		In Progress	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, 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		In Progress	06/30/2016	09/30/2016	09/30/2016	DY2 Q2

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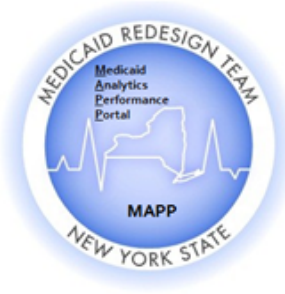
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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 4. Identify resources, timing and expertise required to implement the patient registry plan for PPS primary care partners.	Project		In Progress	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Implement plan across PPS primary care partners	Project		In Progress	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 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.										

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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 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										
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

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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 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: 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										

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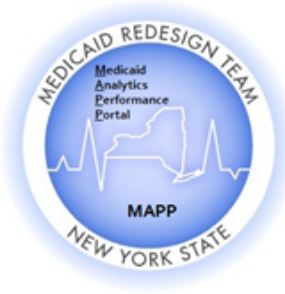
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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
ED patients with: 1. Receiving an immediate appointment with a primary care provider. 2. Identifying and accessing needed community support 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										
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										

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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
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.										
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										

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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
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										
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

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task EHR meets 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 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										

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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
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										
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										

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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
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.										
Task Step 5. Implement plan across PPS primary care partners										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish ED care triage program for at-risk populations	
Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable	
For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	
Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)	
Use EHRs and other technical platforms to track all patients engaged in the project.	

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

Risks: The PPS refers to infrastructure and systemic issues, development time but does not refer to EHRs in a specific comparison of the IT systems used by the partnering HHs and ACOs. PPS does not distinguish behavioral health providers (in network MH vs. SUD providers). It is most important to identify who and how many SUD providers there are.

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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.
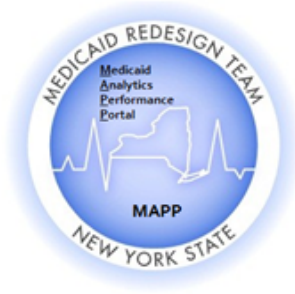

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NYU Lutheran Medical Center (PPS ID:32)

☑ **IPQR Module 2.b.ix.2 - Project Implementation Speed**

Instructions :

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

Benchmarks
100% Total Committed By
DY3,Q2

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	**DY1,Q2**	**DY1,Q3**	**DY1,Q4**	**DY2,Q1**	**DY2,Q2**	**DY2,Q3**	**DY2,Q4**	**DY3,Q1**	**DY3,Q2**
Primary Care Physicians	278	0	0	0	0	0	0	0	0	28	278
Hospitals	6	0	0	0	0	0	0	0	0	1	6
Clinics	38	0	0	0	0	0	0	0	0	4	38
Health Home / Care Management	8	0	0	0	0	0	0	0	0	1	8
Behavioral Health	188	0	0	0	0	0	0	0	0	19	188
Substance Abuse	22	0	0	0	0	0	0	0	0	2	22
Skilled Nursing Facilities / Nursing Homes	34	0	0	0	0	0	0	0	0	3	34
All Other	173	0	0	0	0	0	0	0	0	17	173
Total Committed Providers	**747**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**75**	**747**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**10.04**	**100.00**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	**DY3,Q4**	**DY4,Q1**	**DY4,Q2**	**DY4,Q3**	**DY4,Q4**	**DY5,Q1**	**DY5,Q2**	**DY5,Q3**	**DY5,Q4**
Primary Care Physicians	278	278	278	278	278	278	278	278	278	278	278
Hospitals	6	6	6	6	6	6	6	6	6	6	6
Clinics	38	38	38	38	38	38	38	38	38	38	38
Health Home / Care Management	8	8	8	8	8	8	8	8	8	8	8
Behavioral Health	188	188	188	188	188	188	188	188	188	188	188
Substance Abuse	22	22	22	22	22	22	22	22	22	22	22

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Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Skilled Nursing Facilities / Nursing Homes	34	34	34	34	34	34	34	34	34	34	34
All Other	173	173	173	173	173	173	173	173	173	173	173
Total Committed Providers	**747**	**747**	**747**	**747**	**747**	**747**	**747**	**747**	**747**	**747**	**747**
Percent Committed Providers(%)		**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Current File Uploads

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Provider ramp up: While these figures represent the PPS's best estimate as of August 7, 2015, these estimates may need to be modified for reasons including, but not limited to unforeseeable changes to the PPS partners relationships following MSA and schedule A execution.; Partner movement in between PPS's; Changes to provider classification and General changes in provider marketplace. Provider ramp up dependent on accurate and timely data provided by the State.

Whereas this MAPP tool is based on the speed and scale estimates submitted in January 2015, which states that the NYU Lutheran Medical Center PPS has 6 hospitals in its network, the PPS in fact will introduce this project in one hospital; note that there are only two hospitals in the PPS network as described in the attached Section 3.2 Healthcare Provider Infrastructure table.

Patient Ramp up: While these figures represent the PPS's best estimate as of August 7, 2015, PPS may need to modify these estimates for reasons including, but not limited to Results form the State's "Opt out" process and significant changes in attributed population (including movement to and from Medicaid, and changes in the provider and partner marketplace).

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☑ **IPQR Module 2.b.ix.3 - Patient Engagement Speed**

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY2,Q4	523

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	33	40	131	46	183	220	523	66	262
Percent of Expected Patient Engagement(%)	**0.00**	**6.31**	**7.65**	**25.05**	**8.80**	**34.99**	**42.07**	**100.00**	**12.62**	**50.10**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	314	523	66	262	314	523	0	0	0	0
Percent of Expected Patient Engagement(%)	**60.04**	**100.00**	**12.62**	**50.10**	**60.04**	**100.00**	**0.00**	**0.00**	**0.00**	**0.00**

Current File Uploads

User ID	File Name	File Description	Upload Date
No Records Found			

Narrative Text :

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✅ **IPQR Module 2.b.ix.4 - Prescribed Milestones**

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Establish 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	09/30/2017	DY3 Q2
Task Observation units established in proximity to PPS' ED departments.	Provider	Hospitals	In Progress	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	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		In Progress	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		In Progress	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		In Progress	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		In Progress	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	06/30/2017	DY3 Q1
Task Step 6. Confirm OU staffing model	Project		In Progress	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 7. Recruit, train and assign staff to the OU	Project		In Progress	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
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	12/31/2015	DY1 Q3
Task Step 9. Open the NYU Lutheran OU	Project		In Progress	05/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task	Project		In Progress	01/01/2016	09/30/2017	09/30/2017	DY3 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project	N/A	In Progress	08/01/2015	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	Hospitals	In Progress	08/01/2015	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	Provider	Hospitals	In Progress	08/01/2015	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	Provider	Hospitals	In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3. Identify continuous quality improvement initiatives	Provider	Hospitals	In Progress	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	Provider	Hospitals	In Progress	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 behavioral health or assisted living/SNF.	Project	N/A	In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
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		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Identify case management needs for people being discharged from OU.	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Develop case management protocols and train case management staff	Project		In Progress	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3. Initiate case management for patients being discharged from OU	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4	Project	N/A	In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4

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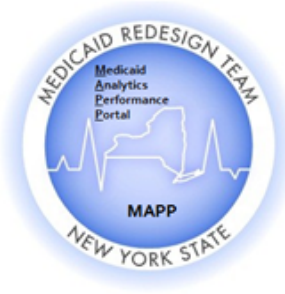| Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information 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.)	Project		In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Primary Care Physicians	In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Hospitals	In Progress	09/01/2015	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.	Provider	Safety Net Hospitals	In Progress	09/01/2015	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.	Provider	Safety Net Hospitals	In Progress	09/01/2015	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 of IDS project 2.a.i for details).	Provider	Safety Net Hospitals	In Progress	03/31/2016	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.	Provider	Safety Net Hospitals	In Progress	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.	Provider	Safety Net Hospitals	In Progress	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	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	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	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Identify gaps highlighting where a) current registries do not exist to	Project		In Progress	12/31/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	Project		In Progress	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		In Progress	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Implement plan across PPS primary care partners	Project		In Progress	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 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										

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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 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 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										

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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
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), 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										

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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
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 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										

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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
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 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

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. 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), 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

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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 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 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.										

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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 5. Implement plan across PPS primary care partners										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date
No Records Found				

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish 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 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.	

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NYU Lutheran Medical Center (PPS ID:32)

☑ **IPQR Module 2.b.ix.5 - PPS Defined Milestones**

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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.

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☑ **IPQR Module 2.c.i.2 - Project Implementation Speed**

Instructions :

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

Benchmarks
100% Total Committed By
DY3,Q2

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Community-based navigators participating in project	78	0	0	0	0	0	0	8	20	39	78
Total Committed Providers	**78**	**0**	**0**	**0**	**0**	**0**	**0**	**8**	**20**	**39**	**78**
Percent Committed Providers(%)		0.00	0.00	0.00	0.00	0.00	0.00	10.26	25.64	50.00	100.00

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Community-based navigators participating in project	78	78	78	78	78	78	78	78	78	78	78
Total Committed Providers	**78**	**78**	**78**	**78**	**78**	**78**	**78**	**78**	**78**	**78**	**78**
Percent Committed Providers(%)		100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Current File Uploads

User ID	File Name	File Description	Upload Date
No Records Found			

Narrative Text :

Provider ramp up: While these figures represent the PPS's best estimate as of August 7, 2015, these estimates may need to be modified for reasons including, but not limited to unforeseeable changes to the PPS partners relationships following MSA and schedule A execution.; Partner movement in between PPS's; Changes to provider classification and General changes in provider marketplace. Provider ramp up dependent on accurate and timely data provided by the State.

Patient Ramp up: While these figures represent the PPS's best estimate as of August 7, 2015, PPS may need to modify these estimates for

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reasons including, but not limited to Results form the State's "Opt out" process and significant changes in attributed population (including movement to and from Medicaid, and changes in the provider and partner marketplace).

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

Instructions :

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

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

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	1,357	1,628	2,715	1,018	4,072	4,886	10,859	2,376	9,502
Percent of Expected Patient Engagement(%)	**0.00**	**5.00**	**6.00**	**10.00**	**3.75**	**15.00**	**18.00**	**40.00**	**8.75**	**35.00**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	11,402	21,718	3,054	12,217	14,660	27,148	0	0	0	0
Percent of Expected Patient Engagement(%)	**42.00**	**80.00**	**11.25**	**45.00**	**54.00**	**100.00**	**0.00**	**0.00**	**0.00**	**0.00**

Current File Uploads

User ID	File Name	File Description	Upload Date
No Records Found			

Narrative Text :

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☑ **IPQR Module 2.c.i.4 - Prescribed Milestones**

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 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	09/30/2017	DY3 Q2
Task Community-based health navigation services established.	Project		In Progress	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		In Progress	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		In Progress	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		In Progress	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		In Progress	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 5. Hire community-based navigators as necessary (phased growth).	Project		In Progress	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		In Progress	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	12/31/2015	DY1 Q3
Task Step 8. Design the infrastructure and work streams of the PPS's Patient Navigation Center (PNC)	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 9. Determine best implementation approach for PNC (e.g. leverage	Project		In Progress	03/31/2016	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
services vendor or build capabilities)							
Task Step 10. Implement the initial PNC call center capabilities.	Project		In Progress	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		In Progress	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	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	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		In Progress	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	03/31/2016	DY1 Q4
Task Step 3. Develop a community care resource guide and enhance based on experience (phased development and implementation).	Project		In Progress	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	03/31/2017	DY2 Q4
Task Navigators recruited by residents in the targeted area, where possible.	Project		In Progress	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
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		In Progress	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		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Hire and train community navigators.	Project		In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Resource appropriately for the community navigators, evaluating placement	Project	N/A	In Progress	01/01/2016	09/30/2017	09/30/2017	DY3 Q2

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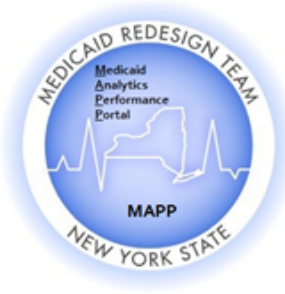
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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
and service type.							
Task Navigator placement implemented based upon opportunity assessment.	Project		In Progress	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Telephonic and web-based health navigator services implemented by type.	Project		In Progress	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 1. Identify skillsets necessary for community navigators.	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Establish standardized job description for community navigators.	Project		In Progress	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		In Progress	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	In Progress	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		In Progress	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		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 2. Train navigators on use of the resource guide.	Project		In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
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	In Progress	08/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Case loads and discharge processes established for health navigators following patients longitudinally.	Project		In Progress	08/01/2015	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		In Progress	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Develop a case load and discharge protocol for community navigators.	Project		In Progress	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #7 Market the availability of community-based navigation services.	Project	N/A	In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Health navigator personnel and services marketed within designated communities.	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 1. Engage the PPS's Communications and Outreach team to develop pamphlet materials regarding available community-based navigation services.	Project		In Progress	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		In Progress	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		In Progress	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	In Progress	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	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	09/01/2015	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		In Progress	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, 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		In Progress	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		In Progress	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Implement plan across PPS primary care partners.	Project		In Progress	06/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #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.										
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										

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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
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.										
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.										

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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
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.										
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.										
Milestone #7 Market the availability of community-based navigation services.										
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										

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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 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.										
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										

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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)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
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.										
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.										

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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 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.										
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.										

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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 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 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.										
Milestone #7 Market the availability of community-based navigation services.										
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.										

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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 #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.										
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 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	

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Prescribed Milestones Narrative Text

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

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☑ **IPQR Module 2.c.i.5 - PPS Defined Milestones**

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

IPQR Module 2.c.i.6 - IA Monitoring

Instructions :

Milestone 3: PPS should develop all new steps appropriate to Milestone 3. Steps entered appear to be a repeat of Milestone 2.

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NYU Lutheran Medical Center (PPS ID:32)

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.

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

Instructions :

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

Benchmarks
100% Total Committed By
DY3,Q4

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	**DY1,Q2**	**DY1,Q3**	**DY1,Q4**	**DY2,Q1**	**DY2,Q2**	**DY2,Q3**	**DY2,Q4**	**DY3,Q1**	**DY3,Q2**
Primary Care Physicians	291	0	0	0	0	0	0	0	0	29	73
Non-PCP Practitioners	338	0	0	0	0	0	0	0	0	34	85
Clinics	38	0	0	0	0	0	0	0	0	4	10
Behavioral Health	188	0	0	0	0	0	0	0	0	19	47
Substance Abuse	4	0	0	0	0	0	0	0	0	0	1
Community Based Organizations	15	0	0	0	0	0	0	0	0	2	4
All Other	290	0	0	0	0	0	0	0	0	29	73
Total Committed Providers	**1,164**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**117**	**293**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**10.05**	**25.17**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	**DY3,Q4**	**DY4,Q1**	**DY4,Q2**	**DY4,Q3**	**DY4,Q4**	**DY5,Q1**	**DY5,Q2**	**DY5,Q3**	**DY5,Q4**
Primary Care Physicians	291	146	291	291	291	291	291	291	291	291	291
Non-PCP Practitioners	338	169	338	338	338	338	338	338	338	338	338
Clinics	38	19	38	38	38	38	38	38	38	38	38
Behavioral Health	188	94	188	188	188	188	188	188	188	188	188
Substance Abuse	4	2	4	4	4	4	4	4	4	4	4
Community Based Organizations	15	8	15	15	15	15	15	15	15	15	15
All Other	290	145	290	290	290	290	290	290	290	290	290

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Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Total Committed Providers	1,164	583	1,164	1,164	1,164	1,164	1,164	1,164	1,164	1,164	1,164
Percent Committed Providers(%)		50.09	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Current File Uploads

User ID	File Name	File Description	Upload Date
No Records Found			

Narrative Text :

Provider ramp up: While these figures represent the PPS's best estimate as of August 7, 2015, these estimates may need to be modified for reasons including, but not limited to unforeseeable changes to the PPS partners relationships following MSA and schedule A execution.; Partner movement in between PPS's; Changes to provider classification and General changes in provider marketplace. Provider ramp up dependent on accurate and timely data provided by the State.

Patient Ramp up: While these figures represent the PPS's best estimate as of August 7, 2015, PPS may need to modify these estimates for reasons including, but not limited to Results form the State's "Opt out" process and significant changes in attributed population (including movement to and from Medicaid, and changes in the provider and partner marketplace).

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	28,192

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	0	0	5,638	1,198	4,793	5,752	14,096	2,819	11,277
Percent of Expected Patient Engagement(%)	**0.00**	**0.00**	**0.00**	**20.00**	**4.25**	**17.00**	**20.40**	**50.00**	**10.00**	**40.00**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	13,532	28,192	3,524	14,096	16,915	28,192	0	0	0	0
Percent of Expected Patient Engagement(%)	**48.00**	**100.00**	**12.50**	**50.00**	**60.00**	**100.00**	**0.00**	**0.00**	**0.00**	**0.00**

Current File Uploads

User ID	File Name	File Description	Upload Date
No Records Found			

Narrative Text :

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Model 1	Project	N/A	In Progress	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	Primary Care Physicians	In Progress	05/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Behavioral health services are co-located within PCMH/APC practices and are available.		Provider	Behavioral Health	In Progress	05/01/2015	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.		Provider	Behavioral Health	In Progress	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").		Provider	Behavioral Health	In Progress	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.		Provider	Behavioral Health	In Progress	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.		Provider	Behavioral Health	In Progress	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Co-location Work Step 5. Identify site-specific staffing needs and recruit, hire and train staff.		Provider	Behavioral Health	In Progress	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Co-location Work Step 6. Start BH screening and co-located services at Phase 1 adopter sites.		Provider	Behavioral Health	In Progress	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Co-location Work Step 7. Document lessons learned to adjust strategies, workflows and practices.		Provider	Behavioral Health	In Progress	04/01/2016	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Co-location Work Step 8. Identify "Phase 2 adopter" sites.		Provider	Behavioral Health	In Progress	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.		Provider	Behavioral Health	In Progress	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.		Provider	Behavioral Health	In Progress	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.		Provider	Behavioral Health	In Progress	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.		Provider	Behavioral Health	In Progress	08/01/2015	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.		Provider	Behavioral Health	In Progress	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.		Provider	Behavioral Health	In Progress	12/01/2015	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.		Provider	Behavioral Health	In Progress	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.		Provider	Behavioral Health	In Progress	05/01/2016	12/31/2017	12/31/2017	DY3 Q3
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.		Provider	Behavioral Health	In Progress	05/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 1	Project	N/A	In Progress	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop		Project		In Progress	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

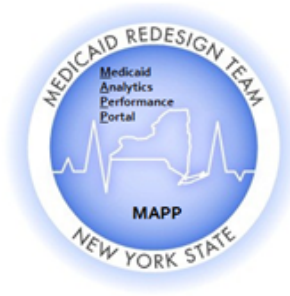## NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
collaborative care practices.								
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.		Project		In Progress	10/01/2015	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		In Progress	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		In Progress	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		In Progress	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		In Progress	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		In Progress	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	03/31/2018	DY3 Q4
Task Policies and procedures are in place to facilitate and document completion of screenings.		Project		In Progress	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	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	03/31/2018	DY3 Q4
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.		Provider	Primary Care Physicians	In Progress	05/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task		Provider	Primary Care Physicians	In Progress	05/01/2015	09/30/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.		Provider	Primary Care Physicians	In Progress	06/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3. Develop site-specific plans to roll-out preventive care screenings at Phase 1 adopter sites and implement plans.		Provider	Primary Care Physicians	In Progress	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.		Provider	Primary Care Physicians	In Progress	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.		Provider	Primary Care Physicians	In Progress	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.		Provider	Primary Care Physicians	In Progress	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 1	Project	N/A	In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		In Progress	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	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	09/01/2015	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		Project		In Progress	12/31/2015	06/30/2016	06/30/2016	DY2 Q1

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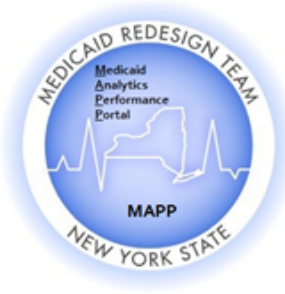| Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
patient data to the PPS project reporting system, c) EHRs do not integrate medical and BH record.								
Task Step 3. Develop roadmap to achieving expansion and/or establishment of EHR capabilities to track engaged patients across PPS primary care partners implementing project.		Project		In Progress	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		In Progress	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Implement plan across PPS primary care partners implementing project.		Project		In Progress	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	03/31/2020	DY5 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.		Provider	Primary Care Physicians	On Hold	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	Primary Care Physicians	On Hold	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	Behavioral Health	On Hold	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	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	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	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	03/31/2020	DY5 Q4
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
screenings.								
Task Screenings are documented in Electronic Health Record.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.		Provider	Primary Care Physicians	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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	03/31/2020	DY5 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #9 Implement IMPACT Model at Primary Care Sites.	Model 3	Project	N/A	In Progress	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task PPS has implemented IMPACT Model at Primary Care Sites.		Provider	Primary Care Physicians	In Progress	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Identify primary care partners that will implement IMPACT.		Provider	Primary Care Physicians	In Progress	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 2. Develop site-specific plans for phased implementation of program model.		Provider	Primary Care Physicians	In Progress	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.		Provider	Primary Care Physicians	In Progress	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		Provider	Primary Care Physicians	In Progress	01/01/2017	06/30/2017	06/30/2017	DY3 Q1

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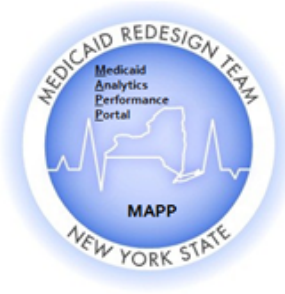
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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
requirements are being addressed.								
Task Step 5. Document lessons learned & challenges at early adopter sites with IMPACT & adapt strategy for later phases of roll-out.		Provider	Primary Care Physicians	In Progress	01/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task Step 6. Monitor implementation and offer technical assistance as needed.		Provider	Primary Care Physicians	In Progress	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Model 3	Project	N/A	In Progress	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		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures include process for consulting with Psychiatrist.		Project		In Progress	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		In Progress	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		In Progress	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		In Progress	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		In Progress	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	In Progress	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		Project		In Progress	03/01/2016	03/31/2017	03/31/2017	DY2 Q4

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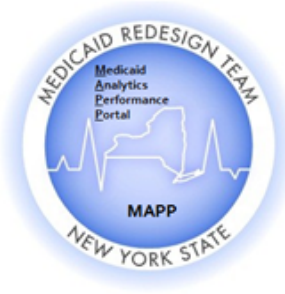
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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Health Records.								
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.		Project		In Progress	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Develop position requirements for Depression Care Manager (CM) per evidence-based model and NYS regulatory/reimbursement mandates.		Project		In Progress	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		In Progress	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Training is provided to Depression Care Managers.		Project		In Progress	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	In Progress	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task All IMPACT participants in PPS have a designated Psychiatrist.		Project		In Progress	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		In Progress	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		In Progress	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Training is provided to consulting psychiatrists at implementing sites.		Project		In Progress	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	In Progress	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		In Progress	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task		Project		In Progress	10/01/2016	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.		Project		In Progress	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	In Progress	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		In Progress	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		In Progress	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2. Train partners implementing IMPACT in stepped care and staff.		Project		In Progress	10/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task Step 3. Develop and implement site-specific plans.		Project		In Progress	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		In Progress	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	In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		In Progress	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	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	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task		Project		In Progress	12/31/2015	06/30/2016	06/30/2016	DY2 Q1

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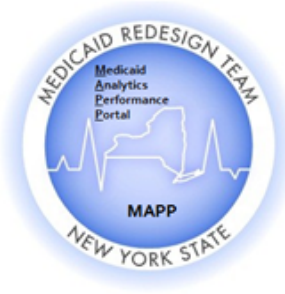
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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 2. Identify gaps highlighting where a) current EHRs do not document PPS's 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.		Project		In Progress	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		In Progress	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Implement plan across PPS primary care partners implementing project.		Project		In Progress	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 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										

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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
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.										
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										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
APCM 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.										
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).										

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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 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 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										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
not 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) 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.										

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 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 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.										

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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 #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 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										

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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
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 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.										

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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 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 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										

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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
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.										
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										

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

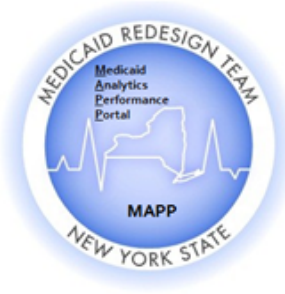| Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
primary care partners with BH co-location with respect to APCM and 2014 Level 3 PCMH standards.										
Task PCMH Work Step 2. Identify gaps highlighting where PPS safety net members' 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, 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.										

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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 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.										
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.										

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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 #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 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										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
including medication management and care engagement process.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices.										
Task Coordinated evidence-based care protocols are in place, including 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.										
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.										

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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 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.										
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										

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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
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 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										

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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
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 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										

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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
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 Name	Description	Upload Date
No Records Found				

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	
Develop collaborative evidence-based standards of care including medication management and care engagement process.	
Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	
Use EHRs or other technical platforms to track all patients engaged in this project.	
Co-locate primary care services at behavioral health sites.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	BB PPS has a two-phased approach to the Behavioral Health Integration Project. Phase 1: Co-location – we will focus on ramping up co-location of BH providers in our 3 largest partnering FQHCs in DY1 and DY2. Given available information, BB PPS understands that 3 of the FQHC partners represent over 70% of Medicaid PCP patient visits in our PPS. Our work will focus on preparing these key partners in implementing the co-location initiative strategically by supporting them to hire qualified staff, and financially through fund flow. Phase 2: IMPACT - We will work with smaller PCP practices to integrate IMPACT protocols into the DCMs' existing practice protocols. A large proportion of these PCPs are part of an NYU physician network and are therefore linked to a single HIE, facilitating integration of screening tools, documenting on-site counselling and tracking referrals. Given the scope of regulatory and financial/reimbursement barriers to the successful implementation of this project, BB PPS continues to raise concerns to the various state governmental agencies in coordination with HANYS, CHCANYS, and other relevant groups and networks.
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.	

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

Model 3: Milestone 1: Ramp up more rapidly. Should begin to see sites in Year 2, at least. Also, careful to determine eventual goal of 291. Keep in mind the need for DCM hiring and training. Each DCM can support a caseload of approx 100 patients. Ensure this is not under or over capacity based on patient population. The PPS should also develop a task that addresses the review of and mitigation of regulatory issues.

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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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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

☑ **IPQR Module 3.c.i.2 - Project Implementation Speed**

Instructions :

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

Benchmarks
100% Total Committed By
DY3,Q4

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	**DY1,Q2**	**DY1,Q3**	**DY1,Q4**	**DY2,Q1**	**DY2,Q2**	**DY2,Q3**	**DY2,Q4**	**DY3,Q1**	**DY3,Q2**
Primary Care Physicians	208	0	0	0	0	0	0	0	0	21	52
Non-PCP Practitioners	346	0	0	0	0	0	0	0	0	35	87
Clinics	38	0	0	0	0	0	0	0	0	4	10
Health Home / Care Management	8	0	0	0	0	0	0	0	0	1	2
Behavioral Health	150	0	0	0	0	0	0	0	0	15	38
Substance Abuse	4	0	0	0	0	0	0	0	0	0	1
Pharmacies	0	0	0	0	0	0	0	0	0	0	0
Community Based Organizations	14	0	0	0	0	0	0	0	0	1	4
All Other	224	0	0	0	0	0	0	0	0	22	56
Total Committed Providers	**992**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**99**	**250**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**9.98**	**25.20**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	**DY3,Q4**	**DY4,Q1**	**DY4,Q2**	**DY4,Q3**	**DY4,Q4**	**DY5,Q1**	**DY5,Q2**	**DY5,Q3**	**DY5,Q4**
Primary Care Physicians	208	104	208	208	208	208	208	208	208	208	208
Non-PCP Practitioners	346	173	346	346	346	346	346	346	346	346	346
Clinics	38	19	38	38	38	38	38	38	38	38	38
Health Home / Care Management	8	4	8	8	8	8	8	8	8	8	8
Behavioral Health	150	75	150	150	150	150	150	150	150	150	150

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Substance Abuse	4	2	4	4	4	4	4	4	4	4	4
Pharmacies	0	0	0	0	0	0	0	0	0	0	0
Community Based Organizations	14	7	14	14	14	14	14	14	14	14	14
All Other	224	112	224	224	224	224	224	224	224	224	224
Total Committed Providers	**992**	**496**	**992**	**992**	**992**	**992**	**992**	**992**	**992**	**992**	**992**
Percent Committed Providers(%)		**50.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Current File Uploads

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Narrative Text :

Provider ramp up: While these figures represent the PPS's best estimate as of August 7, 2015, these estimates may need to be modified for reasons including, but not limited to unforeseeable changes to the PPS partners relationships following MSA and schedule A execution.; Partner movement in between PPS's; Changes to provider classification and General changes in provider marketplace. Provider ramp up dependent on accurate and timely data provided by the State.

Patient Ramp up: While these figures represent the PPS's best estimate as of August 7, 2015, PPS may need to modify these estimates for reasons including, but not limited to Results form the State's "Opt out" process and significant changes in attributed population (including movement to and from Medicaid, and changes in the provider and partner marketplace).

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

☑ **IPQR Module 3.c.i.3 - Patient Engagement Speed**

Instructions :

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

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

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	507	608	2,537	381	1,522	1,826	3,552	508	2,030
Percent of Expected Patient Engagement(%)	**0.00**	**9.99**	**11.98**	**49.99**	**7.51**	**29.99**	**35.98**	**69.99**	**10.01**	**40.00**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	2,436	5,075	634	2,537	3,044	5,075	0	0	0	0
Percent of Expected Patient Engagement(%)	**48.00**	**100.00**	**12.49**	**49.99**	**59.98**	**100.00**	**0.00**	**0.00**	**0.00**	**0.00**

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Narrative Text :

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

☑ **IPQR Module 3.c.i.4 - Prescribed Milestones**
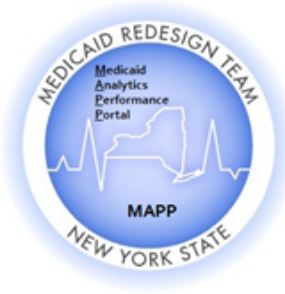
Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement 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	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	03/31/2018	DY3 Q4
Task Step 1. Develop diabetes clinical protocols and to be used by providers across the PPS	Project		In Progress	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		In Progress	09/30/2015	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	12/31/2015	DY1 Q3
Task Step 4. Roll out provider training and materials to primary care provider organizations in the network	Project		In Progress	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		In Progress	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		In Progress	07/01/2017	03/31/2018	03/31/2018	DY3 Q4
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	08/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has engaged at least 80% of their PCPs in this activity.	Provider	Primary Care Physicians	In Progress	08/01/2015	03/31/2017	03/31/2017	DY2 Q4

NYS Confidentiality – **High**

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

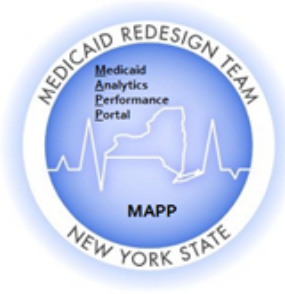**DSRIP Implementation Plan Project**

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 1. Review the PPS's diabetes disease management strategy and best practices with PCMH administrative & medical directors	Provider	Primary Care Physicians	In Progress	08/01/2015	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	Provider	Primary Care Physicians	In Progress	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
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	Provider	Primary Care Physicians	In Progress	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	Provider	Primary Care Physicians	In Progress	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	Provider	Primary Care Physicians	In Progress	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	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		In Progress	06/01/2015	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	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination processes are established and implemented.	Project		In Progress	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Evaluate current diabetes care team models in place across PPS primary care settings, identifying care model strengths and gaps	Project		In Progress	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		In Progress	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task	Project		In Progress	10/01/2015	12/31/2015	12/31/2015	DY1 Q3

NYS Confidentiality – **High**

NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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).	Project		In Progress	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		In Progress	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		In Progress	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		In Progress	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	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.	Project		In Progress	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task If applicable, PPS has established linkages to health homes for targeted patient populations.	Project		In Progress	06/01/2015	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	06/01/2015	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	06/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Implement strategies to address any gaps in the collection of REAL	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4

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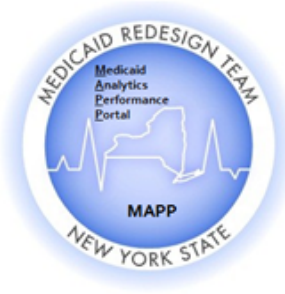
NYU Lutheran Medical Center (PPS ID:32)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project		In Progress	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		In Progress	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		In Progress	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		In Progress	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7. Develop roadmap to run future hot-spotting analyses and expand Stanford Model strategies across targeted communities in the PPS	Project		In Progress	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	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.	Project		In Progress	09/01/2015	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		In Progress	09/01/2015	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		In Progress	09/01/2016	06/30/2017	06/30/2017	DY3 Q1

NYS Confidentiality – **High**

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

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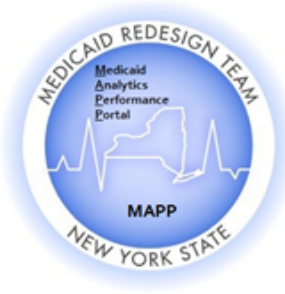| Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 3. Implement value-based payment opportunities for diabetes populations and with new payers, as appropriate.	Project		In Progress	07/01/2017	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	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	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		In Progress	09/01/2015	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 provider network.	Project		In Progress	09/01/2015	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	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		In Progress	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		In Progress	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Implement plan across PPS primary care partners	Project		In Progress	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	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Project		In Progress	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task	Provider	Primary Care Physicians	In Progress	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.							
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	Provider	Safety Net Primary Care Physicians	In Progress	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	Provider	Safety Net Non-PCP Practitioners	In Progress	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	Provider	Safety Net Behavioral Health	In Progress	07/01/2015	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.	Provider	Safety Net Behavioral Health	In Progress	08/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task Step 2. Identify gaps highlighting where PPS safety net members' fail to meet EHR MU, APCM and 2014 PCMH Level 3 certification requirements.	Provider	Safety Net Behavioral Health	In Progress	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.	Provider	Safety Net Behavioral Health	In Progress	12/01/2015	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.	Provider	Safety Net Behavioral Health	In Progress	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.	Provider	Safety Net Behavioral Health	In Progress	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.	Provider	Safety Net Behavioral Health	In Progress	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										

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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
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.	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										

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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
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 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										

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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
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.										
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										

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
& 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.										
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										

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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
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.	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										

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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
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.										

Project 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										

NYS Confidentiality – **High**

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
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 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										

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
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.										
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										

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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
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										
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										

NYS Confidentiality – **High**

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
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										
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										

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
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
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 Name	Description	Upload Date

No Records Found

DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

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.	
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.	

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☑ **IPQR Module 3.c.i.5 - PPS Defined Milestones**

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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NYU Lutheran Medical Center (PPS ID:32)

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.

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NYU Lutheran Medical Center (PPS ID:32)

☑ IPQR Module 3.d.ii.2 - Project Implementation Speed

Instructions :

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

Benchmarks
100% Total Committed By
DY3,Q4

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Primary Care Physicians	264	0	0	0	0	0	0	0	0	26	66
Non-PCP Practitioners	202	0	0	0	0	0	0	0	0	20	51
Clinics	38	0	0	0	0	0	0	0	0	4	10
Health Home / Care Management	8	0	0	0	0	0	0	0	0	1	2
Pharmacies	0	0	0	0	0	0	0	0	0	0	0
Community Based Organizations	15	0	0	0	0	0	0	0	0	2	4
All Other	219	0	0	0	0	0	0	0	0	22	55
Total Committed Providers	**746**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**75**	**188**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**10.05**	**25.20**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Primary Care Physicians	264	132	264	264	264	264	264	264	264	264	264
Non-PCP Practitioners	202	101	202	202	202	202	202	202	202	202	202
Clinics	38	19	38	38	38	38	38	38	38	38	38
Health Home / Care Management	8	4	8	8	8	8	8	8	8	8	8
Pharmacies	0	0	0	0	0	0	0	0	0	0	0
Community Based Organizations	15	8	15	15	15	15	15	15	15	15	15
All Other	219	110	219	219	219	219	219	219	219	219	219

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NYU Lutheran Medical Center (PPS ID:32)

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Total Committed Providers	746	374	746	746	746	746	746	746	746	746	746
Percent Committed Providers(%)		50.13	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Current File Uploads

User ID	File Name	File Description	Upload Date
No Records Found			

Narrative Text :

Provider ramp up: While these figures represent the PPS's best estimate as of August 7, 2015, these estimates may need to be modified for reasons including, but not limited to unforeseeable changes to the PPS partners relationships following MSA and schedule A execution.; Partner movement in between PPS's; Changes to provider classification and General changes in provider marketplace. Provider ramp up dependent on accurate and timely data provided by the State.

Patient Ramp up: While these figures represent the PPS's best estimate as of August 7, 2015, PPS may need to modify these estimates for reasons including, but not limited to Results form the State's "Opt out" process and significant changes in attributed population (including movement to and from Medicaid, and changes in the provider and partner marketplace).

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NYU Lutheran Medical Center (PPS ID:32)

✅ **IPQR Module 3.d.ii.3 - Patient Engagement Speed**

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	2,339

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	0	0	234	88	351	421	819	146	585
Percent of Expected Patient Engagement(%)	**0.00**	**0.00**	**0.00**	**10.00**	**3.76**	**15.01**	**18.00**	**35.01**	**6.24**	**25.01**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	702	1,637	292	1,169	1,403	2,339	0	0	0	0
Percent of Expected Patient Engagement(%)	**30.01**	**69.99**	**12.48**	**49.98**	**59.98**	**100.00**	**0.00**	**0.00**	**0.00**	**0.00**

Current File Uploads

User ID	File Name	File Description	Upload Date
No Records Found			

Narrative Text :

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✅ **IPQR Module 3.d.ii.4 - Prescribed Milestones**
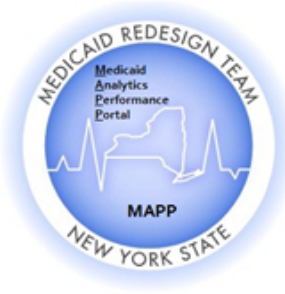
Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 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	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	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		In Progress	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		In Progress	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	09/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 4. Work with vendor to develop referral flows from PPS PCPs, relevant specialists and ERs.	Project		In Progress	10/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Step 5. Roll out provider training and materials to NYU Lutheran emergency department staff and primary care provider organizations in the network.	Project		In Progress	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 portal.	Project		In Progress	01/01/2017	03/31/2018	03/31/2018	DY3 Q4
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		In Progress	07/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #2	Project	N/A	In Progress	08/01/2015	03/31/2017	03/31/2017	DY2 Q4

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DSRIP Implementation Plan Project

NYU Lutheran Medical Center (PPS ID:32)

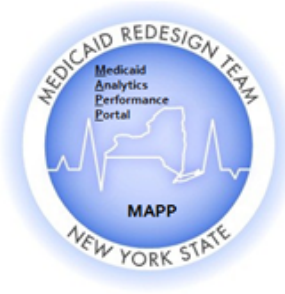| Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change 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.	Project		In Progress	08/01/2015	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		In Progress	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		In Progress	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
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		In Progress	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4. Engage vendor and start referring PPS patients for home-based trigger reduction interventions.	Project		In Progress	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
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		In Progress	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	03/31/2017	DY2 Q4
Task PPS incorporates evidence-based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management.	Project		In Progress	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Adopt comprehensive evidence-based asthma management clinical guidelines to be used across PPS.	Project		In Progress	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	12/31/2015	DY1 Q3
Task	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project		In Progress	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		In Progress	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	09/01/2015	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	09/01/2015	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	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Develop training and communication strategy to be rolled out across the PPS provider network.	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3. Roll out provider training and materials to primary care provider organizations in the network.	Project		In Progress	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		In Progress	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		In Progress	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone #5	Project	N/A	In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project		In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices in PPS have a Clinical Interoperability System in place for all participating providers.	Project		In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has assembled a care coordination team that includes use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Project		In Progress	09/01/2015	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		In Progress	09/01/2015	10/30/2015	12/31/2015	DY1 Q3
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		In Progress	11/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 3. Implement coordinated care model for asthma patients and continue monitoring and reviewing practices to ensure continued success.	Project		In Progress	02/15/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	Project	N/A	In Progress	09/01/2015	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	09/01/2015	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	09/01/2015	10/30/2015	12/31/2015	DY1 Q3
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		In Progress	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task	Project		In Progress	11/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project		In Progress	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	07/01/2015	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	07/01/2015	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 Managed Care plans, and Health Home managers.	Project		In Progress	07/01/2015	10/30/2015	12/31/2015	DY1 Q3
Task Step 2. Identify gaps in current communication and care coordination models.	Project		In Progress	07/01/2015	10/30/2015	12/31/2015	DY1 Q3
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		In Progress	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	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	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	09/01/2015	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	06/30/2016	DY2 Q1
Task	Project		In Progress	06/30/2016	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project		In Progress	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Implement plan across PPS primary care partners	Project		In Progress	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 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										

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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
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.										
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										

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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
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 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.										

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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 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 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										

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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
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 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										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
not 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										

Project 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.										

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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 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.										
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.										

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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 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 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										

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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
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 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.										

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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 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 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.										

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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 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										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	
Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	
Develop and implement evidence-based asthma management guidelines.	
Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	

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✅ **IPQR Module 3.d.ii.5 - PPS Defined Milestones**

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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Run Date : 09/25/2015

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

Instructions :

Milestone 5: It is recommended that the PPS play an active role in ensuring patients receive coordinated social services and support and not solely rely on plans to "engage vendor" to meet this milestone. Additionally, it is recommended that Step 3 be implemented prior to 1/2017 to ensure coordination of care for asthma patients throughout implementation of this project.

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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 - PPS Defined Milestones**

Instructions :

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

Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Milestone #1	In Progress	Convene a collaborative of CBOs to plan, set milestones, and implement a community campaign.	05/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 1	In Progress	Convene an initial planning workgroup with PPS partners to develop a framework for community collaboration.	05/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2	In Progress	Develop a communication strategy to let community partners know that the PPS is pursuing the project and invite collaboration.	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3	In Progress	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	03/31/2016	DY1 Q4
Task Step 4	In Progress	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	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.	05/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 1	In Progress	Convene an initial planning workgroup with PPS partners to develop a framework for community and cross-PPS collaboration.	05/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2	In Progress	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.	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3	In Progress	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	03/31/2016	03/31/2016	DY1 Q4
Task Step 4	In Progress	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	03/31/2020	DY5 Q4
Milestone Milestone #3	In Progress	Agree upon shared resources across partners to implement the 5A tobacco cessation protocol in primary care settings.	05/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 1	In Progress	Develop 5A tobacco cessation clinical protocols to be used by providers in the PPS.	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2	In Progress	Develop flexible 5A workflow model that can be adapted for use by providers across the PPS.	09/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3	In Progress	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	12/31/2015	DY1 Q3
Task Step 4	In Progress	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	03/31/2016	DY1 Q4
Task Step 5	In Progress	Roll out provider training and materials to primary care provider organizations in the network implementing the project.	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6	In Progress	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	03/31/2018	DY3 Q4
Milestone Milestone #4	In Progress	Agree upon a data sharing system to address reporting and implementation needs.	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1	In Progress	Complete current state assessment of EHRs and tobacco cessation patient registries in use across the PPS primary care provider network.	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2	In Progress	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.	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3	In Progress	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	09/30/2016	DY2 Q2
Task Step 4	In Progress	Identify resources, timing and expertise required to implement the patient registry plan for PPS primary care partners.	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5	In Progress	Implement plan across PPS primary care partners	06/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone Milestone #5	In Progress	Repurpose and/or develop outdoor media campaign.	05/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 1	In Progress	Collaborate with NYC DOHMH and community partners to review inventory of existing media campaigns.	05/01/2015	07/31/2015	09/30/2015	DY1 Q2
Task Step 2	In Progress	Review Community Needs Assessment and community data to identify high-risk neighborhoods and evaluate the specific language and cultural requirements of those highest risk communities with regard to effective messaging.	07/31/2015	09/30/2015	09/30/2015	DY1 Q2
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	03/31/2016	DY1 Q4
Task Step 4	In Progress	Perform consumer-testing of media campaigns.	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task	In Progress	Launch outdoor media campaigns in the community.	04/01/2016	06/30/2016	06/30/2016	DY2 Q1

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 5						
Task Step 6	In Progress	Develop a set of metrics to evaluate the success of the campaigns and perform an annual review.	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Step 7	In Progress	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	06/30/2017	DY3 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date
No Records Found				

PPS Defined Milestones Narrative Text

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

NYU Lutheran Medical Center (PPS ID:32)

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

Instructions :

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NYU Lutheran Medical Center (PPS ID:32)

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

☑ IPQR Module 4.c.ii.1 - PPS Defined Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Milestone #1	In Progress	Convening the PPS HIV Collaborative	07/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 1	In Progress	Confirm PPS participation in HIV Collaborative throughout DSRIP implementation.	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.	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3	In Progress	Develop agenda for Learning Collaborative meetings and hold meetings.	01/01/2016	03/31/2020	03/31/2020	DY5 Q4
Milestone Milestone #2	In Progress	Establishing a work plan and timeline for project implementation.	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1	In Progress	Develop work plan and timeline for projects being implemented jointly across multiple PPSs.	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 2	In Progress	Develop work plan and timeline for additional projects being implemented by the Brooklyn Bridges PPS.	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3	In Progress	Validate work plans and timelines with PPS governance bodies and relevant stakeholders, as needed.	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone Milestone #3	In Progress	Developing agreed upon milestones for project implementation.	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1	In Progress	Develop milestones for projects being implemented jointly across multiple PPSs.	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 2	In Progress	Develop milestones for additional projects being implemented by the Brooklyn Bridges PPS.	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3	In Progress	Validate milestones with PPS governance bodies and relevant stakeholders, as needed.	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone Milestone #4	In Progress	Agreeing upon project commonalities and shared resources.	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1	In Progress	Determine 4.c.ii projects that are common across most/all PPSs in the Collaborative and structure for sharing resources needed for implementation.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 2	In Progress	Validate agreement with PPS governance bodies and relevant stakeholders, as needed.	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone Milestone #5	In Progress	Agreeing upon a data sharing system to address reporting and implementation needs.	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1	In Progress	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	03/31/2017	DY2 Q4
Task Step 2	In Progress	Contract with system developer/administrator, as needed.	07/01/2016	03/31/2017	03/31/2017	DY2 Q4

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date
No Records Found				

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Milestone #1	
Milestone #2	BB PPS is part of the NYC-wide collaborative on HIV through, which includes seven PPSs in the metro region. The collaborative, of which BB PPS remains an active member, is currently defining work steps that are coordinated across all seven PPSs to ensure consistency in this population health project, and to advance collaboration to work off of all PPSs' strengths.
Milestone #3	BB PPS is part of the NYC-wide collaborative on HIV through, which includes seven PPSs in the metro region. The collaborative, of which BB PPS remains an active member, is currently defining work steps that are coordinated across all seven PPSs to ensure consistency in this population health project, and to advance collaboration to work off of all PPSs' strengths.
Milestone #4	
Milestone #5	

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IPQR Module 4.c.ii.2 - IA Monitoring

Instructions :

Milestone 2: Suggest writing detailed tasks that explain the projects being implemented.

Milestone 3: Suggest writing detailed tasks that explain the projects being implemented.

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Attestation

The Lead Representative has been designated by the Primary Lead PPS Provider (PPS Lead Entity) as the signing officiate for the DSRIP Quarterly Report. The Lead Representative has the authority to complete this attestation on behalf of the PPS network. The Lead Representative and PPS Lead Entity are responsible for the authenticity and accuracy of the material submitted in this report.

The Lead Representative of the Performing Provider System (PPS) must complete this attestation form in order for the project application to be accepted by the NYS Department of Health. Once the attestation is complete, the Quarterly Report will be locked down from any further editing. Do not complete this section until the entire Quarterly Report is complete.

If the Quarterly Report becomes locked in error and additional changes are necessary, please use the contact information on the Home Page to request that the Quarterly Report be unlocked.

To electronically sign this Quarterly Report, please enter the required information and check the box below:

☑ **I here by attest, as the Lead Representative of the 'NYU Lutheran Medical Center', that all information provided on this Quarterly report is true and accurate to the best of my knowledge**.

Primary Lead PPS Provider:	LUTHERAN MEDICAL CENTER
Secondary Lead PPS Provider:	
Lead Representative:	Claudia Caine
Submission Date:	09/25/2015 02:04 PM

Comments:

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Status Log				
Quarterly Report (DY,Q)	**Status**	**Lead Representative Name**	**User ID**	**Date Timestamp**
DY1, Q1	Submitted	Claudia Caine	cc330208	09/25/2015 02:04 PM
DY1, Q1	Returned	Claudia Caine	sv590918	09/08/2015 07:51 AM
DY1, Q1	Submitted	Claudia Caine	cc330208	08/05/2015 03:45 PM
DY1, Q1	In Process		system	07/01/2015 12:12 AM

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Comments Log			
Status	**Comments**	**User ID**	**Date Timestamp**
Returned	Please address the IA comments provided in the specific sections of your Implementation Plan during the remediation period.	sv590918	09/08/2015 07:51 AM

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Section	Module	Status
Section 01	IPQR Module 1.1 - PPS Budget Report	☑ Completed
	IPQR Module 1.2 - PPS Flow of Funds	☑ Completed
	IPQR Module 1.3 - Prescribed Milestones	☑ Completed
	IPQR Module 1.4 - PPS Defined Milestones	☑ Completed
	IPQR Module 1.5 - IA Monitoring	
Section 02	IPQR Module 2.1 - Prescribed Milestones	☑ Completed
	IPQR Module 2.2 - PPS Defined Milestones	☑ Completed
	IPQR Module 2.3 - Major Risks to Implementation & Risk Mitigation Strategies	☑ Completed
	IPQR Module 2.4 - Major Dependencies on Organizational Workstreams	☑ Completed
	IPQR Module 2.5 - Roles and Responsibilities	☑ Completed
	IPQR Module 2.6 - Key Stakeholders	☑ Completed
	IPQR Module 2.7 - IT Expectations	☑ Completed
	IPQR Module 2.8 - Progress Reporting	☑ Completed
	IPQR Module 2.9 - IA Monitoring	
Section 03	IPQR Module 3.1 - Prescribed Milestones	☑ Completed
	IPQR Module 3.2 - PPS Defined Milestones	☑ Completed
	IPQR Module 3.3 - Major Risks to Implementation & Risk Mitigation Strategies	☑ Completed
	IPQR Module 3.4 - Major Dependencies on Organizational Workstreams	☑ Completed
	IPQR Module 3.5 - Roles and Responsibilities	☑ Completed
	IPQR Module 3.6 - Key Stakeholders	☑ Completed
	IPQR Module 3.7 - IT Expectations	☑ Completed
	IPQR Module 3.8 - Progress Reporting	☑ Completed
	IPQR Module 3.9 - IA Monitoring	
Section 04	IPQR Module 4.1 - Prescribed Milestones	☑ Completed
	IPQR Module 4.2 - PPS Defined Milestones	☑ Completed
	IPQR Module 4.3 - Major Risks to Implementation & Risk Mitigation Strategies	☑ Completed
	IPQR Module 4.4 - Major Dependencies on Organizational Workstreams	☑ Completed
	IPQR Module 4.5 - Roles and Responsibilities	☑ Completed

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Section	Module	Status
	IPQR Module 4.6 - Key Stakeholders	☑ Completed
	IPQR Module 4.7 - IT Expectations	☑ Completed
	IPQR Module 4.8 - Progress Reporting	☑ Completed
	IPQR Module 4.9 - IA Monitoring	
Section 05	IPQR Module 5.1 - Prescribed Milestones	☑ Completed
	IPQR Module 5.2 - PPS Defined Milestones	☑ Completed
	IPQR Module 5.3 - Major Risks to Implementation & Risk Mitigation Strategies	☑ Completed
	IPQR Module 5.4 - Major Dependencies on Organizational Workstreams	☑ Completed
	IPQR Module 5.5 - Roles and Responsibilities	☑ Completed
	IPQR Module 5.6 - Key Stakeholders	☑ Completed
	IPQR Module 5.7 - Progress Reporting	☑ Completed
	IPQR Module 5.8 - IA Monitoring	
Section 06	IPQR Module 6.1 - Prescribed Milestones	☑ Completed
	IPQR Module 6.2 - PPS Defined Milestones	☑ Completed
	IPQR Module 6.3 - Major Risks to Implementation & Risk Mitigation Strategies	☑ Completed
	IPQR Module 6.4 - Major Dependencies on Organizational Workstreams	☑ Completed
	IPQR Module 6.5 - Roles and Responsibilities	☑ Completed
	IPQR Module 6.6 - Key Stakeholders	☑ Completed
	IPQR Module 6.7 - IT Expectations	☑ Completed
	IPQR Module 6.8 - Progress Reporting	☑ Completed
	IPQR Module 6.9 - IA Monitoring	
Section 07	IPQR Module 7.1 - Prescribed Milestones	☑ Completed
	IPQR Module 7.2 - PPS Defined Milestones	☑ Completed
	IPQR Module 7.3 - Major Risks to Implementation & Risk Mitigation Strategies	☑ Completed
	IPQR Module 7.4 - Major Dependencies on Organizational Workstreams	☑ Completed
	IPQR Module 7.5 - Roles and Responsibilities	☑ Completed
	IPQR Module 7.6 - Key Stakeholders	☑ Completed
	IPQR Module 7.7 - IT Expectations	☑ Completed
	IPQR Module 7.8 - Progress Reporting	☑ Completed

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Section	Module	Status
	IPQR Module 7.9 - IA Monitoring	
Section 08	IPQR Module 8.1 - Prescribed Milestones	☑ Completed
	IPQR Module 8.2 - PPS Defined Milestones	☑ Completed
	IPQR Module 8.3 - Major Risks to Implementation & Risk Mitigation Strategies	☑ Completed
	IPQR Module 8.4 - Major Dependencies on Organizational Workstreams	☑ Completed
	IPQR Module 8.5 - Roles and Responsibilities	☑ Completed
	IPQR Module 8.6 - Key Stakeholders	☑ Completed
	IPQR Module 8.7 - IT Expectations	☑ Completed
	IPQR Module 8.8 - Progress Reporting	☑ Completed
	IPQR Module 8.9 - IA Monitoring	
Section 09	IPQR Module 9.1 - Prescribed Milestones	☑ Completed
	IPQR Module 9.2 - PPS Defined Milestones	☑ Completed
	IPQR Module 9.3 - Major Risks to Implementation & Risk Mitigation Strategies	☑ Completed
	IPQR Module 9.4 - Major Dependencies on Organizational Workstreams	☑ Completed
	IPQR Module 9.5 - Roles and Responsibilities	☑ Completed
	IPQR Module 9.6 - Key Stakeholders	☑ Completed
	IPQR Module 9.7 - IT Expectations	☑ Completed
	IPQR Module 9.8 - Progress Reporting	☑ Completed
	IPQR Module 9.9 - IA Monitoring	
Section 10	IPQR Module 10.1 - Overall approach to implementation	☑ Completed
	IPQR Module 10.2 - Major dependencies between work streams and coordination of projects	☑ Completed
	IPQR Module 10.3 - Project Roles and Responsibilities	☑ Completed
	IPQR Module 10.4 - Overview of key stakeholders and how influenced by your DSRIP projects	☑ Completed
	IPQR Module 10.5 - IA Monitoring	

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

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Project ID	Module	Status
	IPQR Module 3.a.i.6 - 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 - Project Implementation Speed	☑ Completed
	IPQR Module 3.c.i.3 - Patient Engagement Speed	☑ Completed
	IPQR Module 3.c.i.4 - Prescribed Milestones	☑ Completed
	IPQR Module 3.c.i.5 - PPS Defined Milestones	☑ Completed
	IPQR Module 3.c.i.6 - 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 - Project Implementation Speed	☑ Completed
	IPQR Module 3.d.ii.3 - Patient Engagement Speed	☑ Completed
	IPQR Module 3.d.ii.4 - Prescribed Milestones	☑ Completed
	IPQR Module 3.d.ii.5 - PPS Defined Milestones	☑ Completed
	IPQR Module 3.d.ii.6 - IA Monitoring	
4.b.i	IPQR Module 4.b.i.1 - PPS Defined Milestones	☑ Completed
	IPQR Module 4.b.i.2 - IA Monitoring	
4.c.ii	IPQR Module 4.c.ii.1 - PPS Defined Milestones	☑ Completed
	IPQR Module 4.c.ii.2 - IA Monitoring	