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

DSRIP Implementation Plan Project

Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

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Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Quarterly Report - Implementation Plan for Sisters of Charity Hospital of Buffalo, New York

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

Status By Section

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

Status By Project

Project ID	Project Title	Status
2.a.i	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management	Completed
2.b.iii	ED care triage for at-risk populations	Completed
2.b.iv	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions	Completed
2.c.ii	Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services	Completed
3.a.i	Integration of primary care and behavioral health services	Completed
3.b.i	Evidence-based strategies for disease management in high risk/affected populations (adult only)	Completed
3.f.i	Increase support programs for maternal & child health (including high risk pregnancies) (Example: Nurse-Family Partnership)	Completed
3.g.i	Integration of palliative care into the PCMH Model	Completed
4.a.i	Promote mental, emotional and behavioral (MEB) well-being in communities	Completed
4.b.i	Promote tobacco use cessation, especially among low SES populations and those with poor mental health.	Completed

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Section 01 – Budget

IPQR Module 1.1 - PPS Budget Report (Baseline)

Instructions :

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

Budget Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	6,871,607	7,322,875	11,842,008	10,486,053	6,871,607	43,394,151
Cost of Project Implementation & Administration	**4,603,976**	**4,027,582**	**5,328,903**	**4,718,724**	**3,092,223**	**21,771,408**
Administration	1,443,037	1,318,118	2,131,561	1,887,490	1,236,889	8,017,095
Implementation	3,160,939	2,709,464	3,197,342	2,831,234	1,855,334	13,754,313
Revenue Loss	**1,236,889**	**1,318,118**	**2,131,561**	**1,887,490**	**1,236,889**	**7,810,947**
Internal PPS Provider Bonus Payments	**618,445**	**1,244,889**	**3,434,182**	**3,145,816**	**2,198,914**	**10,642,246**
Cost of non-covered services	**343,580**	**659,059**	**828,941**	**524,303**	**206,148**	**2,562,031**
Other	**68,717**	**73,228**	**118,421**	**209,720**	**137,433**	**607,519**
Contingency fund	68,717	73,228	118,421	209,720	137,433	607,519
Total Expenditures	**6,871,607**	**7,322,876**	**11,842,008**	**10,486,053**	**6,871,607**	**43,394,151**
Undistributed Revenue	**0**	**0**	**0**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

This budget assumes CPWNY achieving 100% Net Project Valuation. The other revenue categories (Safety Net Equity Guarantee, Safety Net Equity Performance, Net High Performance Fund, and Additional Performance Fund) are not included because only the Net Project Valuation amounts are preloaded in MAPP tool.
"Other" category includes contingency fund.

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Module Review Status

Review Status	IA Formal Comments
Pass & Complete	

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IPQR Module 1.2 - PPS Budget Report (Quarterly)

Instructions :

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

Benchmarks

Waiver Revenue DY1	Total Waiver Revenue	Undistributed Revenue YTD	Undistributed Revenue Total
6,871,607	43,394,151	4,988,640	41,511,184

Budget Items	DY1 Q3 Quarterly Amount - Update	Cumulative Spending to Date (DY1 - DY5)	Remaining Balance in Current DY	Percent Remaining in Current DY	Cumulative Remaining Balance	Percent Remaining of Cumulative Balance
Cost of Project Implementation & Administration	**1,059,997**	**1,882,967**	**2,721,009**	**59.10%**	**19,888,441**	**91.35%**
Administration	666,821					
Implementation	393,176					
Revenue Loss	**0**	**0**	**1,236,889**	**100.00%**	**7,810,947**	**100.00%**
Internal PPS Provider Bonus Payments	**0**	**0**	**618,445**	**100.00%**	**10,642,246**	**100.00%**
Cost of non-covered services	**0**	**0**	**343,580**	**100.00%**	**2,562,031**	**100.00%**
Other	**0**	**0**	**68,717**	**100.00%**	**607,519**	**100.00%**
Contingency fund	0					
Total Expenditures	**1,059,997**	**1,882,967**				

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

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CPWNY is reporting the estimated expenditures incurred by partners during this period. The projects are in various phases of implementation, and the participating providers have started to incur expenditures for projects 2.a.i, 2.b.iii, 2.b.iv, 2.c.ii, 3.a.i, 3.b.i, 3.f.i, and 3.g.i, while projects 4.a.i and 4.b.i has started but not accumulating much expenses.

There have been no disbursements in the categories of revenue loss, provider bonus, cost of non-covered services, and others to date.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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Delivery System Reform Incentive Payment Project

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IPQR Module 1.3 - PPS Flow of Funds (Baseline)

Instructions :

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

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

Funds Flow Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	6,871,607	7,322,875	11,842,008	10,486,053	6,871,607	43,394,151
Practitioner - Primary Care Provider (PCP)	1,924,050	1,977,176	3,197,342	2,726,374	1,821,316	11,646,258
Practitioner - Non-Primary Care Provider (PCP)	0	0	0	0	0	0
Hospital	1,236,889	1,318,118	2,131,561	1,887,490	1,236,889	7,810,947
Clinic	343,580	366,144	592,100	524,303	343,580	2,169,707
Case Management / Health Home	0	0	0	0	0	0
Mental Health	481,013	585,830	1,184,201	1,153,466	721,519	4,126,029
Substance Abuse	137,432	146,458	236,840	209,721	137,432	867,883
Nursing Home	0	0	0	0	0	0
Pharmacy	0	0	0	0	0	0
Hospice	137,432	146,458	355,260	209,721	137,432	986,303
Community Based Organizations	343,580	366,144	592,100	629,163	412,296	2,343,283
All Other	824,593	1,098,431	1,421,041	1,258,326	755,537	5,357,928
PPS PMO	1,443,038	1,318,118	2,131,563	1,887,490	1,305,606	8,085,815
Total Funds Distributed	**6,871,607**	**7,322,877**	**11,842,008**	**10,486,054**	**6,871,607**	**43,394,153**
Undistributed Revenue	**0**	**0**	**0**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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This funds flow assumes CPWNY achieving 100% Net Project Valuation. The other revenue categories (Safety Net Equity Guarantee, Safety Net Equity Performance, Net High Performance Fund, and Additional Performance Fund) are not included because only the Net Project Valuation amounts are preloaded in MAPP tool.

CPWNY PPS plans to directly fund primary care and hospital projects as well as initiatives with behavioral health providers. Care management and skilled nursing facilities are organizational components of the Catholic Health System, therefore funding for these entities will appear with Catholic Health in the "all other category".

Module Review Status

Review Status	IA Formal Comments
Pass & Complete	

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IPQR Module 1.4 - PPS Flow of Funds (Quarterly)

Instructions :

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

Benchmarks

Waiver Revenue DY1	Total Waiver Revenue	Undistributed Revenue YTD	Undistributed Revenue Total
6,871,607	43,394,151	4,988,640	41,511,184

Funds Flow Items	DY1 Q3 Quarterly Amount - Update	Total Amount Disbursed	Percent Spent By Project										DY Adjusted Difference	Cumulative Difference
			Projects Selected By PPS											
			2.a.i	2.b.iii	2.b.iv	2.c.ii	3.a.i	3.b.i	3.f.i	3.g.i	4.a.i	4.b.i		
Practitioner - Primary Care Provider (PCP)	0	0	0	0	0	0	0	0	0	0	0	0	1,924,050	11,646,258
Practitioner - Non-Primary Care Provider (PCP)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital	1,059,997	1,882,967	34.4	16.5	20.4	0	3.5	6.7	8.4	10.1	0	0	-646,078	5,927,980
Clinic	0	0	0	0	0	0	0	0	0	0	0	0	343,580	2,169,707
Case Management / Health Home	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	481,013	4,126,029
Substance Abuse	0	0	0	0	0	0	0	0	0	0	0	0	137,432	867,883
Nursing Home	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospice	0	0	0	0	0	0	0	0	0	0	0	0	137,432	986,303
Community Based Organizations	0	0	0	0	0	0	0	0	0	0	0	0	343,580	2,343,283
All Other	0	0	0	0	0	0	0	0	0	0	0	0	824,593	5,357,928
PPS PMO	0	0											1,443,038	8,085,815
Total Funds Distributed	**1,059,997**	**1,882,967**												

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

CPWNY is reporting the estimated expenditures incurred by partners during this period. The projects are in various phases of implementation, and the participating providers have started to incur expenditures for projects 2.a.i, 2.b.iii, 2.b.iv, 2.c.ii, 3.a.i, 3.b.i, 3.f.i, and 3.g.i, while projects 4.a.i and 4.b.i have started but not accumulating much expenses.

The distribution of estimated expenditures incurred by partners during this period are being reported with the assumption that the reporting requirement is based on Primary Distribution, as 100% of the funds have been distributed to Sisters of Charity Hospital, a Safety Net Provider, and then secondarily distributed to various types of providers and contractors, including payments to Hospitals, Hospice, Behavioral Health providers and Other providers.

There have been no disbursements in the categories of revenue loss, provider bonus, cost of non-covered services, and others to date.

Module Review Status

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

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IPQR Module 1.5 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Complete funds flow budget and distribution plan and communicate with network	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	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	YES
Task 1. Distribute the Project Impact Assessment and Matrix (prepared as part of current state financial stability assessment) to network provider partners with explanation of the purpose of the matrix and how it will be used to finalize funds flow in determining expected impact of DSRIP projects and expectations of costs they will incur	Completed	1. Distribute the Project Impact Assessment and Matrix (prepared as part of current state financial stability assessment) to network provider partners with explanation of the purpose of the matrix and how it will be used to finalize funds flow in determining expected impact of DSRIP projects and expectations of costs they will incur	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Complete a preliminary PPS Level budget for Administration, Implementation, Revenue Loss, Cost of Services not Covered budget categories (Excludes Bonus, Contingency and High Performance categories)	Completed	2. Complete a preliminary PPS Level budget for Administration, Implementation, Revenue Loss, Cost of Services not Covered budget categories (Excludes Bonus, Contingency and High Performance categories)	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3. Review the provider level projections of DSRIP impacts and costs submitted by network providers. During provider specific budget processes, develop preliminary - final provider level budgets including completion of Provider Specific funds flow plan	Completed	3. Review the provider level projections of DSRIP impacts and costs submitted by network providers. During provider specific budget processes, develop preliminary - final provider level budgets including completion of Provider Specific funds flow plan	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task 4. Develop the funds flow approach and	Completed	4. Develop the funds flow approach and distribution plan with drivers and requirements for each of the funds flow budget	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
distribution plan with drivers and requirements for each of the funds flow budget categories		categories							
Task 5. Distribute funds flow approach and distribution plan to Finance Committee and network participating providers for review and input	Completed	5. Distribute funds flow approach and distribution plan to Finance Committee and network participating providers for review and input	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 6. Revise plan based on consultation and finalize; obtain approval from Finance Committee	Completed	6. Revise plan based on consultation and finalize; obtain approval from Finance Committee	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task 7. Prepare PPS, Provider and Project level funds flow budgets based upon final budget review sessions with network providers for review and approval by Finance Committee	In Progress	7. Prepare PPS, Provider and Project level funds flow budgets based upon final budget review sessions with network providers for review and approval by Finance Committee	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 8. Prepare PPS, Provider and Project level funds flow budgets based upon final budget review sessions with network providers for review and approval by Executive Committee	In Progress	8. Prepare PPS, Provider and Project level funds flow budgets based upon final budget review sessions with network providers for review and approval by Executive Committee	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 9. Communicate approved Provider Level Funds Flow plan to each network provider. Incorporate agreed upon funds flow plan and requirements to receive funds into the PPS Provider Partner Operating Agreements	In Progress	9. Communicate approved Provider Level Funds Flow plan to each network provider. Incorporate agreed upon funds flow plan and requirements to receive funds into the PPS Provider Partner Operating Agreements	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 10. Distribute Funds Flow policy and procedure, and schedule DSRIP period close requirements, along with expected Funds distribution schedule, to PPS network provider partners	Completed	10. Distribute Funds Flow policy and procedure, and schedule DSRIP period close requirements, along with expected Funds distribution schedule, to PPS network provider partners	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task 11. Roll out education and training sessions for providers regarding the funds flow plan, the administrative requirements related to the plan, and related schedules for reporting and distribution of funds. Individual sessions will be run for larger providers; collaborative group	Completed	11. Roll out education and training sessions for providers regarding the funds flow plan, the administrative requirements related to the plan, and related schedules for reporting and distribution of funds. Individual sessions will be run for larger providers; collaborative group sessions will be run for smaller providers and for providers with close operational ties	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
sessions will be run for smaller providers and for providers with close operational ties									

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

Milestone Review Status

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

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IPQR Module 1.6 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 1.7 - IA Monitoring

Instructions :

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Section 02 – Governance

IPQR Module 2.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize governance structure and sub-committee structure	Completed	This milestone must be completed by 9/30/2015. Governance and committee structure, signed off by PPS Board.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task 1) Establish PPS committee structure including the governance sub-committees consistent with DSRIP guidelines	Completed	1) Establish PPS committee structure including the governance sub-committees consistent with DSRIP guidelines	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2) Identify members of the governing body and sub-committees with representatives from across our provider network and geography.	Completed	2) Identify members of the governing body and sub-committees with representatives from across our provider network and geography.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3) Confirm governance structure and membership.	Completed	3) Confirm governance structure and membership.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4) Executive Governing Body (EGB) approves sub-committees; charters and membership.	Completed	4) Executive Governing Body (EGB) approves sub-committees; charters and membership.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5) Develop meeting schedules for the EGB and each sub-committee.	Completed	5) Develop meeting schedules for the EGB and each sub-committee.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Completed	This milestone must be completed by 12/31/2015. Clinical Quality Committee charter and committee structure chart	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 1) CPWNY PPS established a Clinical	Completed	1) CPWNY PPS established a Clinical Governance Committee structure. The Clinical Governance Committee is	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Governance Committee structure. The Clinical Governance Committee is chartered to establish clinical standards and processes needed to achieve the DSRIP goals. This includes but is not limited to establishing clinical protocols, disseminating the protocols and training participating PPS providers to build the protocols into their workflow, and evaluating overall adherence to clinical protocols. In addition the committee will set forth the process/outcome measures for each project as well as periodic review of quality of care within CPWNY.		chartered to establish clinical standards and processes needed to achieve the DSRIP goals. This includes but is not limited to establishing clinical protocols, disseminating the protocols and training participating PPS providers to build the protocols into their workflow, and evaluating overall adherence to clinical protocols. In addition the committee will set forth the process/outcome measures for each project as well as periodic review of quality of care within CPWNY.							
Task 2) Recruit members from Erie, Chautauqua and Niagara Counties and community organizations, who understand and are committed to overarching goals of DSRIP and the key metrics for success.	Completed	2) Recruit members from Erie, Chautauqua and Niagara Counties and community organizations, who understand and are committed to overarching goals of DSRIP and the key metrics for success.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3) The Clinical Governance Committee representation includes members from WCA hospital, Buffalo Urban League, Family Health Medical Services, Medicore Chautauqua County, Catholic Charities, Hospice, Spectrum human Services, and providers/practitioners. CPWNY will add additional representations as needed.	Completed	3) The Clinical Governance Committee representation includes members from WCA hospital, Buffalo Urban League, Family Health Medical Services, Medicore Chautauqua County, Catholic Charities, Hospice, Spectrum human Services, and providers/practitioners. CPWNY will add additional representations as needed.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4) CPWNY has delegated to the project teams accountability for oversight and to plan, implement, and evaluate the clinical quality components for each DSRIP project. Project team leadership will be selected who have experience in measuring quality in both acute and ambulatory setting, as well as for mental health, palliative and cardiac care, prenatal and early child development.	Completed	4) CPWNY has delegated to the project teams accountability for oversight and to plan, implement, and evaluate the clinical quality components for each DSRIP project. Project team leadership will be selected who have experience in measuring quality in both acute and ambulatory setting, as well as for mental health, palliative and cardiac care, prenatal and early child development.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task	Completed	5) Develop final clinical charter for clinical governance	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
5) Develop final clinical charter for clinical governance committee		committee							
Task 6) EGB approves a clinical governance charter	Completed	6) EGB approves a clinical governance charter	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 7) Define measurable outcomes for each project based upon the project metrics/deliverables	Completed	7) Define measurable outcomes for each project based upon the project metrics/deliverables	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	Completed	This milestone must be completed by 9/30/2015. Upload of bylaws and policies document or committee guidelines.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task 1) The EGB will draft governance charters and related policies. The EGB is the governing body that has been delegated to oversee the DSRIP initiatives on behalf of Sisters of Charity Hospital, the PPS lead entity.	Completed	1) The EGB will draft governance charters and related policies. The EGB is the governing body that has been delegated to oversee the DSRIP initiatives on behalf of Sisters of Charity Hospital, the PPS lead entity.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2) The EGB will develop a comprehensive committee structure including clinical, financial, and data/IT governance. The committee structure includes representatives from key stakeholders and service providers including acute and ambulatory care, behavioral health, hospice, CBOs, and the PMO's clinical transformation / care management teams.	Completed	2) The EGB will develop a comprehensive committee structure including clinical, financial, and data/IT governance. The committee structure includes representatives from key stakeholders and service providers including acute and ambulatory care, behavioral health, hospice, CBOs, and the PMO's clinical transformation / care management teams.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3) Draft dispute resolution policies	Completed	3) Draft dispute resolution policies	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4) Draft compliance policies	Completed	4) Draft compliance policies	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5) Draft policies to address providers which are underperforming	Completed	5) Draft policies to address providers which are underperforming	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 6) EGB reviews and approves all the above drafts for implementation.	Completed	6) EGB reviews and approves all the above drafts for implementation.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #4 Establish governance structure reporting and	Completed	This milestone must be completed by 12/31/2015. Governance and committee structure document, including	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
monitoring processes		description of two-way reporting processes and governance monitoring processes							
Task 1) The EGB is responsible for providing the proper governance structure for the CPWNY PPS.	Completed	1) The EGB is responsible for providing the proper governance structure for the CPWNY PPS.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 2) Chair person of EGB will sign off on governance and reporting structures.	Completed	2) Chair person of EGB will sign off on governance and reporting structures.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 3) Develop and implement an application through which project status can be recorded, tracked and reported. This will also support bi-directional communication between partner agencies. CPWNY has contracted with Performance Logic a PM application.	Completed	3) Develop and implement an application through which project status can be recorded, tracked and reported. This will also support bi-directional communication between partner agencies. CPWNY has contracted with Performance Logic a PM application.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4) Identify all metrics and deliverables for both projects and work streams and utilize them as the basis for monitoring performance.	Completed	4) Identify all metrics and deliverables for both projects and work streams and utilize them as the basis for monitoring performance.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5) Develop high-level dash-board tools for reporting to the governing body and distribution to participating providers.	Completed	5) Develop high-level dash-board tools for reporting to the governing body and distribution to participating providers.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6) Provide all relevant policies and procedures to partner agencies as needed.	Completed	6) Provide all relevant policies and procedures to partner agencies as needed.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	In Progress	Community engagement plan, including plans for two-way communication with stakeholders.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	NO
Task 1) Identify community organizations which provide services that may impact population health.	Completed	1) Identify community organizations which provide services that may impact population health.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task	Completed	2) Develop a communication plan to engage the identified	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
2) Develop a communication plan to engage the identified services providers that includes types of communications to be utilized and targeted timelines.		services providers that includes types of communications to be utilized and targeted timelines.							
Task 3) Develop a community engagement plan that outlines the processes, by which these organizations will be engaged.	Completed	3) Develop a community engagement plan that outlines the processes, by which these organizations will be engaged.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4) Provide periodic communication with these organizations to provide an opportunity for dialogue, community education, and progress reporting.	In Progress	4) Provide periodic communication with these organizations to provide an opportunity for dialogue, community education, and progress reporting.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	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	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	NO
Task 1) Draft general partnership agreements with all CBOs	Completed	1) Draft general partnership agreements with all CBOs	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2) General partnership agreements executed by Project Management Office and all participating CBOs	In Progress	2) General partnership agreements executed by Project Management Office and all participating CBOs	04/01/2015	12/31/2015	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 3) Project leads assess and select CBOs based on their roles and capabilities regarding CPWNY's project needs	In Progress	3) Project leads assess and select CBOs based on their roles and capabilities regarding CPWNY's project needs	04/01/2015	12/31/2015	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 4) Schedule periodic meetings with these organizations to provide an opportunity for dialogue and updates on overall status	In Progress	4) Schedule periodic meetings with these organizations to provide an opportunity for dialogue and updates on overall status	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 5) Establish payment and/or incentive structure with CBOs, approved by EGB	In Progress	5) Establish payment and/or incentive structure with CBOs, approved by EGB	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Milestone #7 Finalize agency coordination plan aimed at engaging appropriate public sector agencies at	In Progress	Agency Coordination Plan.	04/01/2015	12/31/2015	10/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)									
Task 1) Draft public sector agency coordination plan and obtain approval by the governing body	Completed	1) Draft public sector agency coordination plan and obtain approval by the governing body	04/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2) Ensure adequate participation from public sector agencies with whom to coordinate	Completed	2) Ensure adequate participation from public sector agencies with whom to coordinate	04/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3) Develop a final coordination plan with these agencies	Completed	3) Develop a final coordination plan with these agencies	04/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4) Schedule periodic meetings with these public sector agencies to provide an opportunity for dialogue and updates on overall status	Completed	4) Schedule periodic meetings with these public sector agencies to provide an opportunity for dialogue and updates on overall status	04/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #8 Finalize workforce communication and engagement plan	In Progress	Workforce communication & engagement plan, including plans for two-way communication with all levels of the workforce, signed off by PPS workforce governance body (e.g. workforce transformation committee).	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task 1) Develop Workforce Communication and Engagement Strategy: Establish the vision, objectives and guiding principles as a means to engage key stakeholders, signed off by the executive body of the PPS	In Progress	1) Develop Workforce Communication and Engagement Strategy: Establish the vision, objectives and guiding principles as a means to engage key stakeholders, signed off by the executive body of the PPS	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2) Develop Workforce Communication & Engagement Plan: Outline objectives, principles, target audience, channel, barriers and risks, milestones, and measuring effectiveness, signed off by the executive body of the PPS	In Progress	2) Develop Workforce Communication & Engagement Plan: Outline objectives, principles, target audience, channel, barriers and risks, milestones, and measuring effectiveness, signed off by the executive body of the PPS	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 3) Identify and engage affected staff prior to the restructuring period via meetings, dialogues, and communications on CPWNY website	In Progress	3) Identify and engage affected staff prior to the restructuring period via meetings, dialogues, and communications on CPWNY website	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task	In Progress	4) Participants in planning will include representation from	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
4) Participants in planning will include representation from hospice, behavioral health services, primary care physicians, members of CPWNY clinical transformation and care management teams, and other CPWNY partners.		hospice, behavioral health services, primary care physicians, members of CPWNY clinical transformation and care management teams, and other CPWNY partners.							
Task 5) Engage affected staff through out the restructuring period via periodical updates, ongoing dialogues, and quarterly meetings with all teams and more frequent smaller group meetings of the PMO staff and project teams.	In Progress	5) Engage affected staff through out the restructuring period via periodical updates, ongoing dialogues, and quarterly meetings with all teams and more frequent smaller group meetings of the PMO staff and project teams.	08/01/2015	09/30/2016	08/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Milestone #9 Inclusion of CBOs in PPS Implementation.	In Progress	Explain your plans for contracting with CBOs and their continuing role as your PPS develops over time; detail how many CBOs you will be contracting with and by when; explain how they will be included in project delivery and in the development of your PPS network.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Community Partners of WNY has engaged numerous community partners beginning early in the planning phase of the DSRIP project. Our Executive Governance Board and project leadership includes representation from CBOs such as Erie County Council for The Prevention of Alcohol and Substance Abuse, The Mental Health Association, Buffalo Urban League, NYS Smoker Quitline, etc. It was quickly recognized that many metrics of successful project implementation would be heavily dependent upon close collaboration with these agencies. There are currently 32 CBOs which have aligned with CPWNY. In that regard, key stakeholders from CBOs have been appointed to the CPWNY governing body. Representatives from CBOs will also participate in our Project Advisory Committee to offer insight and promote engagement on projects. Given the integral role these CBOs will have, representatives have also	In Progress	Community Partners of WNY has engaged numerous community partners beginning early in the planning phase of the DSRIP project. Our Executive Governance Board and project leadership includes representation from CBOs such as Erie County Council for The Prevention of Alcohol and Substance Abuse, The Mental Health Association, Buffalo Urban League, NYS Smoker Quitline, etc. It was quickly recognized that many metrics of successful project implementation would be heavily dependent upon close collaboration with these agencies. There are currently 32 CBOs which have aligned with CPWNY. In that regard, key stakeholders from CBOs have been appointed to the CPWNY governing body. Representatives from CBOs will also participate in our Project Advisory Committee to offer insight and promote engagement on projects. Given the integral role these CBOs will have, representatives have also been appointed to project teams to assist in establishing strategy and to ensure a strong sense of community engagement including communication to various constituent groups. As opportunities present themselves, other CBOs will be	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
been appointed to project teams to assist in establishing strategy and to ensure a strong sense of community engagement including communication to various constituent groups. As opportunities present themselves, other CBOs will be engaged. CPWNY will assess the relevant capabilities and resources of participating CBOs. And the PMO will work closely with the finance governance committee to develop a value-based contract and payment plan for the CBOs to support the DSRIP projects. The contract will be approved by the executive governance body and CPWNY will utilize representatives from various types of providers to work with the finance governance committee to establish agreements and alignment.		engaged. CPWNY will assess the relevant capabilities and resources of participating CBOs. And the PMO will work closely with the finance governance committee to develop a value-based contract and payment plan for the CBOs to support the DSRIP projects. The contract will be approved by the executive governance body and CPWNY will utilize representatives from various types of providers to work with the finance governance committee to establish agreements and alignment.							

IA Instructions / Quarterly Update

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

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize governance structure and sub-committee structure	mdjohns	Other	46_MDL0203_1_3_20160201082917_Quality_flow_DSRIP_Organizational_Chart_V7.pdf	Updated organizational chart. Ongoing reporting for milestone 1.	02/01/2016 08:29 AM
	mdjohns	Other	46_MDL0203_1_3_20160129095930_PAC_Charter_APPROVED_JANUARY_2015.pdf	Project Advisory Committee Charter. Ongoing reporting for milestone 1.	01/29/2016 09:59 AM
	mdjohns	Templates	46_MDL0203_1_3_20160129095715_Governance_Committee_Roster_with_PAC_members.pdf	Revised Governance Committee roster. Clinical Governance Quality Committee and Project Advisory Committee included. Ongoing reporting	01/29/2016 09:57 AM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
				for milestone 1.	
	mdjohns	Templates	46_MDL0203_1_3_20160129095319_meeting_schedule_for_governance_committees.pdf	Governance Committee meeting schedule. Ongoing reporting for milestone 1. Template includes Clinical Governance Committee meetings and Project Advisory Committee meetings.	01/29/2016 09:53 AM
	mdjohns	Other	46_MDL0203_1_3_20160129095157_Clinical_Governance_Committee_Charter_APPROVED_12.09.2015.pdf	Clinical Governance Committee Charter. Governance Milestone 1 &2.	01/29/2016 09:51 AM
	mdjohns	Other	46_MDL0203_1_3_20160129094924_approved_revised_Governance_Commitee_Charters.pdf	CPWNY revised and approved Finance Governance Committee Charter and Data IT Governance Committee Charter.	01/29/2016 09:49 AM
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	mdjohns	Templates	46_MDL0203_1_3_20160201110221_CGC_and_subcommittee_member_roster.pdf	Clinical Governance Committee and Subcommittee Roster of Members. Milestone 2.	02/01/2016 11:02 AM
	mdjohns	Other	46_MDL0203_1_3_20160201083225_Clinical_Quality_Flowchart.pdf	Clinical Quality Flowchart. Attachment to Project Quality Team Charter. Milestone 2.	02/01/2016 08:32 AM
	mdjohns	Other	46_MDL0203_1_3_20160201083051_Quality_flow_DSRIP_Organizational_Chart_V7.pdf	Organizational chart. Milestone 2.	02/01/2016 08:30 AM
	mdjohns	Templates	46_MDL0203_1_3_20160129145929_CGC_committee__subcommittee_meeting_template.pdf	Evidence of committee meetings. Milestone 2.	01/29/2016 02:59 PM
	mdjohns	Other	46_MDL0203_1_3_20160129145645_Project_Quality_Team_Charter.pdf	Project Quality Team Charter. Milestone 2.	01/29/2016 02:56 PM
	mdjohns	Other	46_MDL0203_1_3_20160129145517_DSRIP_Veribage_CISG_Committee_Charter_2014_final_.pdf	Clinical Integration and Standardization Group Charter. Milestone 2.	01/29/2016 02:55 PM
	mdjohns	Other	46_MDL0203_1_3_20160129145415_Clinical_Governance_Committee_Charter_APPROVED_12.09.2015.pdf	Clinical Governance Quality Committee Charter. Milestone 2.	01/29/2016 02:54 PM
Finalize bylaws and policies or Committee Guidelines where applicable	mdjohns	Other	46_MDL0203_1_3_20160129101637_Project_Quality_Team_Charter.pdf	Project Quality Team Charter. Ongoing reporting for milestone 3.	01/29/2016 10:16 AM
	mdjohns	Other	46_MDL0203_1_3_20160129101553_PAC_Charter_APPROVED_JANUARY_2015.pdf	Project Advisory Committee Charter. Ongoing reporting for milestone 3.	01/29/2016 10:15 AM
	mdjohns	Other	46_MDL0203_1_3_20160129101422_DSRIP_Veribage_CISG_Committee_Charter_2014_final_.pdf	Clinical Integration and Standardization Group Committee Charter. Ongoing reporting for milestone 3.	01/29/2016 10:14 AM
	mdjohns	Other	46_MDL0203_1_3_20160129101307_Clinical_Governance_Committee_Charter_APPROVED_12.09.2015.pdf	Clinical Governance Quality Committee Charter. Ongoing reporting for milestone 3.	01/29/2016 10:13 AM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	mdjohns	Other	46_MDL0203_1_3_20160129100733_approved_revised_Governance_Commitee_Charters.pdf	Revised and approved Finance Governance Committee Charter and Data IT Governance Committee Charter. Ongoing reporting for milestone 3.	01/29/2016 10:07 AM
Establish governance structure reporting and monitoring processes	mdjohns	Other	46_MDL0203_1_3_20160129113311_S&S_supporting_documentation.pdf	Supporting documentation for Project Monitoring Reporting Process. Milestone 4.	01/29/2016 11:33 AM
	mdjohns	Other	46_MDL0203_1_3_20160129113002_DY1_Q3_Status_Report_PL.pdf	Supporting documentation for Project Monitoring Reporting Process. Milestone 4.	01/29/2016 11:30 AM
	mdjohns	Other	46_MDL0203_1_3_20160129112845_12-09-15_Project_Status_at_a_Glance.pdf	Supporting documentation for Project Monitoring Reporting Process. Milestone 4.	01/29/2016 11:28 AM
	mdjohns	Other	46_MDL0203_1_3_20160129102942_CPWNY_Project_monitor_reporting_CPWNY_process.pdf	CPWNY Project Monitor Reporting Process document. Milestone 4.	01/29/2016 10:29 AM
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.)	mdjohns	Templates	46_MDL0203_1_3_20160129112256_public_sector_engagement_template.pdf	Public Sector Organization template. Milestone 7.	01/29/2016 11:22 AM
	mdjohns	Other	46_MDL0203_1_3_20160129105115_Plan_to_Engage_Public_Sector_Governance_(4).pdf	CPWNY's Plan to Engage Public Sector. Milestone 7.	01/29/2016 10:51 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize governance structure and sub-committee structure	Please see CPWNY's updated Governance roster and charters.
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	
Finalize bylaws and policies or Committee Guidelines where applicable	
Establish governance structure reporting and monitoring processes	
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	
Finalize partnership agreements or contracts with CBOs	
Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g.	Per direction from IA, we have logged this milestone as in progress and are pursuing contracts with public sector agencies in order to mark this milestone complete. End date changed to align with PPS timeline for completion of contracts with these agencies. MAPP tool forced the PPS to change the start date within

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
local departments of health and mental hygiene, Social Services, Corrections, etc.)	the last reporting period; we listed start data as 10/1/15 although milestone was started 4/1/15.
Finalize workforce communication and engagement plan	
Inclusion of CBOs in PPS Implementation.	

Milestone Review Status

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

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IPQR Module 2.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

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.

The key challenge in the governance work steam will be the on-going engagement of all community based organizations; participating providers, public sector organizations and key stakeholders. DSRIP is clearly a significant transition from the "status quo" and will require a high degree of change management expertise as well as a concerted effort put forth toward communications. The PPS governance will be required to create a culture of trust and collaboration with all engaged parties. To those ends, an open transparent process has been and will continue to be utilized to convene appropriate partners at the appropriate cycles. Information will be shared in a non-threatening manor which clearly describes the expectations, requirements and goals of DSRIP. Participating providers will be engaged in developing solutions to challenges as they arise focusing on a "bottom-up" approach to problem solving. Data/information will be presented in documents that can be clearly understood by all constituent groups. General communication will be provided by various means (e.g. during working group meetings; via the PPS' web-site etc.) Meetings will be held at various locations throughout the relevant service area in an effort to further engage various constituent groups (i.e. houses of worship; community centers etc.) Lastly, economic incentives will be used via our funds-flow model to reward providers which achieve the project metrics/deliverables as well as the over-arching DSRIP expected goals and outcomes. An additional risk is the competing DSRIP expectations across the service area due to the presents of multiple PPSs. This will be mitigated through shared work on aligned projects, coordination on community-wide projects, and on-going communication at the leadership and project levels.

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.)

One of the key governance responsibilities is to encourage success through a collective leadership model using a very collaborative and transparent approach. Therefore, critical to this effort will be the development and use of an integrated IT infrastructure that will provide timely, accurate and understandable information utilized by the EGB to monitor the progress of the DSRIP project. Information derived through the performance reporting work stream will also be dependent upon the IT system work stream. The degree of physician (partner) engagement will significantly impact the governance work stream as well. The efforts of the partners at the patient "transaction" level is likely to be the bellwether of overall success. Having partners who are committed to a collaborative model of population health which will reduce duplicative care/services and encourage and increase in self-management, benefits of DSRIP may not be clinically sustainable. Given the DSRIP expectations of change at the provider level, the re-structuring of reimbursement through a valid sustainable funds-flow model will also impact the ability of the governance work streams success. This work stream will be required to provide financial support to various partners so that their risk is mitigated as the system transforms to a new reimbursement model. With the expectation of transformational change within the delivery system, the strategy related to the

workforce will also need to be consistently evaluated as part of the governance' responsibilities. Stakeholders in this area (e.g. both union & non-unionized labor-forces) will need to be informed of the strategic expectations of DSRIP and the workforce implications that will result. Consistent open communication between governance and all workforce groups will assist in mitigating concerns and afford opportunities for a constructive dialogue.

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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/Applicant Entity	Sisters of Charity Hospital	Funding
Project Management	Catholic Medical Partners	Staff resources, policy and procedure development, operational leadership
Major Hospital partners	Mercy Hospital, Kenmore Mercy Hospital, Sisters of Charity Hospital; Mount Saint Mary's Hospital, Women's Christian Association Hospital, Brooks Memorial Hospital, Bertrand Chafee Hospital, Orleans Community Health, Roswell Park Cancer Institute	Board and Committee members, staff support, assist with implementation strategies
Physician organizations and large practices	Catholic Medical Partners, Jamestown Area Medical Associates, Jamestown Primary Care, Medicore Associates, Jamestown Pediatrics, Westfield Primary Care, Spectrum Mental Health Services, Horizon Mental Health Services	Board and Committee members, development of "best-practice" strategies, clinical data reporting
Health Homes	Health Home Partners of WNY, Chautauqua County Health Home	Board representation on EGB, Care coordination/case management
CBOs	E.g. Catholic Charities, Mental Health Association of Erie County, Buffalo Urban League, Erie County Council for Prevention of Alcohol & Substance Abuse, Hospice Buffalo	Board and committee members, community outreach/integration

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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		
Medical Practices	Participating Partners	Project participation, committee membership, patient engagement/outreach
Behavioral Health Providers	Participating Partners	Project participation, committee membership, patient engagement/outreach
Long Term Care Services	Participating Partners	Project participation, committee membership, patient engagement/outreach
Pharmacies	Participating Partners	Project participation, committee membership, patient engagement/outreach
Local and County Department of Health	Participating Partners	Project participation, committee membership, patient engagement/outreach
Behavioral Health CBOs	Participating Partners	Project participation, committee membership, patient engagement/outreach
External Stakeholders		
Educational Institutions	Community Collaborators	PPS participation and collaboration
Housing Organizations	Community Collaborators	PPS participation and collaboration
Transportation Providers	Community Collaborators	PPS participation and collaboration
Food Suppliers/Services	Community Collaborators	PPS participation and collaboration
Day Care Services	Community Collaborators	PPS participation and collaboration
Faith Based Organization	Community Collaborators	PPS participation and collaboration
Local Government Agencies	Community Collaborators	PPS participation and collaboration
Private Sector Employers	Community Collaborators	PPS participation and collaboration

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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.

IT infrastructure is critical for the success of the DSRIP project. This infrastructure will be the platform through which all data is integrated, analyzed, reported and upon which decision and related actions will be based. All performance metrics & deliverables will be tracked using data gathered from multiple providers and other internal and external sources (e.g. Salient.) The status for each will be periodically presented to the governing body. To support the inclusion of various constituent groups, information will be made available in a timely manner tailored to each group so that the data is easily understood in the context of the projects expected goal & outcomes. In addition to the use of this information as a status tool, it will also be available as a basis of communication for all stakeholders, provider partners and the general public. One means by which this will be accomplished by postings done on the PPS web-site. While the majority of the PCPs in this PPS have an electronic medical record and have been submitting data within the context of the Medicare ACO, an additional challenge will be establishing IT platforms that support the availability of patient information from other providers e.g. behavioral health; community based organizations. Various processes are being evaluated including but not limited to use of our local RHIO HEALTHeLINK to support this effort.

IPQR Module 2.8 - Progress Reporting

Instructions :

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

The success of CPWNY governance will be measured against the timely achievement of the creation of the structures (BOD and Committees), the recruitment and empanelment of BOD and committee members, the development and adoption of bylaws, policies and procedures for all key committees and sub-committees, and the development, negotiation and execution of all required provider agreements to allow CPWNY to begin operating. Additionally, success will be measured by the establishment of the performance management systems (including data collection, analyses and reporting) to support effective and efficient decision-making. For example, the Clinical Quality committee will rely on the performance management systems capturing data regarding achievement of PCMH Level 3 requirements across the PPS network providers, compliance with EBM (evidence-based medicine) protocol, and ultimately with the impact on Program goals (e.g., ED visits).

IPQR Module 2.9 - IA Monitoring

Instructions :

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Section 03 – Financial Stability

IPQR Module 3.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize PPS finance structure, including reporting structure	Completed	This milestone must be completed by 12/31/2015. PPS finance structure chart / document, signed off by PPS Board.	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	YES
Task 1. Establish the financial structure of the Governance organization and the finance and compliance roles and responsibilities of the Finance Governance Committee	Completed	1. Establish the financial structure of the Governance organization and the finance and compliance roles and responsibilities of the Finance Governance Committee	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Define the Roles and Responsibilities of the CPWNY Lead and finance and compliance functions	Completed	2. Define the Roles and Responsibilities of the CPWNY Lead and finance and compliance functions	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3. Develop CPWNY Finance Governance Committee Charter and establish schedule for Committee meetings.	Completed	3. Develop CPWNY Finance Governance Committee Charter and establish schedule for Committee meetings.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4. Develop CPWNY Organization chart that depicts the complete finance function with reporting structure to Executive Governance Body and other oversight committees	Completed	4. Develop CPWNY Organization chart that depicts the complete finance function with reporting structure to Executive Governance Body and other oversight committees	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task 5. Obtain Finance Governance Committee approval of CPWNY Finance Governance Committee charter and organization structure chart	Completed	5. Obtain Finance Governance Committee approval of CPWNY Finance Governance Committee charter and organization structure chart	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task 6. Obtain CPWNY Executive Governance Body approval of CPWNY Finance Governance Committee charter and organization structure chart	Completed	6. Obtain CPWNY Executive Governance Body approval of CPWNY Finance Governance Committee charter and organization structure chart	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task 7. Develop reporting format for CPWNY Financial Reporting to include bank reconciliations, reporting package to Finance Committee and Executive Governance.	Completed	7. Develop reporting format for CPWNY Financial Reporting to include bank reconciliations, reporting package to Finance Committee and Executive Governance.	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task 8. Develop instructions and perform training to all CPWNY partners for appropriate expense reimbursement and performance reporting.	Completed	8. Develop instructions and perform training to all CPWNY partners for appropriate expense reimbursement and performance reporting.	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task 9. Develop plan to establish internal controls over financial reporting, as well as processes for auditing and monitoring for CPWNY Finance Committee approval and EGB oversight.	Completed	9. Develop plan to establish internal controls over financial reporting, as well as processes for auditing and monitoring for CPWNY Finance Committee approval and EGB oversight.	04/01/2015	12/30/2015	04/01/2015	12/30/2015	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	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	YES
Task Obtain Finance Governance Committee approval of Distressed Provider Plan (second to last task)	In Progress	Obtain Finance Governance Committee approval of Distressed Provider Plan	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Obtain Executive Governance Body approval of Distressed Provider Plan. (second to last task)	In Progress	Obtain Executive Governance Body approval of Distressed Provider Plan.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Sub-Milestone: Conduct Current State Financial Assessment and Project Impact Assessment	In Progress	Sub-Milestone: Conduct Current State Financial Assessment and Project Impact Assessment	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Sub-Milestone: Assessment of DSRIP Project Impacts	In Progress	Sub-Milestone: Assessment of DSRIP Project Impacts	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Develop project impact matrix template with DSRIP Projects and identify expected impact on overall utilization.	Completed	Develop project impact matrix template with DSRIP Projects and identify expected impact on overall utilization.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Review DRAFT of project impact matrix with Finance Governance Committee.	Completed	Review DRAFT of project impact matrix with Finance Governance Committee.	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task Finalize project impact matrix identifying project participation, expected impact of projects and provider specific view.	In Progress	Finalize project impact matrix identifying project participation, expected impact of projects and provider specific view.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Review and obtain approval of Project Impact Matrix from Finance Governance Committee and Executive Governance Body as basis for determining sustainability strategies and applicable portions of funds flow plan.	In Progress	Review and obtain approval of Project Impact Matrix from Finance Governance Committee and Executive Governance Body as basis for determining sustainability strategies and applicable portions of funds flow plan.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Conduct Current State Financial Assessment and Project Impact Assessment	In Progress	Conduct Current State Financial Assessment and Project Impact Assessment	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Conduct Financial Assessment and Project Impact Assessment	Completed	Conduct Financial Assessment and Project Impact Assessment	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task Aggregate information from DSRIP Project leads/owners to develop the project impact assessments and financial metrics.	Completed	Aggregate information from DSRIP Project leads/owners to develop the project impact assessments and financial metrics.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Review results of Current State Financial Assessment and Project Impact Assessment returned from providers	In Progress	Review results of Current State Financial Assessment and Project Impact Assessment returned from providers	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Prepare report of CPWNY Current State Financial Status for Finance Governance Committee.	In Progress	Prepare report of CPWNY Current State Financial Status for Finance Governance Committee.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Distribute Current State Financial Assessment and Project Impact Assessment documents to providers	In Progress	Distribute Current State Financial Assessment and Project Impact Assessment documents to providers	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Prepare report of CPWNY Current State Financial Status for Executive Governance Body	In Progress	Prepare report of CPWNY Current State Financial Status for Executive Governance Body	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Define procedure for ongoing monitoring of financial sustainability and obtain approval from Executive Governance Body.	In Progress	Define procedure for ongoing monitoring of financial sustainability and obtain approval from Executive Governance Body.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Sub-Milestone: Develop Financially Fragile Watch List	In Progress	Sub-Milestone: Develop Financially Fragile Watch List	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Based upon Financial Assessment and Project Impact Assessment – identify providers (a) not meeting Financial Stability Plan metrics, (b) that are under current or planned restructuring efforts, or that will be financially challenged due to DSRIP projects or (c) that will otherwise be financially challenged and, with consideration of their role in projects, prepare initial Financially Fragile Watch List and obtain approval of Finance Governance Committee.	In Progress	Based upon Financial Assessment and Project Impact Assessment – identify providers (a) not meeting Financial Stability Plan metrics, (b) that are under current or planned restructuring efforts, or that will be financially challenged due to DSRIP projects or (c) that will otherwise be financially challenged and, with consideration of their role in projects, prepare initial Financially Fragile Watch List and obtain approval of Finance Governance Committee.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Have communication with the Fragile providers.	Completed	Have communication with the Fragile providers.	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task Present Fragile Watch List to Finance Governance Committee.	In Progress	Present Fragile Watch List to Finance Governance Committee.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Present Fragile Watch List to Executive Governance Body.	In Progress	Present Fragile Watch List to Executive Governance Body.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Sub-Milestone: Develop Financial Sustainability Plan and obtain approval from CPWNY Finance Committee	In Progress	Sub-Milestone: Develop Financial Sustainability Plan and obtain approval from CPWNY Finance Committee	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Develop CPWNY Financial Sustainability plan. The plan will include metrics, ongoing monitoring process, and other requirements.	Completed	Develop CPWNY Financial Sustainability plan. The plan will include metrics, ongoing monitoring process, and other requirements.	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task Define process for evaluating metrics and implementing a FSP for the initial Fragile Watch List as well as going forward.	In Progress	Define process for evaluating metrics and implementing a FSP for the initial Fragile Watch List as well as going forward.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Develop a communication plan with the Fragile Watch List Board of Directors.	In Progress	Develop a communication plan with the Fragile Watch List Board of Directors.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Present Fragile Watch List to Finance Governance Committee.	In Progress	Present Fragile Watch List to Finance Governance Committee.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Present Fragile Watch List to Executive Governance Body.	In Progress	Present Fragile Watch List to Executive Governance Body.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Sub-Milestone: Implement Project Management oversight for Financial Sustainability Plan and Distressed Provider Plans	Completed	Sub-Milestone: Implement Project Management oversight for Financial Sustainability Plan and Distressed Provider Plans	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task Define role of Catholic Medical Partners (PMO) for Financial Sustainability Plans (FSP) and Distressed Provider Plans (DSP) and their process to manage the plans for CPWNY and CPWNY Lead.	Completed	Define role of Catholic Medical Partners (PMO) for Financial Sustainability Plans (FSP) and Distressed Provider Plans (DSP) and their process to manage the plans for CPWNY and CPWNY Lead.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Implement PMO oversight for active FSP and Distressed Provider Plans	Completed	Implement PMO oversight for active FSP and Distressed Provider Plans	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task Sub-Milestone: Define Distressed Provider Plan and obtain approval of Finance Governance	In Progress	Sub-Milestone: Define Distressed Provider Plan and obtain approval of Finance Governance Committee.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Committee.									
Task Define template for Distressed Provider Plan(s)	Completed	Define template for Distressed Provider Plan(s)	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Completed	This milestone must be completed by 12/31/2015. Finalized Compliance Plan (for PPS Lead).	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 1. Complete review of NY Social Services Law 363-d, determine scope and requirements of compliance program and plan based upon the DSRIP related requirements that are within the scope of responsibilities of the CPWNY Lead.	Completed	1. Complete review of NY Social Services Law 363-d, determine scope and requirements of compliance program and plan based upon the DSRIP related requirements that are within the scope of responsibilities of the CPWNY Lead.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. Develop written policies and procedures that define and implement the code of conduct and other required elements of the CPWNY Lead compliance plan that are within the scope of responsibilities of the CPWNY Lead.	Completed	2. Develop written policies and procedures that define and implement the code of conduct and other required elements of the CPWNY Lead compliance plan that are within the scope of responsibilities of the CPWNY Lead.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Obtain confirmation from CPWNY network providers that they have implemented a compliance plan consistent with the NY State Social Services Law 363-d.	Completed	3. Obtain confirmation from CPWNY network providers that they have implemented a compliance plan consistent with the NY State Social Services Law 363-d.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4. Obtain Finance Governance Committee approval of the Compliance Plan (for the CPWNY Lead) and Implement	Completed	4. Obtain Finance Governance Committee approval of the Compliance Plan (for the CPWNY Lead) and Implement	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5. Develop requirements to be included in the CPWNY Provider Operating Agreement that the network providers will maintain a current compliance plan to meet NY State requirements for a provider.	Completed	5. Develop requirements to be included in the CPWNY Provider Operating Agreement that the network providers will maintain a current compliance plan to meet NY State requirements for a provider.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6. Obtain Executive Governance Body approval of the Compliance Plan (for the CPWNY Lead) and Implement	Completed	6. Obtain Executive Governance Body approval of the Compliance Plan (for the CPWNY Lead) and Implement	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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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	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	YES
Task Develop VBP Work Group representative of CPWNY PPS. Consider representation from CPWNY providers, PCMH, FQHCs and managed care plans.	In Progress	Develop VBP Work Group representative of CPWNY PPS. Consider representation from CPWNY providers, PCMH, FQHCs and managed care plans.	04/01/2015	12/31/2015	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Develop VBP Work Group Charter. The primary goal of the VBP Work Group is to coordinate outreach and educational initiatives that support VBP arrangements throughout our system.	In Progress	Develop VBP Work Group Charter. The primary goal of the VBP Work Group is to coordinate outreach and educational initiatives that support VBP arrangements throughout our system.	04/01/2015	12/31/2015	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Have VBP Charter approved by Finance Governance Committee	In Progress	Have VBP Charter approved by Finance Governance Committee	04/01/2015	12/30/2015	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Have VBP Charter approved by Executive Governance Body	In Progress	Have VBP Charter approved by Executive Governance Body	04/01/2015	12/30/2015	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Develop education and communication plan for providers to facilitate understanding of value based payment (VBP), to include levels of VBP, risk sharing, and provider/MCO contracting options.	In Progress	Develop education and communication plan for providers to facilitate understanding of value based payment (VBP), to include levels of VBP, risk sharing, and provider/MCO contracting options.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Develop educational materials to be used during provider outreach and educational campaign.	In Progress	Develop educational materials to be used during provider outreach and educational campaign.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Conduct education and outreach campaign for CPWNY system providers to broaden knowledge among the CPWNY network of the various VBP models and to enable the CPWNY to employ those models in a coordinated approach (campaign to include in-person and web-based	In Progress	Conduct education and outreach campaign for CPWNY system providers to broaden knowledge among the CPWNY network of the various VBP models and to enable the CPWNY to employ those models in a coordinated approach (campaign to include in-person and web-based educational sessions for providers).	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
educational sessions for providers).									
Task Develop a stakeholder engagement survey to assess the CPWNY provider population and establish a baseline assessment of (at least) the following: Degree of experience operating in VBP models and preferred compensation modalities; Degree of sophistication in ability to negotiate plan contracts, monitor and report on service types; Estimated volume of Medicaid Managed Care spending received by the network; Estimate of total cost of care for specific services (modeled along bundles); Status of requisite IT linkages for network funds flow monitoring; Provider ability (financial stability) and willingness to take downside risk in a risk sharing arrangement; Preferred method of negotiating plan options with Medicaid Managed Care organization (e.g. as a single provider, as a group of providers, through the CPWNY);and Level of assistance needed to negotiate plan options with Medicaid Managed Care (High, Moderate, Low).This will enable CPWNY to make a more informed decision as to the most effective contracting strategy and will inform our contract negotiations with Medicaid plans.	In Progress	Develop a stakeholder engagement survey to assess the CPWNY provider population and establish a baseline assessment of (at least) the following: Degree of experience operating in VBP models and preferred compensation modalities; Degree of sophistication in ability to negotiate plan contracts, monitor and report on service types; Estimated volume of Medicaid Managed Care spending received by the network; Estimate of total cost of care for specific services (modeled along bundles); Status of requisite IT linkages for network funds flow monitoring; Provider ability (financial stability) and willingness to take downside risk in a risk sharing arrangement; Preferred method of negotiating plan options with Medicaid Managed Care organization (e.g. as a single provider, as a group of providers, through the CPWNY);and Level of assistance needed to negotiate plan options with Medicaid Managed Care (High, Moderate, Low).This will enable CPWNY to make a more informed decision as to the most effective contracting strategy and will inform our contract negotiations with Medicaid plans.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Roll out stakeholder engagement survey to the provider population to determine CPWNY baseline demographics.	In Progress	Roll out stakeholder engagement survey to the provider population to determine CPWNY baseline demographics.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Conduct provider outreach sessions to supplement the stakeholder engagement survey and engage stakeholders in open discussion.	In Progress	Conduct provider outreach sessions to supplement the stakeholder engagement survey and engage stakeholders in open discussion.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Compile stakeholder engagement survey results and findings from provider engagement sessions	In Progress	Compile stakeholder engagement survey results and findings from provider engagement sessions and analyze findings.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
and analyze findings.									
Task Sub-Milestone: Conduct stakeholder engagement with MCOs	In Progress	Sub-Milestone: Conduct stakeholder engagement with MCOs	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Conduct stakeholder engagement sessions with MCOs to understand potential contracting options and potential membership along with the requirements (workforce, infrastructure, knowledge, legal support, etc.) necessary to conduct and finalize plan negotiations.	In Progress	Conduct stakeholder engagement sessions with MCOs to understand potential contracting options and potential membership along with the requirements (workforce, infrastructure, knowledge, legal support, etc.) necessary to conduct and finalize plan negotiations.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Finance Governance Committee to sign off on preference for CPWNY central role in contracting.	In Progress	Finance Governance Committee to sign off on preference for CPWNY central role in contracting.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Review summary of stakeholder engagement sessions with Finance Governance Committee and Executive Governing Body. Develop contract preference role and present to FGC and EGB.	In Progress	Review summary of stakeholder engagement sessions with Finance Governance Committee and Executive Governing Body. Develop contract preference role and present to FGC and EGB.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Sub-Milestone: Finalize CPWNY VBP Baseline Assessment	In Progress	Sub-Milestone: Finalize CPWNY VBP Baseline Assessment	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Develop initial CPWNY VBP Baseline Assessment, based on feedback from provider and MCO stakeholder engagement sessions and survey results, providing an overview of the CPWNY provider population (by provider type and specialty areas, a view of preferred compensation modalities, and a detailed overview of contracting options.	In Progress	Develop initial CPWNY VBP Baseline Assessment, based on feedback from provider and MCO stakeholder engagement sessions and survey results, providing an overview of the CPWNY provider population (by provider type and specialty areas, a view of preferred compensation modalities, and a detailed overview of contracting options.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Circulate the CPWNY VBP Baseline Assessment for open comment among network providers to help ensure accuracy and understanding.	In Progress	Circulate the CPWNY VBP Baseline Assessment for open comment among network providers to help ensure accuracy and understanding.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Update, revise and finalize CPWNY VBP Baseline Assessment.	In Progress	Update, revise and finalize CPWNY VBP Baseline Assessment.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	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	12/30/2016	04/01/2015	12/30/2016	12/31/2016	DY2 Q3	YES
Task Sub-Milestone: Prioritize potential opportunities and providers for VBP arrangements.	In Progress	Sub-Milestone: Prioritize potential opportunities and providers for VBP arrangements.	04/01/2015	12/30/2016	04/01/2015	12/30/2016	12/31/2016	DY2 Q3	
Task Analyze health care bundle populations and total cost of care data provided through survey and engagement with providers, to identify VBP opportunities that are more easily attainable and prioritize services moving into VBP.	In Progress	Analyze health care bundle populations and total cost of care data provided through survey and engagement with providers, to identify VBP opportunities that are more easily attainable and prioritize services moving into VBP.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Identify VBP accelerators and challenges within CPWNY related to the implementation of the VBP model, including existing ACO and MCO models with current VBP arrangements, existing bundled payments, or shared savings arrangements . Identify necessary IT infrastructure that can be utilized to monitor VBP activity (accelerators) and contracting complexity, limited infrastructure with experience in VBP or abundance of low performing providers (challenges).	In Progress	Identify VBP accelerators and challenges within CPWNY related to the implementation of the VBP model, including existing ACO and MCO models with current VBP arrangements, existing bundled payments, or shared savings arrangements . Identify necessary IT infrastructure that can be utilized to monitor VBP activity (accelerators) and contracting complexity, limited infrastructure with experience in VBP or abundance of low performing providers (challenges).	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Align providers and PCMHs to identify alignment with VBP accelerators and challenges which are best aligned to expeditiously engage in VBP arrangements.	In Progress	Align providers and PCMHs to identify alignment with VBP accelerators and challenges which are best aligned to expeditiously engage in VBP arrangements.	04/01/2015	12/30/2016	04/01/2015	12/30/2016	12/31/2016	DY2 Q3	
Task Identify providers and PCMHs within the CPWNY with the greatest ability to negotiate VBP arrangements and operate in a VBP model.	In Progress	Identify providers and PCMHs within the CPWNY with the greatest ability to negotiate VBP arrangements and operate in a VBP model. Identification will be based on 1) findings derived from the VBP Baseline Assessment, 2) their	04/01/2015	12/30/2016	04/01/2015	12/30/2016	12/31/2016	DY2 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Identification will be based on 1) findings derived from the VBP Baseline Assessment, 2) their alignment with VBP accelerators and challenges, and 3) their ability to implement VBP arrangements for more easily attainable bundles of care based on DOH provided data.		alignment with VBP accelerators and challenges, and 3) their ability to implement VBP arrangements for more easily attainable bundles of care based on DOH provided data.							
Task Re-assess capability and infrastructure of providers and PCMHs that have been identified as 'advanced,' in order to assess for strengths and weaknesses in ability to continue as early adopters of VBP arrangements. Also, Re-assess capability and infrastructure of providers identified earlier as challenged and continue to move them along the path to VBP.	In Progress	Re-assess capability and infrastructure of providers and PCMHs that have been identified as 'advanced,' in order to assess for strengths and weaknesses in ability to continue as early adopters of VBP arrangements. Also, Re-assess capability and infrastructure of providers identified earlier as challenged and continue to move them along the path to VBP.	04/01/2015	12/30/2016	04/01/2015	12/30/2016	12/31/2016	DY2 Q3	
Task Sub-Milestone: Develop timeline for VBP adoption.	In Progress	Sub-Milestone: Develop timeline for VBP adoption.	04/01/2015	12/30/2016	04/01/2015	12/30/2016	12/31/2016	DY2 Q3	
Task Develop a realistic and achievable timeline for "Advanced" providers and PCMHs to become early adopters of VBP arrangements, taking into account findings of the baseline assessment, alignment with VBP accelerators, and ability to engage in VBP arrangements for the care bundles deemed more attainable and which are supported by DOH data.	In Progress	Develop a realistic and achievable timeline for "Advanced" providers and PCMHs to become early adopters of VBP arrangements, taking into account findings of the baseline assessment, alignment with VBP accelerators, and ability to engage in VBP arrangements for the care bundles deemed more attainable and which are supported by DOH data.	04/01/2015	12/30/2016	04/01/2015	12/30/2016	12/31/2016	DY2 Q3	
Task Engage key financial stakeholders from MCOs, CPWNY and providers to discuss options for shared savings and funds flow. Key elements of this step will include effectively analyzing provider and CPWNY performance, methods of dispersing shared savings and infrastructure required to support performance monitoring and reporting.	In Progress	Engage key financial stakeholders from MCOs, CPWNY and providers to discuss options for shared savings and funds flow. Key elements of this step will include effectively analyzing provider and CPWNY performance, methods of dispersing shared savings and infrastructure required to support performance monitoring and reporting.	04/01/2015	12/30/2016	04/01/2015	12/30/2016	12/31/2016	DY2 Q3	
Task	In Progress	Sub-Milestone: Finalize VBP Adoption Plan	04/01/2015	12/30/2016	04/01/2015	12/30/2016	12/31/2016	DY2 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Sub-Milestone: Finalize VBP Adoption Plan									
Task Collectively review the VBP Adoption Plan with CPWNY.	In Progress	Collectively review the VBP Adoption Plan with CPWNY.	04/01/2015	12/30/2016	04/01/2015	12/30/2016	12/31/2016	DY2 Q3	
Task Update, modify and finalize VBP Adoption plan. Secure approval from Executive Governing Body	In Progress	Update, modify and finalize VBP Adoption plan. Secure approval from Executive Governing Body	04/01/2015	12/30/2016	04/01/2015	12/30/2016	12/31/2016	DY2 Q3	
Milestone #6 Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Milestone #7 Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Milestone #8 >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize PPS finance structure, including reporting structure	dcao	Documentation/Certification	46_MDL0303_1_3_20160126112024_1.9_Internal_Control_Workplan_Summary_and_Detail.pdf	Task 9. Internal Control Workplan Summary and Detail.	01/26/2016 11:20 AM
	dcao	Documentation/Certification	46_MDL0303_1_3_20160126111340_1.8_Training_for_Expense_Reimbursement.pdf	Task 8. Training for Expense Reimbursement Summary.	01/26/2016 11:13 AM
	dcao	Documentation/Certification	46_MDL0303_1_3_20160126111156_1.7_Financial_Reporting_Structure_Summary.pdf	Task 7. Financial Reporting Structure Summary.	01/26/2016 11:11 AM

NYS Confidentiality – High

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	dcao	Communication Documentation	46_MDL0303_1_3_20160126110524_1.5._and_1.6._Milestone_Charter_summary.pdf	Task 5, 6. Evidence of approval for the Finance Governance Committee charter and organizational chart by EGB and by the Finance Governance Committee.	01/26/2016 11:05 AM
	dcao	Documentation/Certification	46_MDL0303_1_3_20160126105938_1.4_Milestone_Organization_Chart.pdf	Task 4. CPWNY organizational chart that depicts the complete finance function with reporting structure to EGB and other oversight committees.	01/26/2016 10:59 AM
	dcao	Meeting Materials	46_MDL0303_1_3_20160126105622_Finance_Committee_December_2015.xlsx	Task 3. Meeting schedule template captures the CPWNY Finance Governance Committee meetings occurred in DY1 Q3. Minutes available on request.	01/26/2016 10:56 AM
	dcao	Meeting Materials	46_MDL0303_1_3_20160126105315_4._2015_CPWNY_Finance_Committee_CALENDAR.pdf	Task 3. Committee meeting schedule established for CPWNY Finance Governance Committee. Charter is available in Task 1 supporting files.	01/26/2016 10:53 AM
	dcao	Documentation/Certification	46_MDL0303_1_3_20160126104527_3._Finance_roles.xlsx	Task 2. Roles, responsibilities, and compliance functions are clearly identified and defined for CPWNY Lead, other entities, and individuals involved.	01/26/2016 10:45 AM
	dcao	Meeting Materials	46_MDL0303_1_3_20160126103755_2._CPWNY_Finance_Committee_Meeting_051815v3.pdf	Task 1. Finance Governance Committee meeting minutes on 5/18/15, evidence of PPS Board approval of committee and chart. EGB minute available on request.	01/26/2016 10:37 AM
	dcao	Documentation/Certification	46_MDL0303_1_3_20160126103506_1._CMP_PPS_Finance_Committee_Charter_4851-5863-4529_v_1.pdf	Task 1. Charter outlines the roles and responsibilities of the Finance Governance Committee. Approved by Finance Committee on 5/18/15.	01/26/2016 10:35 AM
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	dcao	Documentation/Certification	46_MDL0303_1_3_20160126114853_3.1_3.2_3.3_3.4_3.5_3.6_Review_NY_Social_Services_Law.pdf	Milestone 3 summary and evidence of EGB and Finance Governance Committee approval. Minutes available on request.	01/26/2016 11:48 AM
	dcao	Documentation/Certification	46_MDL0303_1_3_20160126114642_3.0.1_Comp_Plan_2015_SOCH_Certifications.pdf	NYS OMIG certification for Sisters of Charity Hospital.	01/26/2016 11:46 AM
	dcao	Policies/Procedures	46_MDL0303_1_3_20160126114545_3.0_CPWNY-100_Comp_Plan_11_4_15.pdf	CPWNY Compliance Plan.	01/26/2016 11:45 AM

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize PPS finance structure, including reporting structure	
Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	
Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	
Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	
Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	
Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	
>=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	

Milestone Review Status

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

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IPQR Module 3.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

Some challenges that could impact efforts to assess and monitor the financial health of the CPWNY providers and effectively manage the administrative and operational aspects of the finance function include: Implementation of a financial reporting infrastructure; Obtaining buy-in from DSRIP partners; Access to data for analytics related to project performance; and failure of providers to meet reporting requirements. Our IT current state assessment revealed a lack of financial reporting infrastructure. A shared reporting infrastructure is essential for timely access to metrics that impact the financial health of CPWNY providers. This risk to our Finance Function will be mitigated by adoption of a shared IT infrastructure throughout the PPS. In addition, the finance team will have access to sources of financial and performance data to identify trends, implement corrective action and update reporting.
We have developed a Data and Technology work plan specific to the finance requirements along with a reporting timeline to ensure CPWNY providers to stay on schedule for submitting reporting information as needed for submission to DOH.
Provider/Partner buy-in is a risk to the functioning of the integrated delivery network and DSRIP success. Some DSRIP objectives may negatively impact provider business models, making them skeptical to participate. Provider support is essential to meeting project requirements and earning full DSRIP payment. To mitigate this risk we will communicate to providers the funds distribution plan and ensure plan requirements, processes and payment schedules are transparent and clearly understood.
Another risk is the ability to transition from fee-for-service reimbursement to a Value Based Payment model. This change presents a significant challenge for CPWNY practices, particularly small providers and those with less experience using VBP models. CPWNY will facilitate this transition through educational campaigns which will cover the objectives of VBP models, including risk sharing. This will empower providers to make more sound and intelligent decisions and pace their practices to achieve VBP arrangements. We will engage partners to develop a flexible, multi-phased approach that enables the most appropriate and effective method of contracting on a VBP basis within our region. We also recognize this task as a challenging process where many considerations, such as contracting complexity and existing provider/MCO relationships must be taken into account. To address this challenge, our approach will take into account the strong relationships that exist between individual providers and MCOs and we will enable our providers to contract directly with regional MCOs. To successfully operate in a VBP arrangement, our partners must maintain a firm understanding of the varying degrees of risk sharing, capitation and fee for service. CPWNY will examine opportunities to facilitate and support contract negotiations between our CPWNY providers and MCOs, wherever possible. We will examine opportunities for standardization in contracting methodologies among MCOs, ultimately streamlining the process for our partners to establish VBP arrangements.
And finally, as with all entities responsible for compliance in healthcare and finance related fields, the CPWNY recognizes that there is a risk that compliance requirements will not be followed or that loss of funds may occur within the finance function. We are developing a robust compliance plan that will establish policies, procedures, and guidelines for operating within the compliance requirements of NY State. In addition we will implement an active education and training initiative to ensure that all partners are aware of the compliance rules and procedures as well as procedures to follow to report or discuss compliance related actions or concerns.

IPQR Module 3.4 - Major Dependencies on Organizational Workstreams

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Instructions :

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

During our preliminary assessment of the finance function for the CPWNY DSRIP application we identified a number of interdependencies with other work streams in key areas which we have outlined below.

• Governance – A fully supportive governance process is essential to establishing the role of Sisters of Charity Hospital as CPWNY Lead. In addition, fully established roles within the governance structure for Finance, Compliance and Audit will inform and drive the finance committee charter, its oversight of the finance function and approach to funds flow.

• DSRIP Network Capabilities and Project Implementation - The successful implementation of CPWNY value based reform strategy, and execution of value based contracts, will require a developed and functioning integrated delivery network and buy-in of the network partners to the value based payment strategy.

• Reporting Requirements – The DSRIP process has extensive reporting requirements linked to DSRIP payments – such as the quarterly reporting is a dependency for receiving DSRIP Process Payments. This reporting is dependent upon input and submission of reports and data from the individual network providers as well as other sources of data that will require the CPWNY to access.

 DSRIP Projects – The CPWNY finance function must have an understanding of projects selected and participation level of providers for each (Provider Participation Matrix) in order to develop a meaningful funds plan for CPWNY. In addition, CPWNY and the providers must understand project costs, impacts and other needs as part of their process of evaluating financial stability and impact going forward.

• IT and Data – This work stream will be essential to providing technology to access data and to implement shared financial reporting infrastructure that is needed by CPWNY as well as the technology for reporting project level performance data that is closely linked to the payments received for DSRIP projects.

• Workforce – The impact of the DSRIP projects is still being reviewed as is the costs related to those impacts and the strategies of CPWNY and each provider to mitigate that impact. Sisters of Charity Hospital will work closely with the workforce work stream to ensure that the appropriate data related to the workforce strategy and impact is being gathered and reported to meet the DSRIP requirements. Sisters of Charity and Catholic Medical Partners (CMP) as the project manager is responsible for communicating these requirements for tracking and reporting to all CPWNY providers to ensure that the CPWNY meets its requirement to report this information to DOH.

• There is a risk in financial reporting regarding the timing of payment receipt and revenue recognition, as well as expense recognition. Additionally there is performance risk for all the members, providers, PPS, regions statewide.

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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
Coordinator of Finance	Job Description created, interview process underway	Responsible for the day-to-day operations of the financial reporting function, including updating policies and procedures, monitoring the general ledger system, and developing protocols around financial reporting.
Staff Accountant - CMP	Job Description created, awaiting compensation grading from HR.	Responsible for the day-to-day operations of the financial reporting function, including updating policies and procedures, monitoring the general ledger system, and developing protocols around financial reporting.
Account Payable Clerk - CHS	Existing CHS staff will assume these responsibilities	Responsible for the day-to-day operations of the Accounts Payable function, including updating policies and procedures, monitoring the accounts payable system, and developing protocols around reporting and AP check write related to the DSRIP funds distribution. Coordinated with the CPWNY Coordinator of Finance and CMP Staff Accountant.
Senior Healthcare Analyst : CMP/DSRIP	Dapeng Cao	This position(s) will be responsible for working with the Director of Finance to determine and monitor the reporting protocols and requirements for the CPWNY providers, the governing body, and DOH.
Healthcare Analyst: CMP	Job description being updated to include advanced programming skills the submission to Human Resources for compensation grading	This position(s) will be responsible for working with the Senior Healthcare analyst and Director of Finance to determine and monitor the reporting protocols/requirements for the CPWNY providers, the governing body, and DOH.
Financial Manager - CHS	Betsy Bittar/Part responsibility Manager Internal Controls	Responsible for the daily operation of the Finance Office, including programmatic development of the infrastructure tools critical to the Funds Flow Plan and the related banking, accounts payable and general ledger functions.The Coordinator of Finance CPWNY will report to the Financial Manager.
Director of Finance/Accounting	Trish Lewandowski, CH Director of Financial Reporting Acute	Responsible for development and management of the Finance Office and its specific functions. The individual will provide guidance and oversight around the Funds Flow Plan, the Financial Stability Plan, and other relevant processes. The responsibilities

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		include ensuring that funds are managed and distributed according to the approved plan, that reporting requirements are met and that communication regarding the Finance related functions is timely and accurate.
Banking Staff	Les Wangelin, Director of Corporate Accounting, and Treasury and Mike Polasik, Manager of Treasury Services	Responsible for the day-to-day operations of the Banking function, including the processing of the DSRIP funds received from DOH and reporting of the status of funds expected and received as well as reconciliation of bank related statements.
Compliance Officer	CPWNY Compliance Officer, TBD	Will oversee the development and implementation of the compliance plan of the CPWNY Lead and related compliance requirements of the CPWNY as they are defined. Scope would include the CPWNY Lead compliance plan related to DSRIP. The Compliance Director will report to the Sisters of Charity Hospital, Catholic Health Compliance Officer, and the CPWNY Executive Governance Body
VBP Project Manager	Existing CMP staff, TBD	Coordinate overall development of VBP baseline assessment and plan for achieving value based payments.

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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		
Director, Performing Provider System NYS DOH DSRIP	Management and oversight.	The DSRIP Project Director has overarching responsibility for oversight of the DSRIP initiative for the CPWNY
Medical Director, DSRIP	Management and oversight.	Oversee policy making and engage providers.
Network Manager	Management and oversight.	Track providers in the network and their performance, update project management tool.
Director of Medical Policy & Accreditation	Management and oversight.	Oversee development of policies and procedures related to projects and workstreams.
10 DSRIP Project Leads	DSRIP Project Leads	Collaboration with finance re: CPWNY Project Implementation, status of project, reporting required to meet DOH requirements.
Internal Auditor	Internal Audit	Oversight of internal control functions; completion of audit processes related to funds flow, network provider reporting, and other finance related control processes
CPWNY Finance Governance Committee	Management and oversight.	Board level oversight and responsibility for the CPWNY Finance function; Review and approval of finance related policies and procedures; oversight of CPWNY Lead role, responsibilities and deliverables; oversight of audit and compliance related processes
CPWNY/Sisters of Charity Hospital Human Resources	Staffing/HR	HR related functions of CPWNY for its employees and guidance related to the CPWNY workforce strategies
CPWNY/Sisters of Charity IT Department	IT Resources	Information Technology related requirements for the finance function; access to data for the finance function reporting requirements
CEOs of CPWNY Network Partners	Participation/Leadership	CPWNY Network Provider partners' CEOs are responsible for their organization's' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies
CFO/Finance Team of CPWNY Network Partner	Participation/Leadership	Primary contact for the CPWNY Lead finance function for conducting DSRIP related business and responsible for their organization's execution of their DSRIP related finance responsibilities and participation in finance related strategies

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Boards of Directors for CPWNY Network Partners	Participation/Leadership	CPWNY Network Provider partners' BOD have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies
External Stakeholders		
External Auditors	External Audit	External Audit Function
MCOs and other payers	MCOs and other payers identified by CPWNY for pursuit of CPWNY Value Based Payment reform strategies	The CPWNY Lead and CPWNY PMO will have responsibilities related to implementing the CPWNYs value based strategy, the contracting process, and implementation / administration of executed value based agreements.
NY DOH	NY DOH defines the DSRIP requirements	The CPWNY Lead and CPWNY finance function has responsibility for the overall administration of DSRIP reporting to DOH and the funds flow process
Community Representatives	Community Representatives	Community needs and interests are significant influencers of DSRIP projects and will contribute to the adoption and buy-in across the network. Communication regarding DSRIP status, results, and future strategies will be important to maintain their contribution and influence.
Government Agencies / Regulators	Government Agencies / Regulators	County and State agencies and regulatory bodies will have oversight and influence in a number of DSRIP related areas - including the importance of waivers or regulatory relief, construction / renovation projects, and other items related to DSRIP. Communication with them regarding DSRIP status, results, future strategies and their role in DSRIP success will be important.
Medicaid Managed Care Plans	Responsible for contracting with individual providers on a VBP basis.	These will be determined pursuant to the development of Baseline Assessment and VBP Adoption Plan.

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IPQR Module 3.7 - IT Expectations

Instructions :

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

The development of shared IT infrastructure across CPWNY will support the CPWNY Finance Office and our work on the financial sustainability of the network by providing the network partners with capability for sharing and submitting reports and data pertaining to project performance and other DSRIP related business in a secure and compliant manner. We will begin the process of establishing a shared financial reporting platform across the network, which will be utilized to provide access and visibility to updates on key financial sustainability metrics at the provider and CPWNY level. We also intend to link to the performance reporting mechanisms that will be utilized across the CPWNY to provide our finance team with current data that may be utilized to track project performance levels and expected DSRIP payments.

Other shared IT infrastructure and functionality across the CPWNY that will support or contribute to the success of the CPWNY Finance Office includes:

• Population Health (Crimson) systems or technology that will support the need to access and report on data related to clinical services and outcomes – for DSRIP required metrics and to meet the needs under value based payment arrangements.

• Care Coordination technology and systems that support broad network integration of services and health management capabilities.

IPQR Module 3.8 - Progress Reporting

Instructions :

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

We will align our CPWNY financial management and sustainability progress reporting with the reporting and oversight structures in place for the DSRIP projects, through the CPWNY and our project management office, CMP. CMP will be responsible for monitoring progress against project requirements and process measures at a provider level, and the preparation of status reports for the quarterly reporting process for DOH. We will integrate into this process the financial reporting that we require in order to be able to monitor and manage the financial health of the network over the course of the DSRIP program. Sisters of Charity Finance Office will be responsible for consolidating all of the specific financial elements of this project reporting into specific financial dashboards for the CPWNY Board and for the tracking of the specific financial indicators we are required to report as part of the financial sustainability assessments and the ongoing monitoring of the financial impacts of DSRIP on the providers. Through ongoing reporting, if a partner trends negatively or if the financial impacts are not in line with expectations, the CPWNY Finance Governance Committee will communicate with the provider in question to understand the financial impact and develop plans for corrective action.

The Sisters of Charity Hospital Finance Office will provide regular reporting to the Finance Governance Committee, CMP PMO, Executive Governance Body and network partners as appropriate regarding the financial health of the CPWNY PPS and updates regarding the Financially

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Fragile Watch List and the Distressed Provider Plan.

IPQR Module 3.9 - IA Monitoring

Instructions :

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Section 04 – Cultural Competency & Health Literacy

IPQR Module 4.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize cultural competency / health literacy strategy.	Completed	This milestone must be completed by 12/31/2015. Cultural competency / health literacy strategy signed off by PPS Board. The strategy should: -- Identify priority groups experiencing health disparities (based on your CNA and other analyses); -- Identify key factors to improve access to quality primary, behavioral health, and preventive health care -- Define plans for two-way communication with the population and community groups through specific community forums -- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors); and -- Identify community-based interventions to reduce health disparities and improve outcomes.	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	YES
Task Step 1….Analysis of health disparities based on the Community needs assessment as well as CMP Disparities NCQA ACO documentation submitted January 2015.	Completed	Step 1….Analysis of health disparities based on the Community needs assessment as well as CMP Disparities NCQA ACO documentation submitted January 2015.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2…Prioritize populations based on Step 1. Utilize MIX to ascertain strategies that work or havent worked for organizations: Use either CAHPS or HCAHPS as an indicator of success.	Completed	Step 2…Prioritize populations based on Step 1. Utilize MIX to ascertain strategies that work or havent worked for organizations: Use either CAHPS or HCAHPS as an indicator of success.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 3…Perform inventory of all partners on what is currently in place to address cultural diversity and health literacy.	Completed	Step 3…Perform inventory of all partners on what is currently in place to address cultural diversity and health literacy.	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task Step 4…Develop registries in performing provider systems that identify race, ethnicity, sex, primary language, disability status, gender identity, and housing status of the beneficiaries they serve	Completed	Step 4…Develop registries in performing provider systems that identify race, ethnicity, sex, primary language, disability status, gender identity, and housing status of the beneficiaries they serve	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task Step 5…Compare results in registries to the Community Needs Assessment and prioritize partners with largest volume of impacted population	Completed	Step 5…Compare results in registries to the Community Needs Assessment and prioritize partners with largest volume of impacted population	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task Step 6…Perform a survey of those providers on their comfort level working with diverse population and their identified educational needs. (This is a collaborative effort with the overlapping PPS and our P2 collaborative (PHIPS grant recipient)	Completed	Step 6…Perform a survey of those providers on their comfort level working with diverse population and their identified educational needs. (This is a collaborative effort with the overlapping PPS and our P2 collaborative (PHIPS grant recipient)	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task Step 7…Link patients with providers of cultural and ethnic similarities to assist in improvement of preventive measures	Completed	Step 7…Link patients with providers of cultural and ethnic similarities to assist in improvement of preventive measures	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task Step 8…Ensure open access at PCMH offices patients are linked with and work with patients that have identified transportation issues	Completed	Step 8…Ensure open access at PCMH offices patients are linked with and work with patients that have identified transportation issues	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task Step 9…Implement cultural diversity , health literacy focus group in each county for input by the community to assist in strategies (contract with CBO - International Institute and Urban League do conduct)	Completed	Step 9…Implement cultural diversity , health literacy focus groups in each county for input by the community to assist in strategies (contract with CBO - International Institute and Urban League do conduct)	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 10…Distribution of findings from Step 6 to our providers and on our website.	Completed	Step 10…Distribution of findings from Step 6 to our providers and on our website.	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task Step 11…Policy and procedure on performing a cultural competence assessment in each patient care setting, inclusive of a health literacy detection system as well.	Completed	Step 11…Policy and procedure on performing a cultural competence assessment in each patient care setting, inclusive of a health literacy detection system as well.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 12….Designate a " gold standard" practice /factility in the network (based upon an audit , processes in place, satisfaction rates) for others to model from.	Completed	Step 12….Designate a " gold standard" practice /factility in the network (based upon an audit , processes in place, satisfaction rates) for others to model from.	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task Step 13…Promote all partners to have designated staff that have a passion and willingness to be "point " people that will provide outreach and creativity in their organization in order to close gaps for cultural differences and literacy.	Completed	Step 13…Promote all partners to have designated staff that have a passion and willingness to be "point " people that will provide outreach and creativity in their organization in order to close gaps for cultural differences and literacy.	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task Step 14…Based on assessment determine needs of each partner for improvement such as in communication skills of teach back, working with interpreters, etc. Inform the partners of the resources	Completed	Step 14…Based on assessment determine needs of each partner for improvement such as in communication skills of teach back, working with interpreters, etc. Inform the partners of the resources	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task Step 15…Annual partner assessment and education as well as for new employees -- will be incorporated in policy-- will include compliance questions with non-discrimination laws to ensure accommodation of people of different races, ethnicities, disabilities, gender identities, languages they speak, and other dimensions of diversity.	Completed	Step 15…Annual partner assessment and education as well as for new employees -- will be incorporated in policy-- will include compliance questions with non-discrimination laws to ensure accommodation of people of different races, ethnicities, disabilities, gender identities, languages they speak, and other dimensions of diversity.	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task	Completed	Step 16…. Implement strategies, inclusive but not limited to ,	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 16…. Implement strategies, inclusive but not limited to , distribution of information regarding substance and alchohol abuse to partners in an effort to reduce social stigma		distribution of information regarding substance and alchohol abuse to partners in an effort to reduce social stigma							
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	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES
Task Step 1….Training strategy will be based on needs assessment of practices and the analysis performed in former milestone. The modules will correspond to the needs identified. Training modules are currently being developed and completed by DY2.Q1.	In Progress	Step 1….Training strategy will be based on needs assessment of practices and the analysis performed in former milestone. The modules will correspond to the needs identified. Training modules are currently being developed and completed by DY2.Q1.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 2…Modules being developed will include various media such as webinars, reading materials, formal training sessions, all based on survey identified needs in previous milestone , step 6.	In Progress	Step 2…Modules being developed will include various media such as webinars, reading materials, formal training sessions, all based on survey identified needs in previous milestone , step 6.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3…Module 1 = Health disparities: define race, culture, ethnicity, disparities; national and local patterns; acknowledge barriers to eliminating disparities; epidemiology of disparities, look for best practice, recognize disparities amenable to intervention	In Progress	Step 3…Module 1 = Health disparities: define race, culture, ethnicity, disparities; national and local patterns; acknowledge barriers to eliminating disparities; epidemiology of disparities, look for best practice, recognize disparities amenable to intervention	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4…Module 2 = Community Strategies: challenges of cross cultural comunication;	In Progress	Step 4…Module 2 = Community Strategies: challenges of cross cultural comunication; community based elements and resources to improve health status and general literacy skills;	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
community based elements and resources to improve health status and general literacy skills; community beliefs and health practices; methods to collaborate with communities to address needs (use focus groups; address social determinants.		community beliefs and health practices; methods to collaborate with communities to address needs (use focus groups; address social determinants.							
Task Step 5…Module 3= Bias and Stereotyping: identify how race and culture relate to health; identify potential provider bias and stereotyping (especially as it relates to stereotyping of substance use disorder, recovery and information about stigma) and including assumptions r/t health literacy; demonstrate strategies to address/reduce bias , with patient communication; strategies to reduce health professional bias.	In Progress	Step 5…Module 3= Bias and Stereotyping: identify how race and culture relate to health; identify potential provider bias and stereotyping (especially as it relates to stereotyping of substance use disorder, recovery and information about stigma) and including assumptions r/t health literacy; demonstrate strategies to address/reduce bias , with patient communication; strategies to reduce health professional bias.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6…Module 4 = Effective communication skills: respect patients cultural beliefs , health literacy and listen non-judgmentally; Use negotiating and problem solving skills in communication; practice a "universal precaution" approach with all patients (not assuming); elicit a cultural, social and medical history in the encounter interview; teach back method for health literacy	In Progress	Step 6…Module 4 = Effective communication skills: respect patients cultural beliefs , health literacy and listen non-judgmentally; Use negotiating and problem solving skills in communication; practice a "universal precaution" approach with all patients (not assuming); elicit a cultural, social and medical history in the encounter interview; teach back method for health literacy	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 7…Module 5 = Use of Interpreters: functions of an interpreter; effective ways of working with interpreter; demonstrate ability to orally communicate accurately and effectively in patients preferred language	In Progress	Step 7…Module 5 = Use of Interpreters: functions of an interpreter; effective ways of working with interpreter; demonstrate ability to orally communicate accurately and effectively in patients preferred language	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Step 8…Module 6 = Self Reflection and Culture of Health Professions: describe provider -patient	In Progress	Step 8…Module 6 = Self Reflection and Culture of Health Professions: describe provider -patient power balance; engage in reflection of own beliefs; use reflective practices in	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
power balance; engage in reflection of own beliefs; use reflective practices in patient care, address personal bias		patient care, address personal bias							
Task Step 9…Roll out specific initiatives in line with findings from office assessments in relation to the aforementioned modules in line with the needs of the community assessment.	In Progress	Step 9…Roll out specific initiatives in line with findings from office assessments in relation to the aforementioned modules in line with the needs of the community assessment.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 10..Evaluation will be based off of patient experience surveys and annual review and post tests.	In Progress	Step 10..Evaluation will be based off of patient experience surveys and annual review and post tests.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize cultural competency / health literacy strategy.	mdjohns	Meeting Materials	46_MDL0403_1_3_20160311113744_CCHL_remediation_submission_EGBminutes_12_09_2015.pdf	This is the copy of CPWNY's Governing Body minutes where the CPWNY cultural competency & health literacy strategy was approved. This document completes the remediation for CC/HL.	03/11/2016 11:37 AM
	mdjohns	Other	46_MDL0403_1_3_20160107123032_View_-_Criteria_Review_sheet_.pdf	Criteria Review Sheet, Milestone 1	01/07/2016 12:30 PM
	mdjohns	Other	46_MDL0403_1_3_20160107122906_View_-_self_management_forums.pdf	Self-Management fourms	01/07/2016 12:29 PM
	mdjohns	Training Documentation	46_MDL0403_1_3_20160107122804_View_-_CC.HL_Training_Materials_Template.pdf	Cultural Competency & Health Literacy Training Materials Template, Milestone 1	01/07/2016 12:28 PM
	mdjohns	Meeting Materials	46_MDL0403_1_3_20160107122704_View_-_Cultural_Competency_._Health_Literacy_Meeting_Schedule_Template.pdf	Cultural Competency & Health Literacy Meeting Schedule template, Milestone 1	01/07/2016 12:27 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	mdjohns	Other	46_MDL0403_1_3_20160107122542_View_-_Final_Approved_CPWNY_CC.HL_Strategy_Milestone_1.pdf	Cultural Competency& Health Literacy Strategy for Milestone 1	01/07/2016 12:25 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize cultural competency / health literacy strategy.	
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	

Milestone Review Status

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

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IPQR Module 4.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

• Lack of engagement by partners-- Mitigation: Progressive improvement plans for partners and meeting specific corrective action plans. Consider content experts in each county to push forth the initiative.
• Lack of patient engagement (affects all projects) -- Mitigation: Assess the specific partners, issues, barriers and strategize with focus groups on patient engagement. Utilize CBOs as health disparities research suggests that valid and reliable data are fundamental building blocks for identifying differences in care and developing targeted interventions to improve the quality of care delivered to specific population groups. (Hasnain-Wynia. R, Baker D, 2006)
• Training plan and assessments prove to be onerous to partners - Mitigation: Obtain feedback from PAC on an annual basis and prior to implementation. CPWNY will share the feedback with EGB and, if feasible, incorporate the changes. Changes will also be shared with focus groups as needed for their input.
• Since there are two PPSs in the area, there is going to be overlapping (or totally different) approaches to improvement initiatives for cultural competency and health literacy --this can cause provider overload and require a lot of resources for both PPSs. This will be mitigated by working with P2 Collaborative (PHIPS grant) and Millennium (other PPS) to provide a strategy that is unified, meaningful and successful for all counties and populations served.

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.)

• Dependencies: Physician engagement - if physicians find the new strategies onerous or not helpful in improving outcomes then this will negatively impact the effectiveness of the program.
• Interdependencies- IT system and performance reporting-- Need to be able to capture quality metrics by various diversity determinants (race, ethnicity, etc.) to see if there is an actual health care disparity between different populations---will collaborate with IT consultants or product vendors for solutions.
• Interdependencies - Partners agreeing on strategies to meet and exceed the needs of the at risk population-Will obtain feedback and assistance of Patient Advisory Committee.

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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
Director of Medical Policy	Patricia Podkulski	Develop policy and procedures
Director of Clinical Transformation	Sarah Cotter	Work with partners; data abstraction
Public relations advisor	Phil Pantano	Communication strategies
Director of Care Management	Peggy Smering	Provide case management strategies based on patients needs to enhance patient engagement
Senior VP of Mission	Bart Rodriguez	Provide a neutral and compassionate voice reflecting the beliefs and concerns of others to the team-ensures judgmental attitudes are checked at the door.
Health Information Program Manager	P2 Collaborative - Mistine Keis	Assist in formulating a program that will be sustained and cohesive in the communities involved
Director of DSRIP	Amy White-Storfer	Ensures that cultural competency and health literacy impacts all projects

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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		
Dr. Carlos Santos	DSRIP Medical Director	Ensure integrated delivery system
Cheryl Friedman	VP Care Management (project lead)	2.b.iii
Bruce Nisbet	Project Lead	3.a.i
Peggy Smering, Sarah Cotter	Project leads	3.b.i, 2.b.iv, 2.a.i
Julie Lulek, Aimee Gomlak	Program Coordinator NFP, Project lead	3.f.i
Dr. Christopher Kerr	Project lead	3.g.i
Urban League	CBO	Assist with training programs for community health workers and patient navigators
International Institute	CBO	Assist with surveys, training, expertise
Catholic Charities	CBO	Assist with expertise on immigrants and migrant workers.
Ken Housknect, Erica Boyce	Project Lead	4.a.i
Dr. Andrew Highland	Project Lead	4.b.i
External Stakeholders		
Mistine Keis and Glenda Meeks	P2 Collaborative PHIP grant managers	Assist PPS in improvement initiatives for cultural competency and health literacy
Faith based organizations in each county	CBO	Assist in representing health needs of immigrants and minority populations
Millennium PPS	Mary Craig	Work collaboratively for WNY improvement in cultural diversity

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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.

As patients receive care anywhere in the health system the preferences of the patient such as cultural needs, literacy needs, interpreter needs is communicated at any and all touch points in the system. Registries in the physician office will collect information pertinent to the patient cultural, linguistic and ethnic needs. EMR downloads of quality indicators could be broken down by the aforementioned identifiers to see if there are disparities win comparison to the Caucasian population. Crimson, a population health software program , will be able to monitor the PPS cultural make up. As we get to know our CBOs (abilities and buy in from people they are intended to serve) then we could link people, based on needs, to appropriate CBOs. Patient experience surveys would also have these identifiers so that a robust analysis can be performed. Health literacy would not be tracked but a universal precaution utilizing a teach back method of communication.

IPQR Module 4.8 - Progress Reporting

Instructions :

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

• Progress reporting will be conducted annually via the Project Management office to Clinical Governance Committee and EGB.

• Information sources: Complaint/grievance mechanisms should be provided to facilitate communication and problem resolution.

• Goals will be: to improve colorectal exams for the African American population, improve behavioral health provider engagement across all cultures and ethnicities, improve cardiac outcome measures for Hispanic and African American populations, decrease gaps in care (mammography, flu vaccine, colorectal screening, referral to cardiology specialist care), improved appointment attendance by all , increase in palliative care uptake by all cultures and ethnicities, improved patient experience survey outcomes for Hispanic, African American and Asian populations.

IPQR Module 4.9 - IA Monitoring

Instructions :

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Section 05 – IT Systems and Processes

IPQR Module 5.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	In Progress	Detailed IT current state assessment. Relevant QEs (RHIOs/HIEs) should be involved in performing this assessment.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task 1. Establish IT Governance and Charter - and committee members of PPS and Partners	Completed	1. Establish IT Governance and Charter - and committee members of PPS and Partners	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Conduct Readiness survey and current state assessment and gap analysis of EMRs and other technologies	In Progress	2. Conduct Readiness survey and current state assessment and gap analysis of EMRs and other technologies	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 3. Establish IT Project Implementation plan. Implementation Plan will be influenced by current state assessment and gap analysis. Project Manager to assist with foundational and ongoing activities.	In Progress	3. Establish IT Project Implementation plan. Implementation Plan will be influenced by current state assessment and gap analysis. Project Manager to assist with foundational and ongoing activities.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 4. CPWNY and Millennium PPS working together to perform assessment of partners to include:	In Progress	Assessment includes: a. Use of EMR, HIE and other information systems; b. data sharing capabilities; c readiness for connection to QE (RHIOs/HIE; Performance reporting capabiliies and modalities; dashboard and platforms for patient genreated data; future plans for IT integration; use of data security and confidenialty plans	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 5. Obtain funding through DSRIP planning	Completed	5. Obtain funding through DSRIP planning dollars for assessment to occur	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
dollars for assessment to occur									
Task 6. Share results of readiness survey with PPS partners	In Progress	6. Share results of readiness survey with PPS partners	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 7. Map future state needs from Project Implementation plan to readiness assessment to identify gaps. Roadmap of future needs will be a requirement in the current state assessment and gap analysis engagement.	In Progress	7. Map future state needs from Project Implementation plan to readiness assessment to identify gaps. Roadmap of future needs will be a requirement in the current state assessment and gap analysis engagement.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 8. Update and approve IT Project Implementation plan	In Progress	8. Update and approve IT Project Implementation plan	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 9. Evaluate current RHIO capabilities to fill identified gaps. HEALTHeLINK will be integrally involved in the current state assessment and gap analysis.	In Progress	9. Evaluate current RHIO capabilities to fill identified gaps. HEALTHeLINK will be integrally involved in the current state assessment and gap analysis.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Milestone #2 Develop an IT Change Management Strategy.	In Progress	IT change management strategy, signed off by PPS Board. The strategy should include: -- Your approach to governance of the change process; -- A communication plan to manage communication and involvement of all stakeholders, including users; -- An education and training plan; -- An impact / risk assessment for the entire IT change process; and -- Defined workflows for authorizing and implementing IT changes	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task 1. Impact/Risk assessment for change process	In Progress	1. Impact/Risk assessment for change process	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 2. Define IT change approval process	In Progress	2. Define IT change approval process	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 3. Publish standard/non-standard change processes	In Progress	3. Publish standard/non-standard change processes	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 4. Develop education and training plan for change processes/provide programs to mitigate	In Progress	4. Develop education and training plan for change processes/provide programs to mitigate risks to include: a. professional management of change as an integral	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
risks to include: a. professional management of change as an integral component in the success of every initiative; b. knowledge and expertise in the management and integration of technology, organizational change, and strategy , c. ensuring continuous communication with the end-user population throughout the change. Effectiveness of training and change management is measured by: speed of adoption by the PPS; ultimate utilization of the employees and proficiency of our change management implementation.		component in the success of every initiative; b. knowledge and expertise in the management and integration of technology, organizational change, and strategy , c. ensuring continuous communication with the end-user population throughout the change. Effectiveness of training and change management is measured by: speed of adoption by the PPS; ultimate utilization of the employees and proficiency of our change management implementation.							
Task 5. Develop Communication plan for change processes	In Progress	5. Develop Communication plan for change processes	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 6. Establish roles/responsibilities for change process	In Progress	6. Establish roles/responsibilities for change process	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 7. Identify workflows for change advisory board	In Progress	7. Identify workflows for change advisory board	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 8. Receive approval for change strategy from PPS Board	In Progress	8. Receive approval for change strategy from PPS Board	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 9. Develop oversight committee to govern change management	In Progress	9. Develop oversight committee to govern change management	04/01/2015	06/30/2016	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	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1	NO

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		all Medicaid providers within the PPS; contracts with all relevant CBOs including a BAA documenting the level of PHI to be shared and the purpose of this sharing).							
Task Development of Roadmap to include the following steps and will be approved and monitored by the IT Governance Committee:	In Progress	Development of Roadmap to include the following steps and will be approved and monitored by the IT Governance Committee:	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1	
Task 1. Establish Governance framework with overarching rules of the road for interoperability and clinical data sharing to include relevant health IT stakeholders, inclusive of compliance representation. Roadmap to be approved by the IT Governance Committee.	In Progress	1. Establish Governance framework with overarching rules of the road for interoperability and clinical data sharing to include relevant health IT stakeholders, inclusive of compliance representation. Roadmap to be approved by the IT Governance Committee.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 2. Current State Assessment of priorities for the development of technical standards, policies and implementation specifications that align with the partners and are business, clinical, cultural and regulatory supportive.	In Progress	2. Current State Assessment of priorities for the development of technical standards, policies and implementation specifications that align with the partners and are business, clinical, cultural and regulatory supportive.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 3. Data Exchange Agreements established in concert with Compliance, inclusive of DEAA 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)	In Progress	3. Data Exchange Agreements established in concert with Compliance, inclusive of DEAA 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	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task 4. Create data sharing policies where gaps have been identified in Step 2 and approve through the governance structure. Policies and procedures will need to be reviewed annually to meet the needs of an ever changing /evolving environment in health care.	In Progress	4. Create data sharing policies where gaps have been identified in Step 2 and approve through the governance structure. Policies and procedures will need to be reviewed annually to meet the needs of an ever changing /evolving environment in health care.	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4	
Task	In Progress	5 Establish monitoring of workflow design of policies and	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4	

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5 Establish monitoring of workflow design of policies and procedures to insure accuracy and integrity of data as well as insuring HIPAA compliance. Interoperability requires technical and policy conformance among networks, technical systems and their components.		procedures to insure accuracy and integrity of data as well as insuring HIPAA compliance. Interoperability requires technical and policy conformance among networks, technical systems and their components.							
Task 6. A training plan to support the successful implementation of new platforms and processes will include but not limited to policies, procedures, new platforms, compliance updates, data set composition, reports related to data, issues and concerns through a 2 way communication forum. Training will impact CPWNY partners, facilities, operational staff, professional staff.	In Progress	6. A training plan to support the successful implementation of new platforms and processes will include but not limited to policies, procedures, new platforms, compliance updates, data set composition, reports related to data, issues and concerns through a 2 way communication forum. Training will impact CPWNY partners, facilities, operational staff, professional staff.	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4	
Task 7. New Platform Installations will be supported through policies, procedures, training and communication	In Progress	7. New Platform Installations will be supported through policies, procedures, training and communication	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1	
Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	In Progress	PPS plan for engaging attributed members in Qualifying Entities, signed off by PPS Board. The plan should include your approach to outreach into culturally and linguistically isolated communities.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task 1. Data-IT Governance Committee responsible for implementing patient consent monitoring	In Progress	1. Data-IT Governance Committee responsible for implementing patient consent monitoring	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task a. Current state gap analysis and assessment . HEALTHeLINK to receive a file from the PPSs containing all the attributed Medicaid patients in WNY. HEALTHeLINK will match each to the HEALTHeLINK master patient index to identify by zip code and overall, the percent of Medicaid patients that have already completed a HEALTHeLINK consent form.	In Progress	a. Current state gap analysis and assessment . HEALTHeLINK to receive a file from the PPSs containing all the attributed Medicaid patients in WNY. HEALTHeLINK will match each to the HEALTHeLINK master patient index to identify by zip code and overall, the percent of Medicaid patients that have already completed a HEALTHeLINK consent form.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 2. Leverage RHIO (HEALTHeLINK) to engage	In Progress	2. Leverage RHIO (HEALTHeLINK) to engage attributed lives to consent. CPWNY will provide physician communication to	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	

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attributed lives to consent. CPWNY will provide physician communication to engage Medicaid Members to sign HEALTHeLINK consent be it letters, in office for example. RHIO consent to be translated in languages representative of the practice population.		engage Medicaid Members to sign HEALTHeLINK consent be it letters, in office for example. RHIO consent to be translated in languages representative of the practice population.							
Task a. Identify key Medicaid engagement points. Our strategy is to identify the PCPs and other first line care providers or care coordinators that are likely to engage the Medicaid patients at least once in DSRIP year one. This strategy will include all the EDs in WNY and leverage the clinical intervention staff being deployed by the PPS in these settings. By focusing the patient consent capture implementation efforts in these high volume front-line care settings, we expect to capture by the end of the first year, a high percentage of the Medicaid patients who have not already completed the HEALTHeLINK consent form. Combined with the HEALTHeLINK community-wide consent model, all PPS health care partners will have access to the vast majority of Medicaid patient's data via the SHIN-NY.	In Progress	a. Identify key Medicaid engagement points. Our strategy is to identify the PCPs and other first line care providers or care coordinators that are likely to engage the Medicaid patients at least once in DSRIP year one. This strategy will include all the EDs in WNY and leverage the clinical intervention staff being deployed by the PPS in these settings. By focusing the patient consent capture implementation efforts in these high volume front-line care settings, we expect to capture by the end of the first year, a high percentage of the Medicaid patients who have not already completed the HEALTHeLINK consent form. Combined with the HEALTHeLINK community-wide consent model, all PPS health care partners will have access to the vast majority of Medicaid patient's data via the SHIN-NY.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task b. Train key Medicaid engagement points. The PPS will determine the practice outreach priorities and plan and imbed HEALTHeLINK patient consent capture training and processes in those PPS efforts. This will align HEALTHeLINK consent and services training efforts with the PPS priorities and assure a coordinated outreach to PPS partners.	In Progress	b. Train key Medicaid engagement points. The PPS will determine the practice outreach priorities and plan and imbed HEALTHeLINK patient consent capture training and processes in those PPS efforts. This will align HEALTHeLINK consent and services training efforts with the PPS priorities and assure a coordinated outreach to PPS partners.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task c. Identify and train community based organizations in the HEALTHeLINK value message and consent capture. We will utilize	In Progress	c. Identify and train community based organizations in the HEALTHeLINK value message and consent capture. We will utilize the PPS patient outreach efforts via faith-based organizations and other community based entities to reach	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	

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the PPS patient outreach efforts via faith-based organizations and other community based entities to reach the linguistically and culturally isolated communities in WNY. HEALTHeLINK will provide direct training and support to the staff of these organizations such that the HEALTHeLINK value message is imbedded in their community messages and outreach and they have the ability to work with patients to make informed consent choices.		the linguistically and culturally isolated communities in WNY. HEALTHeLINK will provide direct training and support to the staff of these organizations such that the HEALTHeLINK value message is imbedded in their community messages and outreach and they have the ability to work with patients to make informed consent choices.							
Task 3. Data-IT Governance Committee to address cultural sensitivity issues identified in c.	In Progress	3. Data-IT Governance Committee to address cultural sensitivity issues identified in c.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task a. Prepare patient education material and consent form in multiple languages. We will identify the top five, non-English, first languages in the attributed patient population and provide translations in these languages of the patient consent form and patient educational material. Preliminarily, the top five, non-English languages spoken as a first language are: • Spanish • Karen • Arabic • Somali • Nepali This preliminary list is based on a paper by Subin Chung and Emily Riordan called "Immigrants, Refugees, and Languages Spoken in Buffalo," published October 2014. CPWNY will also reach out to practices and facilities for other languages that information may need to be translated to .	In Progress	a. Prepare patient education material and consent form in multiple languages. We will identify the top five, non-English, first languages in the attributed patient population and provide translations in these languages of the patient consent form and patient educational material. Preliminarily, the top five, non-English languages spoken as a first language are: • Spanish • Karen • Arabic • Somali • Nepali This preliminary list is based on a paper by Subin Chung and Emily Riordan called "Immigrants, Refugees, and Languages Spoken in Buffalo," published October 2014. CPWNY will also reach out to practices and facilities for other languages that information may need to be translated to .	04/01/2015	12/30/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 4. Quarterly reporting through the development of metrics for patient engagement to the executive committee and success as related to	In Progress	4. Quarterly reporting through the development of metrics for patient engagement to the executive committee and success as related to the engagement methods. HEALTHeLINK will provide to the PPS Data-IT Governance Committee monthly	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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the engagement methods. HEALTHeLINK will provide to the PPS Data-IT Governance Committee monthly reports by zip code indicating the percent of attributed Medicaid patients consented in that zip code and percent of total attributed Medicaid patients consented.		reports by zip code indicating the percent of attributed Medicaid patients consented in that zip code and percent of total attributed Medicaid patients consented.							
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	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task 1. Perform an assessment survey to analyze current security protocols and risks	In Progress	1. Perform an assessment survey to analyze current security protocols and risks	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 2. Define needs for PPS to access and establish protocols for protected data	In Progress	2. Define needs for PPS to access and establish protocols for protected data	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task a. Use existing PPS members security policies and process for PPS	In Progress	a. Use existing PPS members security policies and process for PPS	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 3. Establish Data use/collection/exchange policies	In Progress	3. Establish Data use/collection/exchange policies	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 4. Security Audit plan established; process on it's function created	In Progress	4. Security Audit plan established; process on it's function created	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 5. Identify security gaps and implement mitigation strategies (e.g., via surveys, testing, pilots, roll-outs)	In Progress	5. Identify security gaps and implement mitigation strategies (e.g., via surveys, testing, pilots, roll-outs)	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task 6. Receive PPS board approval for security plan	In Progress	6. Receive PPS board approval for security plan	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task 7. Create ongoing data security progress report to Data-IT Governance Committee	In Progress	7. Create ongoing data security progress report to Data-IT Governance Committee	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task 8. Regularly communicate security items (events,	In Progress	8. Regularly communicate security items (events, changes) to PPS partners	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	

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changes) to PPS partners									

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop a data security and confidentiality plan.	mdjohns	Templates	46_MDL0503_1_3_20160129082228_Community_Partners_of_Western_New_York_PPS_template_in_lieu_of_SSPs_FINALv4-update_2016-01-28.pdf	CPWNY narrative in lieu of the SSP workbooks.	01/29/2016 08:22 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	
Develop an IT Change Management Strategy.	
Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	
Develop a specific plan for engaging attributed members in Qualifying Entities	
Develop a data security and confidentiality plan.	Please see the attached narrative found in the CPWNY in lieu of workbooks document.

Milestone Review Status

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

NYS Confidentiality – High

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Milestone Review Status

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

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IPQR Module 5.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

All PPS members are coming from different backgrounds and at different levels of data exchange. Aligning those disparate environments will pose the PPS a great challenge. Mitigating this risk will require the standardization of population health/business intelligence tools, patient portals, clinical portals, care coordination platforms, and telehealth tools. There may be a lack of partner understanding of change control needs, which should be mitigated through regular communication and participation in workgroups. The Data Governance committee will have to monitor the risk of compliance with security policies. RHIO/SHIN-NY timelines may drive changes in implementation plans. Partners may be constrained fiscally in purchasing some of the tools required in the PPS; mitigation: CPWNY is actively working to secure grant funding to support IT capital needs.

Specific Initiatives (example):
1. The key Medicaid engagement points may not fully engage in the consent education and capture effort. Mitigation: Work with the PPS leadership to stress the criticality of patient consent capture and identify and address partner barriers to performing the capture of patient consent.
2. The speed and scale of the deployment to key Medicaid engagement points may exceed HEALTHeLINK's ability to support the effort. Mitigation: Consider funding an increase of staff to engage all the priority PPS partners for consent capture and utilization of HEALTHeLINK .
3. Consider funding an increase of staff to engage all the priority PPS partners for consent capture and utilization of HEALTHeLINK utilization. Mitigation: Consider funding temp staff to supplement partner organization staff to implement the consent education and capture.

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 development of new IT infrastructure is a crucial factor for many other work streams, but in particular clinical integration, population health management, and performance reporting. We will need to work closely with the financial group as well, to review available capital and operating dollars for all the PPS members. Additional personnel resources will also be required to manage, implement, and support the projects funded, depending heavily on the workforce strategy team.

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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
CIO (CMIO)	Dr. Michael Galang	Data-IT Governance, Strategy
Data-IT Governance Committee	Committee Membership	Oversight
Security and Infrastructure Lead	Pete Capelli	Security plan, Infrastructure plan
Data Lead	David Nielsen	Data exchange plan
PPS Partner Director	In process of hiring. Offer accepted.	Manage PPS Partner expectations
IT Project Manager	In process of hiring. Job description posted.	Progress reports, project portfolio
IT Applications/Platforms Project Manager	In process of hiring. Job description posted.	Application strategy
Behavioral Health Representation	Representative from Spectrum Human Services	Provide expertise for including sensitive information in IT integration

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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		
Practitioner champions	Interface between IT and end-users	System design input
Chief Compliance Officer	Approver	Data Security Plan
Clinical/Quality Governance Committee	Approver	Clinical/Quality Plan
Finance Governance Committee	Approver	Capital and Operating Budget Plans
External Stakeholders		
HEALTHeLINK	RHIO Lead	RHIO Integration
EMR Partner(s)	EMR Vendor(s) Mgmt Team	EMR integration
NY DOH	Sponsor	Oversight and Funding
Health Plan Partners	Data Source	Provide Data

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IPQR Module 5.7 - Progress Reporting

Instructions :

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

To be determined by the Data/IT Governance Committee. PMO office will utilize a PMO tool to rack deliverables and will be accessible to the lead of the IT work stream. It is perceived that regular reports will be given by the sub-groups on deliverables and key performance indicators. These reports should be given on a monthly basis at a minimum, and should include the following highlights:
- Tracking to the IT Strategic and Implementation Plans
- Documentation of process and workflow demonstrating EHR and other clinical integration platform implementations across PPS partners
- MU and PCMH tracking for PPS
- Documentation of patient engagement
- Evidence of use of telemedicine and/or other remote monitoring tools
-Evidence of specific clinical workflow implementation

IPQR Module 5.8 - IA Monitoring

Instructions :

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Section 06 – Performance Reporting

IPQR Module 6.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Establish reporting structure for PPS-wide performance reporting and communication.	In Progress	Performance reporting and communications strategy, signed off by PPS Board. This should include: -- The identification of individuals responsible for clinical and financial outcomes of specific patient pathways; -- Your plans for the creation and use of clinical quality & performance dashboards -- Your approach to Rapid Cycle Evaluation	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	NO
Task 1. Identify individuals ultimately responsible for clinical and financial outcomes of specific projects. These individuals will be held accountable for the realization and continuous improvement needed for the success of the projects.	Completed	1. Identify individuals ultimately responsible for clinical and financial outcomes of specific projects. These individuals will be held accountable for the realization and continuous improvement needed for the success of the projects.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Establish process for communicating state provided data accessed through the MAPP tool to partners through existing templates and excel files as an interim solution until data can be integrated. Initiate development of CPWNY Performance Measurement System	Completed	2. Establish process for communicating state provided data accessed through the MAPP tool to partners through existing templates and excel files as an interim solution until data can be integrated. Initiate development of CPWNY Performance Measurement System	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3. Develop a CPWNY-wide policy and procedure to integrate data from various sources: Claims from health plans and salient data from MAPP tool; encounter data /EMR; RX claims, Lab data; cost data; HIE inclusive of oversight of the data	Completed	3. Develop a CPWNY-wide policy and procedure to integrate data from various sources: Claims from health plans and salient data from MAPP tool; encounter data /EMR; RX claims, Lab data; cost data; HIE inclusive of oversight of the data	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task 4. Finalize arrangements with the Managed Care Organizations for the exchange of key information	Completed	4. Finalize arrangements with the Managed Care Organizations for the exchange of key information	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5. Develop a PPS wide Performance Measurement plan for process measures that support the projects and work streams, thereby driving outcomes	Completed	5. Develop a PPS wide Performance Measurement plan for process measures that support the projects and work streams, thereby driving outcomes	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 6. Purchase/create Project Management Tool to track all process and outcome measures internally along with due dates and people responsible.	Completed	6. Purchase/create Project Management Tool to track all process and outcome measures internally along with due dates and people responsible.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 7. Develop a CPWNY-wide roll out procedure /timeline for dissemination of data to providers Create plan and timeline for collection of data for each of the metrics across the DSRIP Projects, including who is responsible collecting and analyzing the data, where/how is the data going to be collected, frequency of collection, frequency of feedback to partners on performance.	Completed	7. Develop a CPWNY-wide roll out procedure /timeline for dissemination of data to providers Create plan and timeline for collection of data for each of the metrics across the DSRIP Projects, including who is responsible collecting and analyzing the data, where/how is the data going to be collected, frequency of collection, frequency of feedback to partners on performance.	06/30/2015	12/30/2015	06/30/2015	12/30/2015	12/31/2015	DY1 Q3	
Task 8. Develop Rapid Cycle Evaluation strategy to include roll out by existing PCMH practices, those up for renewal, then those providers new to PCMH. Will include care management advisors, physician champions and clinical transformation specialists in performing training at site visits as well as WebEx. See in-depth strategy in performance reporting culture for training.	Completed	8. Develop Rapid Cycle Evaluation strategy to include roll out by existing PCMH practices, those up for renewal, then those providers new to PCMH. Will include care management advisors, physician champions and clinical transformation specialists in performing training at site visits as well as WebEx. See in-depth strategy in performance reporting culture for training.	06/30/2015	12/30/2015	06/30/2015	12/30/2015	12/31/2015	DY1 Q3	
Task 9. Develop an assessment strategy and perform assessment of EMR capabilities of partners - which EMR's care report on what metrics, what	In Progress	9. Develop an assessment strategy and perform assessment of EMR capabilities of partners - which EMR's care report on what metrics, what EMRs will be barriers to reporting	06/30/2015	03/30/2016	06/30/2015	03/30/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
EMRs will be barriers to reporting									
Task 10. Develop assessment of data to be utilized for performance dashboards. Review current clinical quality and performance dashboards from across community partners. Review and verify metrics across the DSRIP projects and create a dashboard(s) for performance improvement, inclusive of health plan quality metrics (MAPP salient data), EMR data, claims , CAHPS.	In Progress	10. Develop assessment of data to be utilized for performance dashboards. Review current clinical quality and performance dashboards from across community partners. Review and verify metrics across the DSRIP projects and create a dashboard(s) for performance improvement, inclusive of health plan quality metrics (MAPP salient data), EMR data, claims , CAHPS.	06/30/2015	03/30/2016	06/30/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 11. Create plan and timeline for collection and communication of data (performance reporting plan) for each of the metrics across the DSRIP Projects, including who is responsible collecting and analyzing the data, where/how is the data going to be collected, frequency of collection, frequency of feedback to partners on performance.	In Progress	11. Create plan and timeline for collection and communication of data (performance reporting plan) for each of the metrics across the DSRIP Projects, including who is responsible collecting and analyzing the data, where/how is the data going to be collected, frequency of collection, frequency of feedback to partners on performance.	06/30/2015	03/30/2016	06/30/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 12. Review and approval of performance reporting plan by Clinical Governance Committee and reporting to Executive Governance.	In Progress	12. Review and approval of performance reporting plan by Clinical Governance Committee and reporting to Executive Governance.	12/30/2015	03/30/2016	12/30/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 13. Develop a training plan to partners on Rapid Cycle Evaluation- strategy is roll out by existing PCMH practices, those up for renewal, then those providers new to PCMH. Will include care management advisors , physician champions and clinical transformation specialists in performing training at site visits as well as WebEx. See in-depth strategy in performance reporting culture.	In Progress	13. Develop a training plan to partners on Rapid Cycle Evaluation- strategy is roll out by existing PCMH practices, those up for renewal, then those providers new to PCMH. Will include care management advisors , physician champions and clinical transformation specialists in performing training at site visits as well as WebEx. See in-depth strategy in performance reporting culture.	06/30/2015	03/30/2016	06/30/2015	03/30/2016	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.	06/30/2015	03/30/2016	06/30/2015	03/30/2016	03/31/2016	DY1 Q4	NO
Task	Completed	1. Assess partners for what type of training has already	06/30/2015	12/30/2015	06/30/2015	12/30/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
1. Assess partners for what type of training has already occurred		occurred							
Task 2. Assess training capacity, particularly at program levels, to sustain quality and performance initiatives. Evaluate need for " train the trainers" or a designated Partners QA point person--depending on capacity. Currently CMP employes staff that have been trained n PDSA and also are PCMH certified trainers. They will impart RCE method beyond practitioners to include system navigators, care coordinators, and similar boundary spanners.	In Progress	2. Assess training capacity, particularly at program levels, to sustain quality and performance initiatives. Evaluate need for " train the trainers" or a designated Partners QA point person--depending on capacity. Currently CMP employes staff that have been trained n PDSA and also are PCMH certified trainers. They will impart RCE method beyond practitioners to include system navigators, care coordinators, and similar boundary spanners.	06/30/2015	03/30/2016	06/30/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 3. Create a plan for when we identify practices, partners or physicians who are in need of performance improvement on one or more measures. This plan will include rapid cycle evaluation (PDSA model), and other intervention opportunities including the use of regional physician leads/Medical Directors (currently in place at CMP) additional educational opportunities, shifting of performance dollars to create a culture of performance improvement	Completed	3. Create a plan for when we identify practices, partners or physicians who are in need of performance improvement on one or more measures. This plan will include rapid cycle evaluation (PDSA model), and other intervention opportunities including the use of regional physician leads/Medical Directors (currently in place at CMP) additional educational opportunities, shifting of performance dollars to create a culture of performance improvement	06/30/2015	12/30/2015	06/30/2015	12/30/2015	12/31/2015	DY1 Q3	
Task 4. Develop training content (see step 5)including Rapid Cycle Evaluation techniques. Insure that the training plan includes SUD services and is across the continuum of care, across service types and modalities.	Completed	4. Develop training content (see step 5)including Rapid Cycle Evaluation techniques. Insure that the training plan includes SUD services and is across the continuum of care, across service types and modalities.	06/30/2015	12/30/2015	06/30/2015	12/30/2015	12/31/2015	DY1 Q3	
Task 5. RCE method will include videos: https://www.youtube.com/watch?v=_-ceS9Ta820&feature=youtu.be and https://www.youtube.com/watch?v=eYoJxjmv_QI&feature=relmfu Teaching Procedure/Instructional Events (PLAN) 1. The educator will explain that the purpose for	In Progress	5. RCE method will include videos: https://www.youtube.com/watch?v=_-ceS9Ta820&feature=youtu.be and https://www.youtube.com/watch?v=eYoJxjmv_QI&feature=relmfu Teaching Procedure/Instructional Events (PLAN) 1. The educator will explain that the purpose for today's session is to come up with a goal or "aim" to use for	06/30/2015	03/30/2016	06/30/2015	03/30/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
today's session is to come up with a goal or "aim" to use for improvement in the office. 2. The educator will distribute a packet of information to representatives from the practice reflecting current measures in that practice. 3. The participants will be asked to examine their data as a group. 4. The participants will be asked to select one area for improvement based on the data that they have just examined. This will include a demographic population, and area for improvement within that population. 5. The educator will lead a group discussion where he/she will ask each group "what is your aim?" 6. The educator will then ask each group what data they used to reach their aim. 7. The educator will finally ask how they believe that aim will reduce unnecessary costs in the practice 8. The educator will explain that for the next [time period] the practice will record and examine the data in their aim.		improvement in the office. 2. The educator will distribute a packet of information to representatives from the practice reflecting current measures in that practice. 3. The participants will be asked to examine their data as a group. 4. The participants will be asked to select one area for improvement based on the data that they have just examined. This will include a demographic population, and area for improvement within that population. 5. The educator will lead a group discussion where he/she will ask each group "what is your aim?" 6. The educator will then ask each group what data they used to reach their aim. 7. The educator will finally ask how they believe that aim will reduce unnecessary costs in the practice 8. The educator will explain that for the next [time period] the practice will record and examine the data in their aim.							
Task Roll out of RCE method will start with a refresher for practices that have undergone this training from CMP and then for new practices and organizations in the PPS.(practices that currently have PCMH must have quality plans in place)	In Progress	Roll out of RCE method will start with a refresher for practices that have undergone this training from CMP and then for new practices and organizations in the PPS.(practices that currently have PCMH must have quality plans in place)	06/30/2015	03/30/2016	06/30/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Consideration of high volume Medicaid practices as priority implementation.	Completed	Consideration of high volume Medicaid practices as priority implementation.	06/30/2015	12/30/2015	06/30/2015	12/30/2015	12/31/2015	DY1 Q3	
Task 4. Initiate the scheduling of performance reporting and RCE training in various venues (WebEx, in-person, group sessions, conference calls)	Completed	4. Initiate the scheduling of performance reporting and RCE training in various venues (WebEx, in-person, group sessions, conference calls)	06/30/2015	12/30/2015	06/30/2015	12/30/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task 5. Plan for assessing training outcomes - ex: successful cooperation in reporting results and PDSA applied to improve results, quality improvement plans reflecting utilization of the PDSA.	Completed	5. Plan for assessing training outcomes - ex: successful cooperation in reporting results and PDSA applied to improve results, quality improvement plans reflecting utilization of the PDSA.	06/30/2015	12/30/2015	06/30/2015	12/30/2015	12/31/2015	DY1 Q3	
Task 6. Roll out training for performance reporting and performance improvement	In Progress	6. Roll out training for performance reporting and performance improvement	06/30/2015	03/30/2016	06/30/2015	03/30/2016	03/31/2016	DY1 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish reporting structure for PPS-wide performance reporting and communication.	
Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	

Milestone Review Status

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

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IPQR Module 6.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

The main risks and challenges include: 1. software/EMR barriers to obtain the information in a consistent manner so that performance reporting is able to be compared and improved upon. This can be a vendor engagement issue, a lack of IT, or an IT system that is lacking in certain capabilities. 2. lack of provider or practice/hospital staff engagement ; These 2 risks and challenges can impact all projects as we want to follow all Medicaid patients, regardless of attribution, to insure they are engaged and involved in the programs offered to the best of our abilities. If provider is engaged then resources that the PPS offers will be utilized to engage patients. If providers are not engaged then we will need to do provider performance remediation through the Clinical Governance committee and Executive Board as well as forming a peer group to address the issues. The peer group may be in the form of an actual committee or singular providers who make outreach visits to assist the providers needing engagement enhancement. Can also provide success stories on the PPS website. Another challenge is skill set of staff being asked to implement some of these performance improvement interventions. With the training and educational sessions we hope to mitigate this risk. Lack of provider engagement may evolve if the provider is in more than one PPS - this can be mitigated with a team approach by CPWNY and other area PPSs - our medical directors have already begun discussion regarding this and will plan a coordinated effort on " who is working with whom" and provide reciprocal updates.

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 success of performance reporting work stream is dependent on the Governance work stream and the expectations of leadership. A culture of accountability emanates from the governance structure of CPWNY. For performance improvement and reporting the entire system is interdependent on IT systems and processes: If the IT systems are not able to provide the data needed to evaluate performance on a timely and reliable manner, the process and engagement will be weakened as well as the ability to financially reward or hold partners accountable for their performance. Through our experiences we will develop ways to have partners, providers report on data in different formats on common metrics to mitigate other dependencies. We are ensuring through education of office staff (Workforce Strategy work stream) that providers documentation is standardized and queryable. Successful performance reporting is a representation of data integration capabilities and of effective policies and procedures of CPWNY. Practitioner Engagement impacts performance as well as it is a crucial dependency for the performance reporting culture. Clinical Integration work stream is the goal that Performance Reporting, Practitioner Engagement, IT systems and Workforce revolves around.

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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
Director of Clinical Transformation	Sarah Cotter-CMP	Involved in performing EMR assessments, data abstraction plan, training program and RCE
Director of Care Management	Peggy Smering - CMP	Involved in training/education development, RCE and patient/provider engagement opportunities
Director of Information Technology	David Nielsen	Data abstraction plan, and data analytics
Director of Medical Policies and Accreditations	Patricia Podkulski	Policies and procedures
Clinical and quality Governance Committee	Carlos Santos, MD	Oversight of performance and reporting
Project teams	Team members	Responsible for the successful project implementation -- will be insuring data received is evaluated and reflective of accurate performance
Finance Governance Committee	J. Dunlop, M. Osborne, B. Stelmach,	Responsible for the successful project implementation -- will be insuring data received is evaluated and reflective of accurate performance
Practitioner Territory Leads	Dr DeGraves, Dr. Stehlik, Dr Laurie, Dr Martinke and another for Chautauqua county	Work with improving practitioner engagement, and EMR content experts.

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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		
Catholic Health System	Leadership role	Lead partners, provide support
Catholic Medical Partners	Leadership role	Serve as project management office for CPWNY
Partner Hospitals	Participatory role	Promote involvement of providers and provide data for integration by PPS
Partner IT departments	Data aggregator and integrator	Tech support, implementation of systems to enable reporting
Executive Governing Board	Accountability for PPS success	Ultimately responsible for the direction of the PPS as it pertains to quality outcomes and reporting initiatives
Physician Practices	Partners	Utilize EBM and drive performance
External Stakeholders		
HEALTHeLINK	data provider and integrator	Provide patient data from non partners as well as partners
Crimson	vendor	Provides data integration and population health tools
DOH	Data provider	Provides claims information and also desires to improve care for Medicaid population
Managed Care Organizations	Contracting and supply data	Supply PPS with data on Medicaid enrollees and metrics needing
Medicaid enrollees	engagement of enrollee impacts performance reporting	Engagement and improved metrics

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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.

The overarching goal is an integrated delivery system functioning in a data-driven paradigm through which the highest quality care is provided to patients in the most cost-effective setting with a focus on prevention and maintenance of health care. The specific challenge and considerations are the assessment of all partners and what systems are currently capable of reporting, consistency based on data definitions of the reporting, integration of patient information across the continuum of care and being able to abstract the information to produce meaningful reports (utilization, satisfaction , quality outcomes , inclusive of cultural ,language and ethnic impact). Data will need to be collated from claims (Salient and managed care data) and the EMR. The most challenging will be from all other levels of care such as tertiary, nursing homes, etc. The goal also includes ongoing optimization of utilization at all levels of care to avoid unnecessary and redundant services. Care management and coordination will be the primary drivers of IT . Performance measures of reductions in ER and inpatient utilization and increase quality measure performance for outpatient measures will be the goals to strive to reflecting the impact of effective care management and coordination of care.

IPQR Module 6.8 - Progress Reporting

Instructions :

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

The purpose of performance measurement is to make progress toward specific objectives that support an organization's overarching goals. First we need to evaluate organizational priorities. CPWNY will need to align our organizational goals; demonstrate a relationship to positive health outcomes; determine what is under the control of the health care system; that the results are valid and reliable ; demonstrate a relationship to positive health outcomes. Using a mix of structural, process, and outcome measures CPWNY will provide a comprehensive picture of our organization's health care quality. Outcome measures are essential because they show direct impact on patient health. Structural and process measures can be used in cases where outcome measures are not available or feasible. We will use these measures to identify the challenges in our organization in achieving optimum patient outcomes.
Initially, measures will use data that our PPS already collects or could collect using existing resources. Once the measurement process is more advanced, we will utilize additional resources necessary to capture data for additional performance measurement. These data will help determine whether a change we make is actually contributing to an improvement. The adjustment in data gathering and processing will be made using the Rapid Cycle Evaluation method.
Success will be measured by the process measure achievement, clinical quality outcomes, and adherence to projected performance reporting timeframes. Reports will be generated that indicate individual practitioner's and group practice's performance, compared to baselines and benchmarks, and to encourage peer to peer motivation. CPWNY will continue to measure performance, to assess the impact of reporting standards, and to make sure they don't result in unintended consequences such as under utilization.

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IPQR Module 6.9 - IA Monitoring

Instructions :

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Section 07 – Practitioner Engagement

IPQR Module 7.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop Practitioners communication and engagement plan.	In Progress	Practitioner communication and engagement plan. This should include: -- Your plans for creating PPS-wide professional groups / communities and their role in the PPS structure -- The development of standard performance reports to professional groups --The identification of profession / peer-group representatives for relevant governing bodies, including (but not limited to) Clinical Quality Committee	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	NO
Task Step 1…Development of CPWNY website with information to public and partner, utilize CMP website, which is a professional association	Completed	Step 1…Development of CPWNY website with information to public and partner, utilize CMP website, which is a professional association	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2…Appoint regional partner professional leads (physicians, nurse practitioners, etc.) to work with all the providers particularly those who are not currently engaged. We will utilize public relations tools that will be instrumental to educate and encourage participation of providers. CMP currently has this in place for Erie and Niagara county but will need to expand to Chautauqua.	Completed	Step 2…Appoint regional partner professional leads (physicians, nurse practitioners, etc.) to work with all the providers particularly those who are not currently engaged. We will utilize public relations tools that will be instrumental to educate and encourage participation of providers. CMP currently has this in place for Erie and Niagara county but will need to expand to Chautauqua.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3…Appoint representatives for relevant governing bodies such as the Clinical Governance Committee, with representatives of	Completed	Step 3…Appoint representatives for relevant governing bodies such as the Clinical Governance Committee, with representatives of CPWNY partners inclusive of such professions as quality, providers, community services, and	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
CPWNY partners inclusive of such professions as quality, providers, community services, and nursing.		nursing.							
Task Step 4…Draft a communication plan: 1. Utilize Clinical transformation specialists to obtain information from practices and partners that can be reported to the CGC and/ or Medical Director of DSRIP. 2. Create a policy and procedure for communication. 3. Open forum meetings for partners to attend, with an WebEx option.	Completed	Step 4…Draft a communication plan: 1. Utilize Clinical transformation specialists to obtain information from practices and partners that can be reported to the CGC and/ or Medical Director of DSRIP. 2. Create a policy and procedure for communication. 3. Open forum meetings for partners to attend, with an WebEx option.	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task Step 5… Develop a process for standard performance reports for professional groups utilizing key representatives for input and development, addressing who, what, when, where and why of standard performance reports.	In Progress	Step 5… Develop a process for standard performance reports for professional groups utilizing key representatives for input and development, addressing who, what, when, where and why of standard performance reports.	07/01/2015	03/30/2016	07/01/2015	03/30/2016	03/31/2016	DY1 Q4	
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	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task BROAD BASED TRAINING: Step 1…Provide DSRIP introductory brochure to all partners explaining who the PPS is, intent of the program, contacts, webpage, etc	Completed	BROAD BASED TRAINING: Step 1…Provide DSRIP introductory brochure to all partners explaining who the PPS is, intent of the program, contacts, webpage, etc	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task BROAD BASED TRAINING: Step 2… Overall "all Partner" meetings to be held , one introductory , one community wide with overlapping PPS, and semi annual (minimally) thereafter. Included in these meetings will be quality improvement activities and performance reporting. May be presented through PAC meetings as well.	Completed	BROAD BASED TRAINING: Step 2… Overall "all Partner" meetings to be held , one introductory , one community wide with overlapping PPS, and semi annual (minimally) thereafter. Included in these meetings will be quality improvement activities and performance reporting. May be presented through PAC meetings as well.	07/01/2015	12/30/2015	07/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task	Completed	PRACTITIONER and PROFESSIONAL GROUP trainings:	07/01/2015	12/30/2015	07/01/2015	12/30/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
PRACTITIONER and PROFESSIONAL GROUP trainings: Step 1… Development of education plan for Provider Territory leads focused on goals of DSRIP, CPWNY projects, and work streams with main themes such as care coordination, BEHAVIORAL HEALTH, value based payment, care management, and clinical integration. Training may be at offices, on WebEx, written materials		Step 1… Development of education plan for Provider Territory leads focused on goals of DSRIP, CPWNY projects, and work streams with main themes such as care coordination, BEHAVIORAL HEALTH, value based payment, care management, and clinical integration. Training may be at offices, on WebEx, written materials							
Task PRACTITIONER and PROFESSIONAL GROUP trainings: Step 2…Development of training for the trainers to assist regional provider territory leads in the dissemination of DSRIP. Training will be for the clinical transformation team and care management teams as they are subject matter experts in care transformation.	In Progress	PRACTITIONER and PROFESSIONAL GROUP trainings: Step 2…Development of training for the trainers to assist regional provider territory leads in the dissemination of DSRIP. Training will be for the clinical transformation team and care management teams as they are subject matter experts in care transformation.	10/01/2015	03/30/2016	10/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task PRACTITIONER and PROFESSIONAL GROUP trainings: Step 3…Leverage trainers and regional territory providers to implement DSRIP education plan that includes but not limited to the following topics: functions of clinical transformation team and enhanced care management team, core goals of CPWNY DSRIP projects, population health, resources available, roles of practitioners in the projects, services and support available to providers/practices to help them improve the efficiency of their operations, new lines of clinical accountability and the expectations around clinical integration, payment methodologies, IT and data sharing goals, and success stories. Education may be in the form of webinars, in person, telephone conference calls to the convenience of the audience.	In Progress	PRACTITIONER and PROFESSIONAL GROUP trainings: Step 3…Leverage trainers and regional territory providers to implement DSRIP education plan that includes but not limited to the following topics: functions of clinical transformation team and enhanced care management team, core goals of CPWNY DSRIP projects, population health, resources available, roles of practitioners in the projects, services and support available to providers/practices to help them improve the efficiency of their operations, new lines of clinical accountability and the expectations around clinical integration, payment methodologies, IT and data sharing goals, and success stories. Education may be in the form of webinars, in person, telephone conference calls to the convenience of the audience.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6...DSRIP training to partner providers	In Progress	Step 3...DSRIP training to partner providers completed	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
completed									
Task Step 7…Survey of participants of training/education in order to ascertain training outcomes and future training needs	In Progress	Step 7…Survey of participants of training/education in order to ascertain training outcomes and future training needs	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 8….Extension of Step 7 on an annual basis to provide continuing education throughout DSRIP process based on needs	In Progress	Step 8….Extension of Step 7 on an annual basis to provide continuing education throughout DSRIP process based on needs	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 9….Training offerings may occur as large PPS meeting, collaborative meetings with Millennium PPS, as webinars, organizational and as territory meetings.	In Progress	Step 9….Training offerings may occur as large PPS meeting, collaborative meetings with Millennium PPS, as webinars, organizational and as territory meetings.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

NYS Confidentiality – High

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Milestone Review Status

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

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IPQR Module 7.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

Communication across such a large group of disparate partners will be a challenge. Currently partners who are also members of Catholic Medical Partners have been engaged in the DSRIP program. Information has been provided at committee meetings, newsletters, and a website. There is practitioner participation at every committee. CPWNY has a communication team that will ensure roll out of timely communication. Another risk is that practitioners do not see the benefit of resources in the office. This will be mitigated by peer teams meetings with those practitioners to introduce and share their best practices. Practitioner engagement will also be defined in practitioners /partner agreements , which incorporates obligations and remediation/consequences for lack of engagement. Reliance on a web portal for the providers is another risk and may lead to subsequent "information overload". This aspect may be mitigated with periodic phone call outreach and office visits by the Clinical Transformation team, enhanced care managers, social workers. Every contact by CPWNY resource staff will be an opportunity to provide information and engage the provider as well as the office manager. CMP has had a great deal of success with office manager meetings to impart information and engage the providers-- this strategy will be adapted for DSRIP. There is also a risk of conflicting information from an overlapping PPSs. This will be mitigated and has already been discussed between the Medical Directors of the PPSs. The preliminary plan is to coordinate provider engagement activities so that providers are primarily engaged by just one of the overlapping PPSs. Funds flow formulas will be clearly communicated along with performance and reporting obligations to DSRIP partners to avoid the risk of any misunderstandings. This will be further mitigated by including the office managers in training sessions and a recorded webinar /telephone conferences for those needing more information as well as contact personnel in the DSRIP office. Currently CMP has trained personnel performing many of the aforementioned duties with minimal turnover. There will be a need to train more people to work with practices and providers for an aggressive roll out.

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 impacts the following work streams: clinical integration (if the practitioner is not engaged then all the policies and procedures as well as funding will not make a difference in patient care for the Medicaid population. There must be a common goal, a belief that one can make a difference and we can learn from each other on successes and failures); population health (to run reports and focus efforts on aspects of a population the practitioner must be engaged and see the need for succinct and accurate information); cultural competency and health literacy (If the practitioner is not engaged then they may not be concerned about failure to reach goals, which may be related to the inability to understand a population based on culture, language and ethnicity); governance (may impact practitioner engagement as it sets the tone for communication, motivation, purpose, and financial performance incentives); IT performance (lack of effective IT infrastructure will discourage practitioners and will be a barrier to DSRIP project achievement, as will low utilization of IT infrastructure and/or the failure to adopt IT tools).

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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
Executive Governance Board	Members	DSRIP project oversight
Clinical Governance Committee	Members	DSRIP project oversight
Medical Lead	Dr. Carlos Santos	Lead facilitator for practitioner engagement
Clinical Transformation	Sarah Cotter	Leads for practice transformation, communication and data gathering
Director DSRIP Projects	In process of hiring	Ensure projects are on task
Director IT and Health information	Dr. Michael Galang	Data integration
Care Management department	Peggy Smering	Work with practices and practitioners, impart information
Regional physician leads	Dr. Stehlik, Dr. DeGraves, Dr. Laurie, Dr. Martinke and Dr. Santos	Provide information and education to practices and practitioners regarding DSRIP program to encourage participation
Community based providers	Urban League, Evergreen, Calvary Food pantry, Catholic Charities etc	Provide information and education to practices and practitioners regarding DSRIP program to encourage participation and relationships with the CBO
Behavioral Health providers	Spectrum, Horizons	Provide information and education to practices regarding behavioral health services and relationships (colocation for example) DSRIP program to encourage participation

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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		
Internal stakeholders and External stakeholders	Strategy to engage key stakeholders will be conducted the project leads, the CBO liason, the territory leads and will include organizational meetings, town hall meetings, project specific meetings , webinars, surveys, phone conferences and face to face as well as contracts.	Engage key stakeholders.
Community Based Organizations	Supportive	Provide assistance to practitioners in meeting patient needs
All Providers	Need to become engaged in program	Work with patients and engage in determining the success of the projects
Safety Net providers	Need to become engaged in program	Work with patients and engage in determining the success of the projects
External Stakeholders		
P2 Collaborative	Support, rollout assistance	Practice transformation
NYS DOH	funding, guidance	Success in Medicaid management
Population-Medicaid	Targeted population	Engaged practitioner, engaged patient

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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.

Patient Information is fragmented by provider, payer and sites of service. There are multiple EMR' s utilized by the practitioners and different processes at each site of service in the PPS. The development of a strong IT infrastructure will integrate patient information and provide a comprehensive patient health record which will satisfy the need to provide practitioners with timely, accurate, complete patient information. This will provide a major sense of satisfaction for the provider and , in turn, promote engagement in the DSRIP program. We also expect there will be regional collaboration regarding IT integration solutions in the area of communication tools, care management records and data analytic reporting mechanisms (Crimson , GSI, etc.)

IPQR Module 7.8 - Progress Reporting

Instructions :

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

Practitioners' engagement success will be measured by: 1. The ability of the provider to work with their practice office staff and be involved as a team with delegated responsibilities as evidenced by results of provider surveys; 2. responses from patient experience surveys; 3. progress on assignments that are given by the Clinical Transformation team in attainment of PCMH; and 4. quality team formation within the office that is involved with performance reporting and rapid cycle evaluation (RCE). Progress reports will be a combination of anecdotal assessments by the Clinical Transformation team (completion of assignments by the practice), the Care Management team (effectiveness of managing the patient barriers to care) and the Regional Lead physicians (practitioner meetings) as well as results in quality outcome reports and patient experience surveys.

IPQR Module 7.9 - IA Monitoring

Instructions :

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Section 08 – Population Health Management

IPQR Module 8.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop population health management roadmap.	In Progress	Population health roadmap, signed off by PPS Board, including: -- The IT infrastructure required to support a population health management approach -- Your overarching plans for achieving PCMH 2014 Level 3 certification in relevant provider organizations --Defined priority target populations and define plans for addressing their health disparities.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task According to IHI Leadership Blog, March 19, 2014 (web accessed March 26, 2015) , Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group. Population medicine is the design, delivery, coordination, and payment of high-quality health care services to manage the Triple Aim for a population using the best resources we have available to us within the health care system. The efforts today such as the Accountable Care Organization, risk stratification methods, patient registries, Patient Centered Medical Home, and other models of team-based	In Progress	According to IHI Leadership Blog, March 19, 2014 (web accessed March 26, 2015) , Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group. Population medicine is the design, delivery, coordination, and payment of high-quality health care services to manage the Triple Aim for a population using the best resources we have available to us within the health care system. The efforts today such as the Accountable Care Organization, risk stratification methods, patient registries, Patient Centered Medical Home, and other models of team-based care are all part of a comprehensive approach to population medicine and population health. Step 1....CPWNY Population health management roadmap, based off of the Catholic Medical Partners ACO and inclusive	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
care are all part of a comprehensive approach to population medicine and population health. Step 1....CPWNY Population health management roadmap, based off of the Catholic Medical Partners ACO and inclusive of population medicine, includes the following actions:		of population medicine, includes the following actions:							
Task a. Analyze current status of EMR systems used, data available to supplement our MAPP tool, the status of meaningful use and status of PCMH in relevant provider organizations. Create a work plan and timelines for getting practices at Level 3 PCMH and MU to achieve both by year end DY3.	In Progress	a. Analyze current status of EMR systems used, data available to supplement our MAPP tool, the status of meaningful use and status of PCMH in relevant provider organizations. Create a work plan and timelines for getting practices at Level 3 PCMH and MU to achieve both by year end DY3.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task b. Assign each PCP practice a CPWNY clinical transformation specialist to work with them and be their point of contact on EMR, MU, PCMH, and Population Health/Quality Outcome Measures. CPWNY care management advisors (CMA) will also assess workforce capabilities to perform population health . CMA will be assigned to assist with high risk /challenging patients and mentor staff at offices.	In Progress	b. Assign each PCP practice a CPWNY clinical transformation specialist to work with them and be their point of contact on EMR, MU, PCMH, and Population Health/Quality Outcome Measures. CPWNY care management advisors (CMA) will also assess workforce capabilities to perform population health . CMA will be assigned to assist with high risk /challenging patients and mentor staff at offices.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task c. Complete a workforce assessment of provider practices care management capabilities , including staff skills and resources required to manage the key conditions identified in the population via registries.	In Progress	c. Complete a workforce assessment of provider practices care management capabilities , including staff skills and resources required to manage the key conditions identified in the population via registries.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task d. Adopt evidence based clinical practice guidelines and establish metrics for each clinical area to monitor progress in managing population health.	In Progress	d. Adopt evidence based clinical practice guidelines and establish metrics for each clinical area to monitor progress in managing population health.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task e. Incremental Approach to population health: Start with clinical data to prioritize patients within the key disease states at offices; build in claims	In Progress	e. Incremental Approach to population health: Start with clinical data to prioritize patients within the key disease states at offices; build in claims data to get holistic population view; use visits and partnerships to capture patient data; deploy	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
data to get holistic population view; use visits and partnerships to capture patient data; deploy team to fill in remaining data gaps on riskiest patients; incorporate social and behavioral risk factors into segmentation (refer to step 8) , prioritize pts by greatest benefit potential.		team to fill in remaining data gaps on riskiest patients; incorporate social and behavioral risk factors into segmentation (refer to step 8) , prioritize pts by greatest benefit potential.							
Task f. The targeted population is based on chronic condition prevalence from the community needs assessment population health data on behavioral health, cardiovascular conditions, high hospital utilizers and HCC scores > 1.1 (stratification methodology) , and those patients with social determinants and disparities as barriers to care. By including social determinants and disparities, population health is fluid and not restricted to a disease entity /condition but can focus on preventive care as well.	In Progress	f. The targeted population is based on chronic condition prevalence from the community needs assessment population health data on behavioral health, cardiovascular conditions, high hospital utilizers and HCC scores > 1.1 (stratification methodology) , and those patients with social determinants and disparities as barriers to care. By including social determinants and disparities, population health is fluid and not restricted to a disease entity /condition but can focus on preventive care as well.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task g. As registries are implemented, monitor integrity of data to be used to identify success of population health -Integrity includes but not limited to the following: are providers documenting in queryable fields, is the data pulling on patients based on data definitions, completeness of data.	In Progress	g. As registries are implemented, monitor integrity of data to be used to identify success of population health -Integrity includes but not limited to the following: are providers documenting in queryable fields, is the data pulling on patients based on data definitions, completeness of data.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task h. Develop registries so that data can be dissected to compare patient outcomes based on race, ethnicity and language to identify disparities thereby increasing provider awareness.	In Progress	h. Develop registries so that data can be dissected to compare patient outcomes based on race, ethnicity and language to identify disparities thereby increasing provider awareness.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task i. Crimson data warehouse and MedInsight rollout will enable CPWNY to use collected patient data (EMR, MAPP) to attribute patents and produce utilization and quality reports: will support identification and prioritization of improvement initiatives; identification of health	In Progress	i. Crimson data warehouse and MedInsight rollout will enable CPWNY to use collected patient data (EMR, MAPP) to attribute patents and produce utilization and quality reports: will support identification and prioritization of improvement initiatives; identification of health disparities and; will collate information into PPS registries that identify gaps in care and needed interventions, thereby creating dashboards for the	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
disparities and; will collate information into PPS registries that identify gaps in care and needed interventions, thereby creating dashboards for the PPS and providers to monitor.		PPS and providers to monitor.							
Task j. Identify and develop training programs needed to further develop practices for PCMH and attain PCMH, Meaningful Use and Population Health objectives.	In Progress	j. Identify and develop training programs needed to further develop practices for PCMH and attain PCMH, Meaningful Use and Population Health objectives.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 2…Approval of population roadmap by Clinical Governance Board	In Progress	Step 2…Approval of population roadmap by Clinical Governance Board	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Milestone #2 Finalize PPS-wide bed reduction plan.	In Progress	PPS Bed Reduction plan, signed off by PPS Board. This should set out your plan for bed reductions across your network, including behavioral health units/facilities, in line with planned reductions in avoidable admissions and the shift of activity from inpatient to outpatient settings.	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4	NO
Task Analyze creative use of inpatient beds such as increasing hospice or enhanced surgical lines	In Progress	Analyze creative use of inpatient beds such as increasing hospice or enhanced surgical lines	04/01/2015	12/30/2016	04/01/2015	12/30/2016	12/31/2016	DY2 Q3	
Task CPWNY Hospital partners have no intentions of reducing the certificate of bed occupancy levels.	On Hold	CPWNY Hospital partners have no intentions of reducing the certificate of bed occupancy levels.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

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Prescribed Milestones Narrative Text

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

Milestone Review Status

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

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IPQR Module 8.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

The key challenge (risk) for population health is practitioner practice engagement- PCMH and meaningful use require an office transformation that can be complex and challenging. By meeting PCMH and Meaningful use standards the practices will be positioned to provide evidence based care with open access. To mitigate challenges, a clinical transformation person will be assigned to the provider office to assist and to provide guidance and oversight to insure the PCMH/meaningful use standards are met. Trained workforce gaps may exist and pose a risk within the mitigation strategy but CMP (the project team for CPWNY) has a pool of competent and seasoned trained staff that can mentor new staff and close workforce gaps. Another risk is lack of patient engagement in population health --For those patients facing socioeconomic challenges CPWNY will provide social worker resources to create linkages and means to deliver the care needed. CPWNY will also provide the support of care managers assisted by community health workers. Another risk is the ability to transform the IT systems fast enough (EMR issues, report issues) so that the PPS has central information to guide task groups that guide practitioners. This will be mitigated by reverting to an office registry vs. a central registry until a central registry is available. This will enable population health management to succeed. Having overlapping PPSs in the area may create confusion for the providers and patients, particularly if mixed messages are being delivered. To mitigate this the Medical Directors from the overlapping PPSs have agreed to discuss strategies, have regular communication, and work in alignment with providers. The overlapping PPSs will have Crimson and are discussing utilizing GSI platform (communication tools, care management records and data analytic reporting mechanisms).

IPQR Module 8.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

Population health is dependent on IT Systems and processes (need a robust data gathering and integrator system), Practitioner Engagement (if providers are not engaged then there will be minimal patient engagement), Cultural Competency (need to consider barriers to patient care, lack of patient education, lack of empathy). If practitioners do not understand the patient or vice verse , inclusive of cultural beliefs, then no health improvement initiative can be realized. Clinical Integration is necessary as it centers on "the patient, the person" with information access to enhance the patient's health care experience as well as provide feedback to the provider and PPS on the impact of population health interventions. Performance reporting is a reciprocal dependency -- it demonstrates impact of possible successful population health strategies as well as reward the provider that he/she is "making a difference."

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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
Population Health Management Workstream Lead	Patricia Podkulski	Oversee the population health strategy and workstream and report to the Project Director CPWNY for EGB update
Clinical Transformation office	Sarah Cotter	Assess, analyze practices for PCMH and Meaningful use inclusive of resources, gaps, solutions, oversight, training
IT Team	David Nielsen, Dapeng Cao and Scott Kitchen	Integrate data and produce utilization reports by PPS, by Practice/provider, by institution for monitoring purposes and care management interventions
Care Management Team	Peggy Smering	Assist practices with care management strategies . This team has assignment of practices to teach, mentor staff working with patients and prevent practice burnout by prioritizing.

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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		
CPWNY project management office	Oversight of projects	Reporting , plans, polices
Community and Community Based orgs	Offer assistance in reducing social barriers	Work with the care management teams and practices
Hospitals and nursing homes represented on utilization monitoring team	bed reduction	Monitoring utilization with analysis.
Project Advisory Committee	peer and partner representation.	Provide guidance on Evidence Based guidelines , training and education materials.
Providers	Partners	Engage patients in population health activities
External Stakeholders		
Managed Care Organizations	Collaborator /sustainability	collaborate and provide resources to intervene in patient care
Department of Health	Collaborator	Provide opportunity to improve the care of the disadvantaged.
Patients	Impacted by population health	Become or remain engaged in their health care.

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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.

Population health management, to be effective, will require information systems, tools and processes to facilitate an operational integrated delivery system to facilitate transformation to a population health operating model. Care Management and coordination will be a primary driver for IT systems and processes implemented and optimized , thereby providing communication and access to clinical data to patients and clinicians in these roles from all service levels within the PPS. With this access and communication, patients and clinicians will be able to work collaboratively; clinicians will be able to detect at-risk patients for adverse health events, identify those missing appointments or other maintenance testing, and ensure timely ambulatory follow up care for patient receiving inpatient care. Our data & analytics team will be responsible for ensuring that practitioners have the data and the tools available to allow them to develop interventions and services that will address the wider determinants of population health for their local population. This effort will be facilitated by the use CPWNY MAPP PPS-specific Performance Measurement Portal, which will help our team monitor performance of both claims-based, non-hospital CAHPS DSRIP metrics and DSRIP population health metrics. The analysis of population-level outcome data will also be the basis for our assessment of the impact of population health management on the priority groups and clinical areas identified in our population health management roadmap (see above).

Our IT team will work with current RHIO(s), such as HEALTHeLINK, and leadership will encourage all partners to connect with the selected RHIO(s) to service their population. This effort will be conducted in tandem with the EHR platforms, care management, and population health management systems that we have already implemented, or are currently implementing.

IPQR Module 8.8 - Progress Reporting

Instructions :

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

Performance measures will be based on reductions in emergency and inpatient utilization, improved quality measure performance for outpatient measures, and the extensive collection of DSRIP metrics. CPWNY will monitor the impact of our population health management work stream through a combination of the DSRIP outcome measures and our own specific population health metrics, CMS ACO Metrics. These CPWNY - specific metrics will be identified in the population health roadmap and will be monitored by CPWNY and reported to the Clinical Governance Committee. We will build continuous quality improvement into the population health road map, establishing timeframes for the reevaluation of data sets, functionality of registries, and of our priority issues for population health management. Regional physician leads will play a role in identifying groups of providers that have been particularly successful in tackling the broader determinants of health and having a measurable impact on population health. These groups of providers will then become case studies to spread best practice throughout the CPWNY network.

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IPQR Module 8.9 - IA Monitoring

Instructions :

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Section 09 – Clinical Integration

IPQR Module 9.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform a clinical integration 'needs assessment'.	In Progress	Clinical integration 'needs assessment' document, signed off by the Clinical Quality Committee, including: -- Mapping the providers in the network and their requirements for clinical integration (including clinical providers, care management and other providers impacting on social determinants of health) -- Identifying key data points for shared access and the key interfaces that will have an impact on clinical integration -- Identify other potential mechanisms to be used for driving clinical integration	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1…Design a needs assessment (NA) document regarding alignment, population risk management, proactive patient care and referral management. NA will identify key data points for shared access and interfaces that impact on clinical integration. Utilizing URAC Clinical Integration Accreditation standards assess for the following:	In Progress	Step 1…Design a needs assessment (NA) document regarding alignment, population risk management, proactive patient care and referral management. NA will identify key data points for shared access and interfaces that impact on clinical integration. Utilizing URAC Clinical Integration Accreditation standards assess for the following:	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task a. Policy and written agreements that address the rights of clinically integrated provider (s) to resolve performance issues	In Progress	a. Policy and written agreements that address the rights of clinically integrated provider (s) to resolve performance issues	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task b. Required training of provider(s) is documented	In Progress	b. Required training of provider(s) is documented	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task c. Participating Provider Agreements (PPA)	In Progress	c. Participating Provider Agreements (PPA) addressing organizational expectations (clinical practice and evidence	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
addressing organizational expectations (clinical practice and evidence based guidelines, quality standards and care coordination programs, performance measurement and reporting procedures, contribution to core goals, non-compliance with performance standards, provider rights, dispute resolution, business associate requirements regarding confidentiality) in place		based guidelines, quality standards and care coordination programs, performance measurement and reporting procedures, contribution to core goals, non-compliance with performance standards, provider rights, dispute resolution, business associate requirements regarding confidentiality) in place							
Task d. Clinician led leadership team has established goals and outcomes that address foundational components for achieving clinical integration such as regulatory compliance with federal, state laws; performance reporting and monitoring for improved health care and cost; compensation plan for meeting metrics, periodic evaluation of meeting metrics	In Progress	d. Clinician led leadership team has established goals and outcomes that address foundational components for achieving clinical integration such as regulatory compliance with federal, state laws; performance reporting and monitoring for improved health care and cost; compensation plan for meeting metrics, periodic evaluation of meeting metrics	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task e. Health system capabilities to ensure implementation and support for essential components for shared access and interfaces for each project such as : provider communications, care collaboration , care transition and management, system usage by network providers, comparative reporting for provider performance (individual, practice), transition and usage plan regarding electronic health information systems, adoption of performance metrics and integration with providers (i.e. COB) impacting social determinants.	In Progress	e. Health system capabilities to ensure implementation and support for essential components for shared access and interfaces for each project such as : provider communications, care collaboration , care transition and management, system usage by network providers, comparative reporting for provider performance (individual, practice), transition and usage plan regarding electronic health information systems, adoption of performance metrics and integration with providers (i.e. COB) impacting social determinants.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task f. Written policies /procedures for clinical management that addresses : adoption of performance metrics, performance reporting , measuring actual provider performance against established benchmarks/goals, ensuring provider participation with care/case management programs, coordinating patient referrals,	In Progress	f. Written policies /procedures for clinical management that addresses : adoption of performance metrics, performance reporting , measuring actual provider performance against established benchmarks/goals, ensuring provider participation with care/case management programs, coordinating patient referrals, notification process for treatments provided to patients, establishing care /case management services criteria for patients.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
notification process for treatments provided to patients, establishing care /case management services criteria for patients.									
Task g. Population health program in place that addresses: criteria for individual assessments, care plans, health education, prevention and wellness and performance reporting.	In Progress	g. Population health program in place that addresses: criteria for individual assessments, care plans, health education, prevention and wellness and performance reporting.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task h. CPWNY has evidence-based clinical resources readily available for providers and staff	In Progress	h. CPWNY has evidence-based clinical resources readily available for providers and staff	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task i. CPWNY will annually measure, track, and document actual outcomes regarding provider access and availability to supply care according to policy/procedure	In Progress	i. CPWNY will annually measure, track, and document actual outcomes regarding provider access and availability to supply care according to policy/procedure	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task J. CPWNY has written polices/procedures that address requirements to participate with coordinating care such as appropriate utilization of services, care management, management of transition of care, case management//Utilize evidence based care transition program and perform a gap analysis of what is currently in place and what is needed to meet evidence based programs	In Progress	J. CPWNY has written polices/procedures that address requirements to participate with coordinating care such as appropriate utilization of services, care management, management of transition of care, case management//Utilize evidence based care transition program and perform a gap analysis of what is currently in place and what is needed to meet evidence based programs	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task k. CPWNY internally reports clinical and financial performance measures on an annual basis	In Progress	k. CPWNY internally reports clinical and financial performance measures on an annual basis	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task l. CPWNY has written policies/procedures that address requirements for appropriately sharing of performance data with key stakeholders.	In Progress	l. CPWNY has written policies/procedures that address requirements for appropriately sharing of performance data with key stakeholders.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task Step 2…Obtain approval of the Clinical Integration Needs Assessment from Clinical Governance Committee	In Progress	Step 2…Obtain approval of the Clinical Integration Needs Assessment from Clinical Governance Committee	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task	In Progress	Step 3… Needs assessment to be completed by CPWNY	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 3… Needs assessment to be completed by CPWNY Project Management team with key components of assessment tool assigned to accountable personnel with oversight by CPWNY medical director.		Project Management team with key components of assessment tool assigned to accountable personnel with oversight by CPWNY medical director.							
Milestone #2 Develop a Clinical Integration strategy.	In Progress	Clinical Integration Strategy, signed off by Clinical Quality Committee, including: -- Clinical and other info for sharing -- Data sharing systems and interoperability -- A specific Care Transitions Strategy, including: hospital admission and discharge coordination; and care transitions and coordination and communication among primary care, mental health and substance use providers -- Training for providers across settings (inc. ED, inpatient, outpatient) regarding clinical integration, tools and communication for coordination -- Training for operations staff on care coordination and communication tools	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Step 1…Create and implement referral agreements between partners, as needed	Completed	Step 1…Create and implement referral agreements between partners, as needed	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task Step 2…Create and execute partner agreements to facilitate clinical integration participation	Completed	Step 2…Create and execute partner agreements to facilitate clinical integration participation	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task Step 3…Involve representatives from partners on all CPWNY committees	Completed	Step 3…Involve representatives from partners on all CPWNY committees	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3	
Task Step 4… Categorize needs (similarities and unique) by projects for IT infrastructure and processes and define a mechanism for 2-way communication between providers and PPS.	In Progress	Step 4… Categorize needs (similarities and unique) by projects for IT infrastructure and processes and define a mechanism for 2-way communication between providers and PPS.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5.. Based on the needs assessment conducted, CPWNY will determine what the clinically integrated PPS will look like based on each DSRIP project , inclusive of workforce,	In Progress	Step 5.. Based on the needs assessment conducted, CPWNY will determine what the clinically integrated PPS will look like based on each DSRIP project , inclusive of workforce, technology and data. Identify barriers by practitioners, office, equipment, people, facilities from achieving the Clinically	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
technology and data. Identify barriers by practitioners, office, equipment, people, facilities from achieving the Clinically integrated PPS		integrated PPS							
Task Step 6… Prioritize roll out of closure of gaps based on needs assessment and develop steps between current state of IDS and desired state.	In Progress	Step 6… Prioritize roll out of closure of gaps based on needs assessment and develop steps between current state of IDS and desired state.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 7…Develop care transition strategy inclusive of Hospital admission and discharge coordination; care transitions coordination and communication among primary care, mental health, and substance abuse providers, utilization of CBOs and Health Homes.	In Progress	Step 7…Develop care transition strategy inclusive of Hospital admission and discharge coordination; care transitions coordination and communication among primary care, mental health, and substance abuse providers, utilization of CBOs and Health Homes.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 8… Develop training programs for providers and operational staff (ongoing training strategy) that includes: sharing of policies , care transitions process. (can be through multiple mediums such as web based, webinars, at offices in facilitated engagement) and communication tools.	In Progress	Step 8… Develop training programs for providers and operational staff (ongoing training strategy) that includes: sharing of policies , care transitions process. (can be through multiple mediums such as web based, webinars, at offices in facilitated engagement) and communication tools.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 9... Identify enhancements/incentives to encourage provider engagement based upon improvement of baseline metrics. CPWNY will need baseline metrics or goals from DOH to finalize CI plan)-This may be based on Data abstraction that will occur , according to specs table on page 8 , of the DSRIP Measure Specification and Reporting Manual, April 2, 2015 version	In Progress	Step 9... Identify enhancements/incentives to encourage provider engagement based upon improvement of baseline metrics. CPWNY will need baseline metrics or goals from DOH to finalize CI plan)-This may be based on Data abstraction that will occur , according to specs table on page 8 , of the DSRIP Measure Specification and Reporting Manual, April 2, 2015 version	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 10… Finalize the Clinical Integration Strategy by the Clinical Quality Committee. (Interim strategy will be based off of current health plan metrics)	In Progress	Step 10… Finalize the Clinical Integration Strategy by the Clinical Quality Committee. (Interim strategy will be based off of current health plan metrics)	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

Milestone Review Status

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

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IPQR Module 9.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

Major risks to Clinical Integration are: 1. Technology and connectivity - According to the Community Needs Assessment ,the level of enhanced communication and care management data sharing between primary care and specialists, mental health, health homes, community support agencies does not exist and the interoperability with hospitals and pharmacies needs to be enhanced. There are also gaps in data contributed to the HIE: data from outpatient practices, ED discharge reports, Hospital discharge reports not timely, Medication information not complete. An area that can improve some of this connectivity is the patient consent to participate in RHIO. To mitigate connectivity issues a variety of actions will take place: the provider influence on having the Patient sign consent for RHIO; the effectiveness of Crimson - the population health integrator tool; possibly hiring a consultant for solutions to barriers of data / patient information integration. 2. Workforce - According to the CNA there are already gaps in workforce such as dedicated staff in the practitioners office for care management duties, accessible behavioral health services, patient navigation gaps just to name a few. To mitigate the workforce issue the PPS will design accountable job descriptions and maximize the work performed by staff to alleviate practitioners with appropriate training lead by Catholic Medical Partners; 3. Practitioner engagement poses a risk to clinical integration related to workflow and need to accept change in the delivery of patient care in the office, the adoption of clinical protocols into everyday patient treatment and the maximization of EMR usage to facilitate communication flow. Practitioner engagement will be mitigated through the leadership of CPWNY, the participating provider agreement, resource incentives for practitioners and their offices and physician territory leads who will meet to engage practitioners; 4. Overlapping PPS poses a risk due to misalignment of providers and PPSs. This will create provider and partner confusion and wasted resources due to multiple PPSs engaging the same providers in project work. CPWNY will collaborate where possible to eliminate this risk.

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.)

Clinical integration has interdependencies with IT, Practitioner Engagement (as it relates to the leadership, contracts and participation criteria), Financial Sustainability (flow of funds) , Performance Reporting and Improvement. One of the key Clinical Integration responsibilities is to encourage success through a collective leadership model using a very collaborative and transparent approach. Therefore, critical to this effort will be the development and use of an integrated IT infrastructure that will provide timely, accurate and understandable information utilized by the EGB to monitor the progress of the DSRIP project. Information derived through the performance reporting work stream will also be dependent upon the IT system work stream. The degree of physician (partner) engagement will significantly impact the Clinical Integration work stream as well. The efforts of the partners at the patient "transaction" level is likely to be the indicator of overall success. Having partners who are committed to a collaborative model of population health / culture competency which will reduce duplicative care/services/disparities and encourage and increase in self-management, benefits of DSRIP may not be sustainable. Given the DSRIP expectations of change at the provider level, the re-structuring of

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reimbursement through a valid sustainable funds-flow model will also impact the ability of the Clinical Integration work stream success. Financial support will be required to enable transformation to a new reimbursement model. With the expectation of transformational change within the delivery system, the strategy related to the workforce will also need to be consistently evaluated as part of the governance' responsibilities. Stakeholders in this area (e.g. both union & non-unionized labor-forces) will need to be informed of the strategic expectations of DSRIP and the workforce implications that will result. Consistent open communication between governance and the partners regarding clinical integration and all workforce groups will assist in aligning our efforts and insuring we are all on the same mission and vision.

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IPQR Module 9.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Clinical Governance Committee	Members	Clinical oversight of the DSRIP program
CPWNY Medical Director	Dr. Carlos Santos	Work with practitioners
Director of Physician services, CMP	Kathy Obstarczyk	Work with practitioners and facility partners
Director Clinical transformation	Sarah Cotter	Work with clinical transformation
Directors of Finance	Barry Stelmach, Mike Osborne	Work with physician incentive -outcome rewards
IT Governance Committee	Members	IT solutions for data integration
Regional physician leads	Dr Stehlik, Dr DeGraves, Dr Laurie, Dr Martinke and Dr Santos	Meetings with partners
Director Care Management	Peggy Smering and CPWNY partners	Care transitions program
Behavioral Health specialist	Bruce Nesbit, Spectrum Services	Collaborate and provide CI Strategy input

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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		
IT Department	IT Solutions	Integrated information for population health
Home Care	Partner in integrating care	Provide a continuum of care/ transitions of care
Skilled nursing facilities	Partner in integrating care	Provide a continuum of care/ transitions of care
Tertiary care	Partner in integrating care	Provide a continuum of care/ transitions of care
Primary care and Specialty care	Partner in integrating care	Provide a continuum of care/ transitions of care
Hospice /palliative care	Partner in integrating care	Provide a continuum of care/ transitions of care
External Stakeholders		
CBOs not in network	patient navigation related to referral agreements	assist patients - refer to health home
NYS DOH	Originator of work streams concepts	Assist with grant - keep CPWNY knowledgeable regarding shortcomings and improvements /claims data
Providers not in the network	Stakeholders in integrating care	Provide a continuum of care/ transitions of care

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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.

The key to effective clinical integration is health care technology. An integrated health care delivery system must be able to manage a vast network of information—collecting, maintaining and providing appropriate access to administrative, clinical and financial data—in order to monitor quality and costs of care. The shared IT infrastructure will support those processes and behaviors necessary for clinical integration, including:
•Standardization of clinical care: Deliver providers the right protocol data from clinical care guidelines at the point of care, with embedded controls that maximize adherence to these protocols.
•Care management: Ensure that system-wide data can identify high-risk patients and establish standard protocols and processes for outreach to these patients. Care managers should follow care protocols and support caregivers by alerting them to gaps in care and reduce overutilization of services.
•Shared measurement: Develop and implement shared clinical quality and integration measures across the network, emphasizing adherence to care guidelines and the delivery of quality care.
•Workflow optimization: Adopt tools that standardize workflow (and which can be continually updated and innovated) to ensure the right information is captured, the right decisions are considered, and the right recipients get the information they need throughout the system.
•Clinical integration compliance: Ensure that all stakeholders participate and comply with clinical integration through partner agreements, provider education, provider report cards and other trainings.
Ultimately, clinical integration relies on tools and solutions that are flexible, affordable, and provide appropriate access to patient data across various clinical settings such as secure messaging and alerts, patient and physician portals, EHRs, and affiliates. Ideally, health care technology should support a continuous process of alignment across the care continuum, bringing the right information to the right person at the right time, and prompting appropriate care events and narrowing gaps in care.
IT infrastructure is critical for the success of the DSRIP project. This infrastructure will be the platform through which all data is integrated, analyzed, reported and upon which decision and related actions will be based. All performance metrics & deliverables will be tracked using data gathered from multiple providers and other internal and external sources (e.g. Salient.) The status for each will be periodically presented to the governing body. To support the inclusion of various constituent groups, information will be made available in a timely manner tailored to each group so that the data is easily understood in the context of the projects expected goal & outcomes. In addition to the use of this information as a status tool, it will also be available as a basis of communication for all stakeholders, provider partners and the general public. This will be accomplished by postings on the CPWNY web-site. While the majority of the PCPs in this PPS have an electronic medical record and have been submitting data within the context of the Medicare ACO, an additional challenge will be establishing IT platforms that support the availability of patient information from other providers e.g. behavioral health; community based organizations. Various processes are being evaluated including but not limited to use of our local RHIO HEALTHeLINK to support this effort.

IPQR Module 9.8 - Progress Reporting

Instructions :

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

A successful clinical integration program (1) provides measurable clinical improvements for patients (2) common metrics used to evaluate physician performance and (3) cost reductions or changed economics for physicians. Clinical integration is more than data exchange and interoperability. It requires aligning incentives, knowledge and behavior by establishing relationships. Strong physician leadership and a cultural shift of all partners will lead to the success of the PPS. CPWNY will measure success through the extensive list of metrics specified in the DSRIP application and included in our Clinical Integration plan. CPWNY will be measuring the progress of clinical integration based on but not limited to: 1. Completion of process measures; 2. Quality performance and utilization metrics on a quarterly basis; 3.Patient experience surveys will be measured on an annual basis; 4. PCMH progress; 5. Patients having a RHIO consent form; and 6. Provider scale of performance and engagement.

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.

Community Partners of WNY (CPWNY) governance strategy is designed to engage partners, promote competency and reward performance. The governance charter delineates a broad representation on the Executive Governance Body (EGB) which is empowered with board oversight and management of CPWNY DSRIP project plans. The EGB is supported by 3 committees comprised of individuals with expertise in finance, data/IT and clinical performance. The majority of the EGB and its committees have demonstrated success working in integrated delivery systems. The EGB will set forth roles and responsibilities, comprehensive performance expectations, policy and procedures for distribution of funds, clinical and data sharing responsibilities, and guidelines for dispute resolution. Governance strategy milestones include: partner completion of education and training (knowledge and competency), formation of central policies and processes that speak the same message to providers, patients and stakeholders, evaluation of effectiveness of the policies and processes, transformation in healthcare delivery, performance evaluation including competency/integration/clinical evaluation (aligned with project metrics). CPWNY will seek input from the Project Advisory Committee (PAC) for advice and feedback on project plans and initiatives. The PAC will oversee workforce impact and develop plans for retraining and redeployment. CPWNY will align the organizational, clinical and utilization goals for the PPS partners into Sisters of Charity Hospital/CMP's current integration program and by doing so share expertise and establish common expectations for performance on each metric for PPS partners' contractual arrangements. CPWNY will have a central project management office (PMO) that will be the hub for input from the project teams and will perform project monitoring and provide transparency to our partners. The Director of the PMO will sit on the EGB to share status updates on the projects and all DSRIP activities. The PMO will utilize a project management tool and will support the projects by: providing direction and oversight; facilitating collaboration across and among the projects and work streams; sharing best practices and the knowledge and skills gain through CMP's successful ACO; providing monitoring and feedback for achievement of milestones; and support to resolve challenges to milestone achievements. The regional roll out of projects (meetings already conducted) by project leads and the hiring of project coordinators, will be overseen by the PMO. Commitment of the partners and providers will be maintained through contractual arrangements, shared work and oversight. Our central implementation strategy is designed to enhance and expand the IDS success through consistent communication and transparency, IT project implementation focused on integration and shared comprehensive health record, the training and education of staff, and incorporation of best practice interventions in patient and provider engagement, while monitoring achievement of speed and scale for each project. We have already engaged P2 Collaborative for our Population Health initiatives along with the Millennium PPS, focusing on the cultural competency and health literacy work stream in various aligned projects. We will continue to engage our partners and colleagues such as CBOs, County Health Departments and other social services providers.

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

Instructions :

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Please describe how your approach will handle interdependencies between complementary projects, as well as between projects and cross-cutting PPS initiatives - for example, an IT infrastructure upgrade, or the establishment of data sharing protocols.

The major areas of overlap between projects are: IT, workforce, clinical integration, budget, finance, and funds flow. Community Partners of WNY has its own governance structure that will enable oversight over these overarching areas. CPWNY has established formal committees for each of these areas to develop policies and protocols and ensure coordination, performance, and efficiency. CPWNY central project management office designed "Dependencies Orbit charts" by project and work streams, which have been shared with each project team. For example this chart outlines the projects that are dependent on PCMH achievement (2.a.i, 2.b.iii, 3.ai, 3.b.i), to be facilitated by a central clinical transformation team. Multiple projects are dependent on workforce transformation, such as 2.a.i, 3.a.i, 3.b.i, 2.b.iii, and 3.g.i, which will be conducted to enable the shift in workforce from inpatient work to outpatient services. Dependencies have been communicated to the project leads through the "orbits model". Dependencies such as cultural competency and health literacy will be overseen centrally and implemented by county (utilizing the DSRIP community needs assessment). CPWNY will work with a collaborative (P2) and overlapping PPSs so that the approach will be consistent. Many projects are dependent on population health, such as 2.b.iii, 2.b.iv, 3.a.i, 3.b.i, 3.g.i, 4.b.i, and 4.a.i, which includes utilization of standardized protocols and evidenced based medicine, communicated through IT integration with EMRs, providing resultant performance reporting. 2.b.iv is provided as an example to describe the dependence and coordination of projects: In 2.b.iv, Communication among stakeholders and across projects will occur in a variety of ways depending on the type and quantity of information that needs to be shared. During the transition of care the Transitions Coach will notify the PCP Care Manager telephonically, they will also encourage patients to enroll in a Health Home and obtain consent for information sharing through HEALTHeLINK. Individuals that enroll in the Health Home will have information communicated throughout the care delivery network by secured messaging and information sharing through the use of GSI Software. The GSI software has the capabilities of receiving ADT alerts any time an enrolled individual access the emergency room allowing for intervention and coordination between the Transition Coach and Case Manager. Discharge summary and Medication reconciliations will be available to the PCP electronically. Discharged patients will all receive copies of Discharge instructions, medication reconciliations, Health Home and PCP contact information as well as a Patient/Physician communication booklet that they will be encouraged to bring to their medical appointments. The use of secured texting and appointment reminders will be made available to those patients that have an active cell phone. This process for 2.b.iv is also integral to the population health projects mentioned above. In another example of population health, 4.b.i smoking cessation is a project that has elements applicable to many other projects included in our application, such as IT compatibility and data sharing, which will be critical for successful implementation. Population health protocols developed for screening and engaging patients will be useful in this project as well. The use of community or health educators for other projects may also be used in project 4.b.i. Project 3.b.i, cardiovascular disease in particular, has a lot of opportunities for the work done in project 4.b.i to be integrated into that project. We will continue to identify linkages between projects through regular communication with other project leads and we also will regularly communicate with the central administrative team for their input on opportunities to create synergy.

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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
DSRIP Central Project Management Team	Catholic Medical Partners	Responsible for ensuring efficiencies, effectiveness and synergy between and amongst the projects. Responsible for oversight of quarterly reporting by the teams. Provide education to teams regarding DSRIP. Manage a central reporting project management tool to keep projects to task and promote connectivity on what each project is doing .
Central Clinical Transformation Team	Sarah Cotter and team	Responsible for defining and driving Catholic Medical Partners (CMP) physician offices in their improvement of quality of patient outcomes, patient experience of care, and utilization through the use of health information technology, use of team based care, and overall practice process improvement. Responsible traveling and meeting with the staff at CMP physician offices, reviewing office workflow, teaching physicians & office staff to correctly document data utilizing EHR, how to run and analyze quality reports utilizing their EHR and measurement of their improvement in utilizing systems, as well as utilization of prevention and chronic illness quality reports.
Central Care Management Team	Peggy Smering and team	The Care Management team will support practices in the following: 1. Develop, implement and monitor population health management processes. 2. Identify and stratify patient populations to provide relevant interventions. 3. Identify complex, high risk patients and provide enhanced care management. 4. Implement care management interventions including pre visit planning, coaching, patient advocacy, performing holistic assessment and measuring results. 5. Assist office based staff in closing gaps in quality and in developing improvement action plans. 6. Develop, implement and monitor an effective transitional care management program.

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		7. Support practices with Patient Center Medical Home (PCMH) recognition preparation and submission. The Care Management Advisor will partner with the regional physician lead to provide resources, facilitation and guidance to Catholic Medical Partners (CMP) members and their care teams on clinical quality and utilization improvement.
Project Leads and coordinators	Project Leads: Sarah Cotter, Peggy Smering, Bruce Nisbet, Dr. Andy Hyland, Ken Houseknecht, Erica Boyce, Dr. Christopher Kerr, Julie Lulek, Cheryl Friedman, Dr. Carlos Santos coordinators: in process of hiring, interviews scheduled.	Work to engage partners and keep projects to task .
IT and HIT departments	Dr Michael Galang and Dr Dapeng Cao	Integrate data and produce a " total patient picture " as well as data to monitor for success of PPS
Finance Management Team	Dave Macholtz, Mike Osborne, Les Wangelin	Financial management

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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		
CPWNY Executive Governance Board	Members	The CPWNY PPS EGB is assigned responsibility for the planning, implementation and evaluation of the PPS and shall receive direct support and assistance from CMP in carrying out its responsibilities
CPWNY Financial Governance Committee	Financial Impact Monitoring	The FGC assists the Executive Governance Body in the oversight of (1) the integrity of the financial reporting for the PPS, (2) the compliance with legal and regulatory requirements (3) developing a methodology for receiving and distributing project funds, and (4) the oversight of financial performance, capital expenditures and operating results.
Clinical Governance Committee	1) Setting standards of clinical care delivery needed to meet or exceed the DSRIP program goals and objectives; 2) Within the specific project areas selected by the CPWNY PPS, determining the areas of care delivery that should be the focus of improvement efforts; 3) Prioritizing the creation, implementation, oversight and continuous improvement of evidence based medical practices to address identified clinical performance gaps and to improve clinical and financial results; and 4) Developing and overseeing the creation of the committees and subcommittees necessary to undertake the development and implementation of best evidence based practices within the PPS.	1. Recommending to the CPWNY PPS Executive Governance Body clinical integration initiatives to achieve the DSRIP goals; 2. Standardizing and adopting clinical processes across the continuum of care; 3. Establishing processes to improve alignment and communication between and among PPS Partners and collaborators; 4. Recommending to the CPWNY PPS Executive Governance Body quality improvement activities to achieve DSRIP goals; and 5. Reviewing and adopting national evidence based guidelines, care pathways, care protocols and community standards of care which shall be utilized by PPS partners and collaborators to achieve DSRIP goals.
Data Governance Committee (DGC)	The DGC is to provide leadership, oversight, and strategic level recommendations to the Executive Governance Body of the Community Partners PPS in order to meet the requirements set forth by NYSDOH	The primary goal of the DGC is to establish the health information technology system to support the workforce in the PPS to close quality and utilization gaps through the effective and efficient exchange of health information.
DSRIP Central Workforce Management Team	Managing the delivery of the workforce transformation strategy as written in the DSRIP projects	The Workforce Management Team will consolidate and manage the (re) training , redeployment and new hire needs of each of the projects. Individual project leadership teams will report all of tier workforce needs up to the Central Workforce Management team

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Compliance Officer	Ensures PPS compliance	Reviews PPS's conduct in terms of adherence to DSRIP guidelines, laws, and regulations.
Cultural Competence Committee	Manages the cultural competency and health literacy initiatives	Assess, develop, implement the cultural competency education program and Health literacy patient program
Project Advisory Committee	Advisory committee	Upon implementation of the DSRIP program, the PAC shall serve as an advisory body to the Executive Governance Body of the CPWNY PPS
External Stakeholders		
County specific Offices of the Aging	Project Implementation support	Provide assistance in relation to implementation of projects as it relates to the elderly
County specific Office of Mental Health	Project Implementation Support	Provide assistance in relation to implementation of projects as it relates to the behavioral health initiatives
Labor Unions	Labor representation	The labor unions have been involved in the workforce strategy and will continue to do so.
Other regional PPSs (Millennium, FLPPS)	Collaborate on specific joint projects	Collaborate in the implementation of joint projects and work streams such as cultural competency for overlapping counties and network providers- prevent redundancy and waste.
Patient Focus groups	Patient groups	CMP has utilized a focus group on an annual basis to drive home the concerns regarding patient engagement as it relates to health beliefs and literacy.

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IPQR Module 10.5 - IT Requirements

Instructions :

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

The Key elements to the IT infrastructure include : 1. Data Analytics- Decision support software system - will provide monitoring to improve quality and cost, plus a care management /care coordination work flow and analytics tool impacting projects 2.a.i, 2.b.iii, 2.b.iv, 3 a.i, 3.b.i , 3.g.i; 2. Enterprise master patient index-- will facilitate the aggregation of clinical data from multiple sources impacting 2.ai, 2.b.iii, 2.b.iv, 3.a.i, 3.b.i, 3.g.i, 4.a.i, 4.b.i, focusing on care management, coordination of care, performance reporting; 3. Enterprise data warehouse - will provide an analytical suite (business intelligence tool kit) that well help aggregated, normalize, organize, and assimilate data from numerous sources - required for effective work streams; 4. Health Information Exchange (HIE) - will provide a patient and clinical portal plus other features and functions, along with integration with the RHIO (HEALTHeLINK), and leveraging its features/functions . Data systems need to be in place to allow for the secure transmission of data between organizations; 5.Pharmacy decision support software - will support population health management initiatives, improve patient safety and reduce avoidable pharmacy costs by integrating pharmacy data across the IDS care continuum ; 6. Home care devices and care coordination application- will support communication across the provider network for the purpose of the case management functions associated with many regional DSRIP projects; 7. Management of information Network hardware and software - will further build the technology infrastructure to care for our patient population; 8. personal computers, laptops, and tablet- will provide the desktop and laptop commuters and tablets that will be need or accessing the IDS applications --this would apply to projects 2.a.i, 2.b.iii, 2.b.iv, 3.a.i, 3.g.i, 3.f.i, 4.a.i, 3.f.i . 9. Deployment of installation personnel resources r/t to the IDS- will mobilize the personnel necessary to install IDS technology (applies to all projects and work streams); 10. Training of Trainers -- will educate in house trainers on the specifics of an IDS management information system, including all associated hardware and applications (applies to projects).

IPQR Module 10.6 - Performance Monitoring

Instructions :

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

CPWNY will utilize quality performance dashboards that will report on the system overall, by provider, by county, with dates of data collection, how data is collected, and with numerators and denominators reported. Process measures as in Domain 1 and outcome measures in Attachment J will be reported. Pay for performance will tie to the overarching theme of DSRIP : utilization, quality metrics, access. Transparency will be key to the quality reporting system as it will encourage competition amongst providers, promoting excellence in patient care. Culture will focus on service, individuality and meeting needs of providers, patients, caregivers. The quality of care will improve through enhanced access, patient engagement, coordination of care, complete exchange of reliable and valid data, improved provider performance reporting, adherence to best clinical and operational practices, and a culture of accountability built upon the values of the common good. Bidirectional impact will occur between successful implementation of projects and performance reporting. AS outcomes improve from the projects providers will receive performance reports on a regular basis that will encourage the providers to "stay the course" or make adjustments (RCE) to effect improvement. The integrated delivery system will set forth roles and responsibilities , comprehensive performance expectations, distribution of funds, clinical and data sharing

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responsibilities-- eventually leading to a high performing health system with the skills, knowledge and ability to assume full clinical and financial risk for population health. The structures and /or mechanisms needed to execute this vision are a data warehouse, a data analytic system, integration of information during transitions in care and patient "touch points", population health with patient and provider engagement, quality improvement initiatives and transparency reporting.

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IPQR Module 10.7 - Community Engagement

Instructions :

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

CPWNY will work collaboratively on overlapping projects and community-wide initiatives with neighboring PPSs and P2 Collaborative . CPWNY has engaged P2 Collaborative for our Population Health initiatives along with other neighboring PPSs, focusing on the cultural competency and health literacy, palliative care, behavioral health, and maternal and child care. As the PPS gains experiences with the projects, opportunities for collaborating and sharing information will occur, resulting in a unified approach. We will continue to engage with our partners and colleagues (i.e. CBOs, County Health Department, social services). Currently it is felt that our network of CBO's is representative of the aligned counties. CPWNY will conduct outreach to other CBOs, as needed , regardless of PPS partnership for the wellbeing of the patient population. CBOs will be engaged in many aspects of the DSRIP projects: community involvement, training of patient navigators/community health workers, expertise with cultural disparities and literacy issues. CPWNY will : 1. Determine which community based organizations are the most appropriate partners for each project; 2. Examine the financial status of the organization -- do they have the financial capacity to sustain the effort; 3. Be aware of political and public connections the organization might have therefore we will need straightforward criteria demonstrating why a CBO was chosen over another; 4. Be considerate of our labor agreements and check with human resources dept. of our PPS so that we are not violating any existing contract; 5. Recognize the CBO as a partner, not necessarily a contractor. Risks associated with community engagement would be: 1. too many competing overarching committees, 2. Political undertones, 3. communication issues; 4. CBO commitment to PPS may be overzealous in related to capacity to get the job done, and 5. trust and mutual respect. Strategies to overcome the risks will be, first and foremost, open dialogue, a partnership agreement, which includes follow through with the patient and examining barriers impeding the patient follow through with the CBO.

IPQR Module 10.8 - IA Monitoring

Instructions :

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Section 11 – Workforce

IPQR Module 11.1 - Workforce Strategy Spending

Instructions :

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

Funding Type	Year/Quarter										
	DY1(Q1/Q2)($)	DY1(Q3/Q4)($)	DY2(Q1/Q2)($)	DY2(Q3/Q4)($)	DY3(Q1/Q2)($)	DY3(Q3/Q4)($)	DY4(Q1/Q2)($)	DY4(Q3/Q4)($)	DY5(Q1/Q2)($)	DY5(Q3/Q4)($)	Total Spending($)
Retraining	0	350,000	175,000	175,000	100,000	100,000	37,500	37,500	37,500	37,500	1,050,000
Redeployment	0	225,000	112,500	112,500	62,500	62,500	50,000	50,000	25,000	25,000	725,000
Recruitment	0	225,000	112,500	112,500	50,000	50,000	25,000	25,000	12,500	12,500	625,000
Other	0	200,000	100,000	100,000	50,000	50,000	37,500	37,500	37,500	37,500	650,000

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

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IPQR Module 11.2 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Define target workforce state (in line with DSRIP program's goals).	In Progress	Finalized PPS target workforce state, signed off by PPS workforce governance body.	09/01/2015	03/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task Step 2: Identify the specific Workforce Requirements of each DSRIP project and work stream. This will be accomplished through implementation plan review, and a series of meetings and /or surveys with project representatives/leads and key stakeholders.	In Progress	Step 2: Identify the specific Workforce Requirements of each DSRIP project and work stream. This will be accomplished through implementation plan review, and a series of meetings and /or surveys with project representatives/leads and key stakeholders.	09/01/2015	03/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 3: Summarize data from Workforce Requirements Assessment. Based on the Future Workforce State report completed by a third party (e.g. what roles will be significantly impacted, what changes to the workforce will be needed), define the future workforce that is required for DSRIP projects to succeed	In Progress	Step 3: Summarize data from Workforce Requirements Assessment. Based on the Future Workforce State report completed by a third party (e.g. what roles will be significantly impacted, what changes to the workforce will be needed), define the future workforce that is required for DSRIP projects to succeed	09/01/2015	03/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 4: Finalize future workforce state; secure sign off by CPWNY Executive Governance Body.	In Progress	Step 4: Finalize future workforce state; secure sign off by CPWNY Executive Governance Body.	09/01/2015	03/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 1: Establish Workforce Project Team. Team may include representation from DSRIP PMO, project leads, partner/provider human resource/training professionals, subject matter experts and key stakeholders who are tasked with implementing and executing workforce	In Progress	Step 1: Establish Workforce Project Team. Team may include representation from DSRIP PMO, project leads, partner/provider human resource/training professionals, subject matter experts and key stakeholders who are tasked with implementing and executing workforce related activities as laid out in the Implementation Plan.			10/01/2015	12/31/2016	12/31/2016	DY2 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
related activities as laid out in the Implementation Plan.									
Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	In Progress	Completed workforce transition roadmap, signed off by PPS workforce governance body.	09/01/2015	03/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task Step 1: With outside consultation, develop workforce decision-making model that defines how and by whom any decisions around resource availability, allocation, training, redeployment and hiring will be made and approved.	In Progress	Step 1: With outside consultation, develop workforce decision-making model that defines how and by whom any decisions around resource availability, allocation, training, redeployment and hiring will be made and approved.	09/01/2015	03/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 2: Based on future state workforce assessment (defined in milestone #1) and current state workforce assessment (defined in milestone #3), third party will develop consolidated workforce transition roadmap of all specific workforce changes required; define timeline of when these changes are expected to take place and what the dependencies are (for training, redeployment and hiring in line with project timeline and needs)	In Progress	Step 2: Based on future state workforce assessment (defined in milestone #1) and current state workforce assessment (defined in milestone #3), third party will develop consolidated workforce transition roadmap of all specific workforce changes required; define timeline of when these changes are expected to take place and what the dependencies are (for training, redeployment and hiring in line with project timeline and needs)	09/01/2015	03/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 3: Finalize workforce transition roadmap; secure sign off by CPWNY Executive Governance Body.	In Progress	Step 3: Finalize workforce transition roadmap; secure sign off by CPWNY Executive Governance Body.	09/01/2015	03/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	In Progress	Current state assessment report & gap analysis, signed off by PPS workforce governance body.	09/01/2015	03/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task "Step 1: Engage necessary Third Party to perform current state assessment of staff availability and capabilities across CPWNY and partner organizations. Identify staff who could fill future state roles	In Progress	"Step 1: Engage necessary Third Party to perform current state assessment of staff availability and capabilities across CPWNY and partner organizations. Identify staff who could fill future state roles through up-skilling and training and staff who could potentially be redeployed directly into future state roles "	09/01/2015	03/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
through up-skilling and training and staff who could potentially be redeployed directly into future state roles "									
Task Step 2: Third Party review current state analysis against future state workforce (defined in milestone #1) to identify new hire needs	In Progress	Step 2: Third Party review current state analysis against future state workforce (defined in milestone #1) to identify new hire needs	09/01/2015	03/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 3: Create workforce budget analysis to establish a revised Workforce budget for the projects over the duration of the DSRIP project	In Progress	Step 3: Create workforce budget analysis to establish a revised Workforce budget for the projects over the duration of the DSRIP project	09/01/2015	03/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 4: Update future state roadmap based on detailed gap analysis to articulate how (e.g. retraining, redeployment) and when (e.g. timing of redeployments) the transition of the workforce from the current state to the future state will occur	In Progress	Step 4: Update future state roadmap based on detailed gap analysis to articulate how (e.g. retraining, redeployment) and when (e.g. timing of redeployments) the transition of the workforce from the current state to the future state will occur	09/01/2015	03/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	In Progress	Compensation and benefit analysis report, signed off by PPS workforce governance body.	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES
Task Step 1: Utilizing the current state analysis performed in Milestone #3, if applicable, identify the origin and destination of staff that are being redeployed to understand changes that impact jobs and member facilities	In Progress	Step 1: Utilizing the current state analysis performed in Milestone #3, if applicable, identify the origin and destination of staff that are being redeployed to understand changes that impact jobs and member facilities	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 2: Third party to organize activities with partner human resource offices to gather compensation and benefits information for existing roles that will potentially be redeployed	In Progress	Step 2: Third party to organize activities with partner human resource offices to gather compensation and benefits information for existing roles that will potentially be redeployed	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 3: Third Party to assess changes to compensation and benefits, comparing current and future state compensation and benefits for impacted staff, taking into account job role, function, and location	In Progress	Step 3: Third Party to assess changes to compensation and benefits, comparing current and future state compensation and benefits for impacted staff, taking into account job role, function, and location	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4: If applicable, work with partner human resource offices to determine the number of staff trained and/or redeployed/hired	In Progress	Step 4: If applicable, work with partner human resource offices to determine the number of staff trained and/or redeployed/hired	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5: Finalize compensation and benefit analysis; sign off by CPWNY Executive Governance Body	In Progress	Step 5: Finalize compensation and benefit analysis; sign off by CPWNY Executive Governance Body	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Milestone #5 Develop training strategy.	In Progress	Finalized training strategy, signed off by PPS workforce governance body.	09/01/2015	06/30/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task Step 1: Third Party to support team in determining & defining current state training needs, including the specific skills and certifications that staff will require.	In Progress	Step 1: Third Party to support team in determining & defining current state training needs, including the specific skills and certifications that staff will require.	09/01/2015	06/30/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 2: Third Party to perform a Skills Assessment to understand existing capability for staff that will need to be retrained and document future state capability and skills needs for impacted staff	In Progress	Step 2: Third Party to perform a Skills Assessment to understand existing capability for staff that will need to be retrained and document future state capability and skills needs for impacted staff	09/01/2015	06/30/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 3: Third party to help ccordinate Training Strategy, including goals, objectives and guiding principles for the detailed training plan; confirm process and approach to training	In Progress	Step 3: Third party to help ccordinate Training Strategy, including goals, objectives and guiding principles for the detailed training plan; confirm process and approach to training	09/01/2015	06/30/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 4: Finalize detailed Training Plan, signed off by CPWNY Executive Governance Body	In Progress	Step 4: Finalize detailed Training Plan, signed off by CPWNY Executive Governance Body	09/01/2015	06/30/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task	In Progress	Step 5. Assess training effectiveness in relation to training	09/01/2015	06/30/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 5. Assess training effectiveness in relation to training goals.		goals.							

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Define target workforce state (in line with DSRIP program's goals).	Realigned our Milestone end dates to mirror those of Millennium Collaborative Care PPS, as both PPS's have incorporated the same Workforce consulting vendor.
Create a workforce transition roadmap for achieving defined target workforce state.	Realigned our Milestone end dates to mirror those of Millennium Collaborative Care PPS, as both PPS's have incorporated the same Workforce consulting vendor
Perform detailed gap analysis between current state assessment of workforce and projected future state.	Realigned our Milestone end dates to mirror those of Millennium Collaborative Care PPS, as both PPS's have incorporated the same Workforce consulting vendor
Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	
Develop training strategy.	Realigned our Milestone end dates to mirror those of Millennium Collaborative Care PPS, as both PPS's have incorporated the same Workforce consulting vendor

Milestone Review Status

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

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Milestone Review Status

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

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IPQR Module 11.3 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

"The key risks we have identified that could impact our ability to meet our baseline process measures in the future are:
1. RISK: Availability and timing of DSRIP funding to offset the cost of new hires, training/retraining and redeployment. MITIGATION: Resources will be deployed strategically until funding stream is known.

2. RISK: Ability to recruit, hire, and train in a timely and efficient manner to meet project performance metrics. MITIGATION: Will utilize contractors as necessary to streamline the process where possible.
3. RISK: Accurate and early identification of workforce resources, considering projects are still in the early stages of development and may change and evolve over the course of the DSRIP initiative. MITIGATION: Will ensure effective communication throughout development though the use of cross function teams and shared access & reporting through CPWNY website.
4. RISK: Challenges associated with obtaining partner support, data, collaboration and participation. MITIGATION: Project management office will utilize communication and training to maximize full engagement of partners.
5. RISK: Duplication of human resources across providers , such as care coordinators and navigators. MITIGATION: CPWNY has begun the establishment of work groups with representation across projects which share common strategies and similar resources. This is encouraging collaboration, alignment of work effort and sharing of resources, including workforce."

IPQR Module 11.5 - Major Dependencies on Organizational Workstreams

Instructions :

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

"The major interdependencies between our workforce transformation plans and other organizational workstreams are significant. The success of many of the projects is directly dependent on sufficient and timely support of workforce recruitment, training, etc. The Finance Committee of the CPWNY Board will designate a member to serve on the Workforce Project Team to ensure that funding for workforce functions stays in sync with project timelines to support recruitment, retraining, redeployment and other workforce needs. Finance engagement is also crucial to the development of a sustainable, valued based model, where resources, such as workforce, are utilized in the most efficient manner, to achieve the best results at a sustainable cost. The success of this work stream also depends on cultural competency, based upon partner surveys and specific needs of workforce.

"

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IPQR Module 11.6 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Workforce Project Team "	TBD	A group of cross-functional resources (e.g. Finance, HR, DSRIP lead, project leads, stakeholders, etc.) responsible for overall direction, guidance and decisions related to the workforce transformation agenda
CPWNY Executive Governance Body.	Edbauer Michael Markiewicz Joyce Bergmann Peter Horrigan Dennis Kerr Chris Nisbet Bruce Osborne Michael Rodrigues Bartholomew Stehlik Edward Sullivan Mark Tate Grace Walcyzk Dennis Wright Betsy Cotter Sarah Nees Rachael Nielsen David Santos Carlos Schifferli Tom Smering Peggy Stelmach Barry Sullivan Mark	Responsible for oversight
Workforce Project Manager	TBD	Dedicated Human Resource Manager accountable for support of all workforce-related activities.
WF Training Vendor(s)& Consultants	TBD	A training vendor(s)/consultant(s) to fill the identified gaps in training resources. Sisters Hospital/CHS currently has a Regional Training Center and relationships with most educational institutions in WNY. May utilize recruitment assistance as needed.

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IPQR Module 11.7 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Human Resource Professionals (Partners Organizations)	HR leadership of CPWNY PPS	Support data collection of compensation and benefit information; current state workforce information, future state design and potential hiring needs. Provide insights and information related sources and destinations of redeployed staff by project
Training Professionals(Catholic Health System and Partner Organizations)	Training Leadership of CPWNY	Provide oversight and input to development of training needs assessment, and subsequent training strategy and plan
External Stakeholders		
Labor Unions	Labor/Union Representation	Expertise and input around job impacts resulting from DSRIP projects
WF Training Vendor(s) & Consultants	TBD	Technical training /curriculum development/recruitment.

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IPQR Module 11.8 - IT Expectations

Instructions :

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

Relationship between IT and Workforce is an important one, and alignment between these two will be critical to DSRIP success. First, once our training strategy and plan are implemented, we will rely on IT platforms significantly to track training progress (e.g. tracking who's been trained, the subject matter of the training, when the training took place, certification levels, etc.). This will require a cross-member organization learning management system capability. CPWNY will be using Enterprise resource planning (ERP) business management software (Lawson and other) and a project management software (Performance Logic) to assist with collecting, analyzing, and reporting workforce process measures.

IPQR Module 11.9 - Progress Reporting

Instructions :

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

"The headline measures of the success of our workforce transformation program will be the targets of redeployed, retrained, and hired staff and the workforce budget, as articulated in the baseline information to be provided later in DY1. Community Partners of WNY will utilize an electronic survey mechanism and a performance tool (Performance Logic) to collect and report this data. We have established a reporting structure for these numbers that allows us to gather information from our whole network on a quarterly basis and funnel this information to the workforce committee. Each of the DSRIP project committees will include a representative of the Workforce Project Team in order to ensure the workforce project team has a real-time view of how the recruitment, redeployment and retraining efforts are affecting the individual projects, so that we can manage any risks as they arise.
The Workforce Project Team will develop a process to manage the data collection and ratification for the quarterly progress reports."

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IPQR Module 11.10 - Staff Impact

Instructions :

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

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

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

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

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

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Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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IPQR Module 11.11 - IA Monitoring:

Instructions :

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

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

Instructions :

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

1. Inability to engage all practices based on scale and speed projections. Will closely monitor and track, utilize territory physicians to work with physician offices to get provider engagement--implement remediation strategies. Will have a shared vision and transparency that shows the progress of the partners in the program. Performance initiatives will be enhanced in a clinical integration program.
2. Clinical Practices have HIT limitation including EMR without HISP connections to other EMR system that impact interoperability and functionality. (Data import)-convert to EMRs with capabilities of interoperability when feasible - various EHR CCD exchange through direct exchange with HIE, use of MobileMD (direct messaging capabilities) and Crimson will help data exchange between platforms.
3. Issues with HEALTHeLINK/RHIO. Under utilization of the RHIO due to access and multiple sign-on requirements ; RHIO is not receiving paid claims from local payers or NYSDOH and claims data will require significant time for mapping and challenges in data governance; Only one EMR system is currently sending CCDs to the local RHIO; RHIO virtual health record is generally a PDF, not discrete data able to be fully consumed into the host EMR. Mitigation: Until EMR vendors are able to send discrete CCD data, recipient EMRs will be able to upload PDF documents.
4. Ability of data repository to generate patient registry reports for population health interventions and to close gaps in care. (Data export/extraction)--Implementation of Crimson will mitigate this issue as they are population health tools. Currently, we have a manual way to manage population health.
5. Patient resistance to engagement/care coordination. Patients' failure to make/maintain appointments. This issue will be mitigated through the use of community health workers in high need areas --will start off by gaining knowledge of this new role and identifying issues. CPWNY will use community health workers with similar cultures and ethnic backgrounds to the target population. CPWNY will develop a customized care planning workflow for Medicaid patients (psychosocial issues) that may be different from Commercial/Medicare patients. We will set up a central case management hotline to discuss issues and mitigate patient resistance (esp. psychosocial issues). Staffing demands will be mitigated with workforce development and cross-training of staff. Catholic Health will provide recruitment expertise in attracting workers. CPWNY will also set up a central transportation resource for those who have barriers related to transportation, as indicated in the Community Needs Assessment.
6. Potential shortage of PCP access point. Monitoring of patient experience surveys and input from community workers will allow CPWNY to evaluate the services provided in the various areas -- Mitigation: Provide transportation and open access to health homes to meet the patients where they are at thereby mitigating access issues.
7. Significant financial reserve to cover value-based financial risk contracts. CMP will work with health plans and increase reserves set aside to offset risk.
8. EMR capability not fully implemented due to staff competencies and system limitations. This will be mitigated by the Clinical Transformation team who will provide education via web, in-person, and work with vendors to improve upon system limitations. The Clinical Transformation team at CMP knows short-comings of EMRs utilized in WNY and will be able to remedy the system limitations quickly (even recommending a new EMR system if need be)
9. Heath home GSI care coordination system not integrated with the Virtual Heath Record. Care coordination application and home care devices to

support communication across care settings --CPWNY has reached out to Millennium PPS leaders regarding GSI for care coordination integration.

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.	Project	N/A	In Progress	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.	Project		In Progress	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 1…..According to Thorpe and Ogden (1) An Integrated Delivery System is characterized by comprehensive services across the continuum of care and includes the fiollowing : 1. Patient focus; 2. Geographic coverage and rosters; 3. Performance Management; 4. Information Systems; 5. Organization culture and leadership ; 6. Physician integration ; 7. Governance Structure; Financial Management.The inclusion of all providers , institutions, payers, and CBOs:	Project		In Progress	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 1 SUB STEPS: a. Align hospitals, physicians and other providers across the continuum , inclusive but not limited to behavioral health specialists , in governance meetings. Recognize that acute care is not the hub of the system and the primary care provider is. This includes but not limited to finance committee, IT/data committee and ad hoc committees.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task b. The delivery system is designed around the patient, not the	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
provider. Adopt shared decision making tools throughout the continuum of care and utilize care managers to meet the needs of the complex patient.									
Task c. Adopt system wide evidence based guidelines, policies and procedures.	Project		In Progress	09/01/2015	10/31/2016	09/01/2015	10/31/2016	12/31/2016	DY2 Q3
Task d. Build consensus regarding a variety of performance measures and goals including access to care, clinical outcomes, functionality, satisfaction and value received and incentives.	Project		In Progress	08/01/2015	09/30/2016	08/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task e. Create a process to that tracks provider performance compared to contract terms /requirements , including corrective action plans	Project		In Progress	08/01/2015	09/30/2016	08/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task f. Establish a plan to monitor PPS provider performance periodically and report to the PPS governance, with corrective action and performance improvement initiatives, as needed.	Project		In Progress	08/01/2015	12/31/2016	08/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task g. CEOs participate (through the governance board, in facilitating a network of healthcare delivery organizations and provide strategic management and leadership to their own organizations.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task h. Adopt a " no wrong door approach " policy and procedure to health care delivery, ensuring an individual can be treated , or referred to treatment , whether he or she seeks help for mental health problems, a substance abuse problem or general medical conditions.This would be reflected in educational trainings, PCMH rollout, health homes, and hospital alignments with outpatient care.	Project		Completed	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task i. IT integration will be crucial to success of the IDS: Initiate assessments of systems and identification of gaps that will be prioritized and remedied.	Project		In Progress	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task J. Complete full provider list of all PPS participants , defined by provider type, NPI and Practice name- post PPS provider	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
network directory on web site. Maintain periodic audit trail report of log of changes to network list , periodic reports with changes to network list and contractual agreements.									
Task k. Develop a list of elements that will need to be part of each provider agreement/cotnract to develop draft contract	Project		In Progress	08/01/2015	12/31/2015	08/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task l. Set up accountability agreements with partners (with behavioral health, ancillary providers, facilities, palliative care)as well as acute care , outpatient care, long term care, urgent care, home care, etc. Process of tracking agreements established.	Project		In Progress	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task m. Create a process to track all executed provider contractual agreements.	Project		In Progress	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task n. Engage key internal unit level PPS partners to participate in IDS project	Project		In Progress	08/01/2015	09/30/2016	08/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 2…Set up and maintain regular meetings /communication and involvement with all relevant stakeholders : (though there are target dates to sub steps meetings are continuous , especially when setting clinical integration metrics and informing of outcomes. SUB STEPS In relation to Step 2:	Project		In Progress	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task a. Meet with Primary Care Providers - start with large Medicaid practices who need PCMH and communicate DSRIP initiatives utilizing physician lead , clinical transformation and enhanced care management team. (This is continuous)	Project		In Progress	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task b. Meet with all small panel Medicaid practices utilizing Clinical Transformation team , Care Management team and Territory physicians (as needed) (This is continuous)	Project		In Progress	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task c. Meet with Behavioral health through project involvement and Medical director as needed (this is continuous)	Project		In Progress	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task d. Meet with post acute , long term care, community based service providers , social service organizations through project	Project		In Progress	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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involvement, project leads. (this is continuous)									
Task e. Initiate meetings with payers on a monthly basis	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task f. Will use a variety of communication methods: webinars, emails, open forums, surveys, letters, Newsletters, and a fully functioning website with contacts for questions regarding our integrated network. A list of our network will be on the website with contact info.	Project		In Progress	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task g. Communicate with other WNY PPS leadership to ensure no mixed messages on overlapping projects and present WNY as aligned and focused on the improvement of health care in the communities.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS produces a list of participating HHs and ACOs.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Expand our current systems in place for ACO population health: MedInsight, Crimson, HEALTHeLINK. This provides the network and population management analytics and reporting application to monitor the sources of care for patients: Following sub steps refer to Step 1:	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task a. Data Acquisition: inpatient data interfacing= DY 1, Q2; Ambulatory (hospital based interfacing) data interfacing = DY 1, Q2; Completion of physician practice interfacing = DY2, Q2	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task b. User Acceptance testing: inpatient analytics - DY 1,Q2;	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Ambulatory (hospital based) analytics = DY2, Q2; physician practice (medical groups) analytics - DY 2, Q2									
Task Step 2 - Utilize current CMP ACO MedInsight to aggregate and stratify patients for population health utilizing health plan (payer) data (inclusive of Medicaid Salient data once pt. specific info is available) and EMR data rollout. (Medent, Clinical, Allscripts, etc.) --see Project requirement #6 Step 3 =Ensure data is getting into the EMR via queryable fields	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 3…Social services link to HEALTHeLINK and other partners via Mirth Mail	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	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	06/01/2015	03/31/2017	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		In Progress	06/01/2015	03/31/2017	06/01/2015	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	06/01/2015	03/31/2017	06/01/2015	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	06/01/2015	03/31/2017	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS trains staff on IDS protocols and processes.	Project		In Progress	06/01/2015	03/31/2017	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Our data analytics system is designed to identify gaps in care of the population and will be able to drill down to individual gaps in care. Obtain data of partners (refer to project requirement 2, step 2- Utilize current CMP ACO Med insight to aggregate and stratify patients for population health utilizing health plan (payer) data (inclusive of Medicaid Salient data once pt. specific info is available) and EMR data rollout (Medent, eClinicalWorks, Allscripts, etc.).	Project		In Progress	06/01/2015	03/31/2017	06/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Task Step 2…Maximize usage of claims data, EMR data, and patient self-report data by partnering with payers and providers in data collection -- set up discussions with payers: Starting with obtaining Medicaid claims data from health plans, in particular, data for high risk Medicaid patients.	Project		In Progress	06/01/2015	03/31/2017	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 3…Engage CBOs in executive governing body; assess the CBO resources and capabilities; and engage them according to alignment with projects and work streams.	Project		In Progress	06/01/2015	03/31/2017	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4…Develop and utilize a patient dashboard approach to deploy community health workers , care managers, social workers, and other resources as needed to augment primary care practice.	Project		In Progress	06/01/2015	03/31/2017	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5 ...Deploy mobile clinical transformation team (EMR specialists and QA specialists) to assist in identifying and addressing gaps in care and prioritize where the Medicaid population is the largest. Gaps will be closed through the use of registries, use of portal and secure messaging in reaching out to patients; the care management team will prioritize patients (and caregivers) and assist practices in tracking and interventions. Regional physician leads will work with practices in each county to improve practitioners engagement.	Project		In Progress	06/01/2015	03/31/2017	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6…Staff trained on IDS protocol and processes by region utilizing CPWNY website, WebEx, clinical transformation teams and regional physicians.	Project		In Progress	06/01/2015	03/31/2017	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY	Provider	Safety Net Practitioner - Primary Care Provider	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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requirements.		(PCP)							
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Hospital	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Nursing Home	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…Create inventory of Safety Net and non-Safety Net providers are signed on to HEALTHeLINK, whether they send complete CCD after encounter, whether they send/receive via HISP, whether they can do virtual record lookup. Determine the EMRs they are using.	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2…Roll out of partner agreements that stipulate the sharing of health information and use of the RHIO	Project		In Progress	05/01/2015	03/31/2017	05/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 3…In addition to agreements, HEALTHeLINK will be purchasing 500 authentication tokens for PPS practices that will make authentication for access to the RHIO information easier and no cost to the partner. This will enable providers to access information securely and easier.	Project		In Progress	05/01/2015	03/31/2017	05/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4…HEALTHeLINK will provide a community wide patient event notification service that keys on multiple event types and is configurable to the practice/provider level	Project		In Progress	05/01/2015	03/31/2017	05/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5…Build a directory that contains the DIRECT address of providers and practices across the community . This would facilitate the direct exchange of patient information between	Project		In Progress	05/01/2015	03/31/2017	05/01/2015	03/31/2017	03/31/2017	DY2 Q4

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healthcare settings and would be readily accessible by any provider/user									
Task Step 6…Data exchange solution that enables Omni-directional communication between care providers and patients: a. Roll-out of patient portal to PPS partners without EMR= DY 1,Q 4; Roll-out to other PPS partners= DY 2, Q 4; Integrate MobileMD with RHIO (HEALTHeLINK) = DY 1, Q4; Integrate MobileMD with PPS EMR , first PPS EMR = DY2, Q4; Integrate with all other PPS EMRs such as behavioral health, SNF, home care= DY 3, Q4 (NOTE: MobileMD is an HIE that provides comprehensive data exchange solutions and will be directly integrated with the community-wide HEALTHeLINK RHIO/SHIN-NY).	Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1... Analyze current status of EMR systems used, the status of Meaningful Use (AUI, Stage 1, Stage 2, or none), and status of PCMH (Level 3, 2, 1, in process, or none) by participating provider practices. Create a work plan and timelines for getting practices not yet at PCMH Level 3 and MU to achieve them both by end of DY3.	Project		In Progress	09/01/2015	12/31/2015	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step2... Assign each PCP practice a Clinical Transformation Specialist to work with them and be their point of contact on EMR, MU, PCMH, and Population Health/Quality Outcome Measures. Need to hire additional personnel to take on additional practices and workload. Roll out will be in phases starting with those practices with the largest volume of Medicaid	Project		In Progress	09/01/2015	12/31/2015	09/01/2015	06/30/2016	06/30/2016	DY2 Q1

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patients.									
Task Step 3... Understand EMR system capabilities and if they have the ability to meet MU/PCMH for those who are not currently there. If there are gaps in capabilities create a work plan and timeline for working with the vendor or possibly transitioning some practices to more "ready" vendors(those practices that need to transition to more " ready" vendors will need more time and will not be completed until DY 3, Q4)	Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 4… Have 100% of practices on EMR systems that enable them to meet MU and PCMH	Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Create and maintain patient registries from Practices EMRs. For practices who don't currently have EMR, do manual registry based on claims data to start with , and eventually merge them to EMR registry workflow.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 2...Create data dictionary of registry elements	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3...Ensure data is getting into the EMR via queryable fields	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4…Data quality check and robust data aggregation /reporting	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5…Data analytics function in place	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6…Appropriate clinical oversight /review in place	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 7…Maintain centralized patient registries that will be used	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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to stratify patients by condition and by responsible providers. Prioritize by HCC (patient stratification on severity/complexity) and other coding methodologies to assist the practices in population health interventions.									
Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1...Analyze current status of EMR systems used, the status of Meaningful Use (AUI, Stage 1, Stage 2, or none), and status of PCMH (Level 3, 2, 1, in process, or none) by participating provider practices. Create a work plan and timelines for getting practices not yet at PCMH Level 3 and MU to achieve them both by end of DY3.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2...Assign each PCP practice a Clinical Transformation Specialist to work with them and be their point of contact on EMR, MU, PCMH, and Population Health/Quality Outcome Measures. Need to hire additional personnel to take on additional practices and workload	Project		In Progress	09/01/2015	12/31/2015	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3...Create a survey or contact practices to understand practice readiness to engage in PCMH or MU activities (if not currently engaged). Create work plan for training and educating those who are ready. Create an intervention strategy to help	Project		In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3

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engage those who are not ready through the use of Regional Primary Care Leaders, Hospital leadership, and other resources yet to be determined (such as providing more care management assistance or behavioral health assistance to help the practice feel more comfortable with their ability to take on PCMH Project.)									
Task Step 4...Create educational training materials for Meaningful Use. Provide targeted education based on each practices needs, especially for those who did not meet MU on DY1, for either in person training, web based (WebEx), or user-group by EMR vendor training	Project		In Progress	06/01/2015	03/31/2018	06/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task a. Provide education and training to greater than half practices on Meaningful Use	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task b. Provide education and training to greater than 75% practices on Meaningful Use	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task c. Provide education and training to 100% practices on Meaningful Use	Project		In Progress	07/01/2015	06/30/2017	07/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task d. All practices on Meaningful Use by end of DY 3= Steps listed below that correspond with PCMH 2014 standards but focusing on EMR capabilities and practice use of these capabilities:	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 5…Improving quality ,safety , efficiency and reducing health disparities (these measures will help to provide better access to comprehensive patient data for patients health team; use evidence based order sets and Computer Order entry; apply clinical decision support at the point of care; generate list of patients who need care and use them to reach out to patients.)	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 6…Engage patients and families in their health care (these measures will provide patients and families with timely access to data; tools to make informed decisions and manage their health)	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 7…Improve care coordination (These measures will allow practices to exchange meaningful clinical information among a	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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professional health care team)									
Task Step 8…Improve population and public health (these measures will allow physicians to communicate with public health agencies and better track of health information across communities)	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 9…Ensure adequate privacy and security protections for personal health information (These measures will help ensure : the privacy & security protections for confidential health information through operating policies , procedures and technology; compliance with applicable law; and transparency of data sharing to the patient.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 10...Create educational and training materials for Patient Centered Medical Home recognition. Create a series of classes (teaching of standards, leadership skills, project management skills, IT/EMR support) for practices not yet achieved PCMH to teach the steps of how to achieved Level 3 recognition. Find practices that have already achieved Level 3 that are willing to participate as mentors and leaders to other practices that have not yet achieved and connect them.	Project		In Progress	06/01/2015	03/31/2016	06/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task a. Provide education and training to greater than half practices on PCMH	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task b. Provide education and training to greater than 75% practices on PCMH	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task c. Provide education and training to 100% practices on PCMH	Project		In Progress	07/01/2015	06/30/2017	07/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task d. All Primary Care practices achieve PCMH by end of DY3==Steps listed below that are individualized to the assessment of each practice and has meaningful use standards embedded in the applicable standard:	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 11… Ensure PCMH policies and procedures in place with a process to review , revise and reapprove (templates are provided for office adaptation, customization)	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Task Step 12…Ability to run reports to track missed appointments, upcoming appointments, gaps in preventive care, gaps in chronic disease management, hospitalization and transitions of care documentation, care management interventions.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 13…Appointment Access and availability reports completed (and follow policy). Enhance recruitment of providers based on access and availability report and CAHPS surveys through hospital and IPA recruitment offices	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 14…Roles and job descriptions completed for practice team members in PCMH and training to PCMH as noted above	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 15…Evidence Based guidelines built into the EMR along with tools to manage patient care(care management including referrals to COBs, educational tools, follow up , motivational interviewing)	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 16…Assessment of diversity in the practice and ability to run quality metrics based on culture, language, and ethnicity	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 17…Track outreach to patients in attempts to close gaps in care(along with preferred methods of contact as stipulated by the patient)	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 18…Exchange of information (care coordination)-- reports to show timeliness of incoming and outgoing patient information.(referral agreements in place and information exchanged according to agreements and policy)	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 19…Quality improvement program in the office, utilizing Rapid Cycle Evaluation	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 20…Evaluation of usefulness of community referrals.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 21…Medication management (monitors cost, best practice,	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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allergies, interactions, e-scripts)									
Task Step 22... Set up a process for continued education and assistance with PCMH and Meaningful Use. PCMH renewals occur every three years, and meaningful use is yearly. So many practices will have to renew PCMH recognition during this time period, as well as continuing their MU attestations. We want to set up a process to ensure their continued success in the future. There are also standards in which you must show achievement during the interim years of recognition like the measurement and improvement of quality measures.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	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	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Medicaid Managed Care contract(s) are in place that include value-based payments.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1...Assess current state of Medicaid Managed care contracts, compare with current value based payment arrangements for other products such as commercial or Medicare managed care.	Project		Completed	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…Meet with major health plans to discuss establishing performance based contracts.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3…Develop additional performance /value contracts that incorporate financial and quality risk for Medicaid population.	Project		In Progress	06/01/2015	03/31/2017	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
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	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
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	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 1…Establish monthly meetings with health plans to focus	Project		Completed	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3

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on medical management with actuarial/financial and medical/nursing staff discussing improvement initiatives , either separately or together .Catholic Medical Partners (CMP) has monthly meetings (rotating basis) with health plans reviewing utilization trends and discussing performance issues, return on investment, and payment reform. There is never an end date or completion date with healthplan meetings -- they will be ongoing but will add CPWNY partners to the table.									
Task Step 2… Currently CMP has risk arrangements and Value based contracts. We are working on with Fidelis (main product Medicaid) on Value based contracting . With existing contracts CPWNY will bring forth those partners interested in Value based contracting (ie Hospice Buffalo has expressed a desire to be included in talks for Palliative Care)	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3…. Include key stakeholders in the meetings with MCOs as they express their interest in negotiating Value based contracts once data available indicating ROI.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4….Meetings to escalate to Monthly as needed if value based contracting for PPS is not on target r/t to agreement of incentives, shared savings or risk arrangements.	Project		In Progress	12/01/2015	06/30/2016	12/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5… Provide Executive Board with updates to Value Based Contracting progress on a quarterly basis	Project		In Progress	12/01/2015	06/30/2016	12/01/2015	06/30/2016	06/30/2016	DY2 Q1
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	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation	Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.	Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 1...Develop a negotiating committee inclusive of representatives of our partners for discussions of value based	Project		Completed	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3

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contracts									
Task Step 2… CPWNY will utilize resources including a Contract Sub Committee and a Strategic Planning Sub Committee to engage impacted providers / partners and assist in the individual contracting done with HMO's.	Project		On Hold	06/01/2015	12/31/2015	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 3…CPWNY will use an existing shared savings compensation model and existing value based contracts for the establishment of value based agreements with the health plans.CPWNY will explore various VBP models such as total population, integrated primary care, acute care, and chronic care and payment methodologies. Plan the orderly implementation of VBP through the Strategic Planning Committee.	Project		Completed	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4… Insure that health plan data is available in a timely manner to all partners so action may be taken- CPWNY receives paid claims data and monitors cost and frequency of hospital inpatient and outpatient services , physician services, pharmacy and other expenses.	Project		In Progress	06/01/2015	03/31/2016	06/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5…Insure the global budgets are risk adjusted for age and gender	Project		In Progress	06/01/2015	06/30/2016	06/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6…Develop a stop-loss mechanism with the health plan contracts	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 7…Review actuarial reports and trends with the PPS governance.	Project		In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 8…Compare utilization and cost to industry wide benchmarks	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 9…Align performance measures with community and industry standards utilizing a clinical integration program.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #11 Engage patients in the integrated delivery system through	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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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.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Utilizing healthcare data analytics complete an assessment of our PPS attributed Medicaid members. Using clinical transformation team, extract data from EMRs - all Medicaid patients; sort by who has not been in office for 1 year or greater; by disease conditions (Cardiovascular , HTN, Renal, Diabetes, Behavioral health); impending doctor appointment; build in claims data to ascertain hospitalizations and ER visits to obtain holistic view of patient; Stratify population by the aforementioned and also segment by culture, ethnicity and language; Connect patients to health home (who also uses community health workers). Set up documentation in EMR to run reports on care management care plans, care transitions. To be overseen by CPWNY Clinical Transformation and CPWNY IT teams.	Project		In Progress	06/01/2015	03/31/2017	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 2… Identify and train community health workers and patient navigators- work with our CBO partners including our Health Homes to assist in developing a community health worker program.	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3…Survey CBOs on their capabilities, value they bring for the Medicaid patient, hours of operation and after hours access, their role in meeting the needs of the Medicaid patient to avoid hospital usage as a first line health access component. Utilize social workers to make recommendations to connect partners with various CBOs , based on population needs of the provider.	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4…Each county will identify their community based partners, utilizing the Community Needs Assessment as a guide after the survey in step 3 is completed, and set up agreements/contracts regarding exchange of information and	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4

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their committed help for the Medicaid patient.									
Task Step 5…Utilizing a behavioral health subcommittee, focus workgroup , draw on existing knowledge base of behavioral health providers regarding the needs and concerns of their patient base.Based on this information develop a strategy to engage patients.	Project		In Progress	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 6…CPWNY Care management team will assist practices, prioritizing outreach and developing a workflow on patient engagement, examining patient expressed barriers to seeking health care on an outpatient basis. Barriers may be related to lack of understanding, social, cultural, travel time, family dynamics, prioritization, etc. and utilize Community Based Organizations for overcoming these barriers.	Project		In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3

Project 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…..According to Thorpe and Ogden (1) An Integrated Delivery System is characterized by comprehensive services across the continuum of care and includes the fiollowing : 1. Patient focus; 2. Geographic coverage and rosters; 3. Performance Management; 4. Information Systems; 5. Organization culture and leadership ; 6. Physician integration ; 7. Governance Structure; Financial Management.The inclusion of all providers , institutions, payers, and CBOs:										
Task Step 1 SUB STEPS:										

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a. Align hospitals, physicians and other providers across the continuum , inclusive but not limited to behavioral health specialists , in governance meetings. Recognize that acute care is not the hub of the system and the primary care provider is. This includes but not limited to finance committee, IT/data committee and ad hoc committees.										
Task b. The delivery system is designed around the patient, not the provider. Adopt shared decision making tools throughout the continuum of care and utilize care managers to meet the needs of the complex patient.										
Task c. Adopt system wide evidence based guidelines, policies and procedures.										
Task d. Build consensus regarding a variety of performance measures and goals including access to care, clinical outcomes, functionality, satisfaction and value received and incentives.										
Task e. Create a process to that tracks provider performance compared to contract terms /requirements , including corrective action plans										
Task f. Establish a plan to monitor PPS provider performance periodically and report to the PPS governance, with corrective action and performance improvement initiatives, as needed.										
Task g. CEOs participate (through the governance board, in facilitating a network of healthcare delivery organizations and provide strategic management and leadership to their own organizations.										
Task h. Adopt a " no wrong door approach " policy and procedure to health care delivery, ensuring an individual can be treated , or referred to treatment , whether he or she seeks help for mental health problems, a substance abuse problem or general medical conditions.This would be reflected in educational trainings, PCMH rollout, health homes, and hospital alignments with outpatient care.										
Task i. IT integration will be crucial to success of the IDS: Initiate assessments of systems and identification of gaps that will be prioritized and remedied.										
Task J. Complete full provider list of all PPS participants , defined by										

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provider type, NPI and Practice name- post PPS provider network directory on web site. Maintain periodic audit trail report of log of changes to network list , periodic reports with changes to network list and contractual agreements.										
Task k. Develop a list of elements that will need to be part of each provider agreement/cotnract to develop draft contract										
Task l. Set up accountability agreements with partners (with behavioral health, ancillary providers, facilities, palliative care)as well as acute care , outpatient care, long term care, urgent care, home care, etc. Process of tracking agreements established.										
Task m. Create a process to track all executed provider contractual agreements.										
Task n. Engage key internal unit level PPS partners to participate in IDS project										
Task Step 2…Set up and maintain regular meetings /communication and involvement with all relevant stakeholders : (though there are target dates to sub steps meetings are continuous , especially when setting clinical integration metrics and informing of outcomes. SUB STEPS In relation to Step 2:										
Task a. Meet with Primary Care Providers - start with large Medicaid practices who need PCMH and communicate DSRIP initiatives utilizing physician lead , clinical transformation and enhanced care management team. (This is continuous)										
Task b. Meet with all small panel Medicaid practices utilizing Clinical Transformation team , Care Management team and Territory physicians (as needed) (This is continuous)										
Task c. Meet with Behavioral health through project involvement and Medical director as needed (this is continuous)										
Task d. Meet with post acute , long term care, community based service providers , social service organizations through project involvement, project leads. (this is continuous)										
Task e. Initiate meetings with payers on a monthly basis										
Task f. Will use a variety of communication methods: webinars,										

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emails, open forums, surveys, letters, Newsletters, and a fully functioning website with contacts for questions regarding our integrated network. A list of our network will be on the website with contact info.										
Task g. Communicate with other WNY PPS leadership to ensure no mixed messages on overlapping projects and present WNY as aligned and focused on the improvement of health care in the communities.										
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…Expand our current systems in place for ACO population health: MedInsight, Crimson, HEALTHeLINK. This provides the network and population management analytics and reporting application to monitor the sources of care for patients: Following sub steps refer to Step 1:										
Task a. Data Acquisition: inpatient data interfacing= DY 1, Q2; Ambulatory (hospital based interfacing) data interfacing = DY 1, Q2; Completion of physician practice interfacing = DY2, Q2										
Task b. User Acceptance testing: inpatient analytics - DY 1,Q2; Ambulatory (hospital based) analytics = DY2, Q2; physician practice (medical groups) analytics - DY 2, Q2										
Task Step 2 - Utilize current CMP ACO MedInsight to aggregate and stratify patients for population health utilizing health plan (payer) data (inclusive of Medicaid Salient data once pt. specific info is available) and EMR data rollout. (Medent, Clinical, Allscripts, etc.) --see Project requirement #6 Step 3 =Ensure data is getting into the EMR via queryable fields										
Task										

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Step 3…Social services link to HEALTHeLINK and other partners via Mirth Mail										
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…Our data analytics system is designed to identify gaps in care of the population and will be able to drill down to individual gaps in care. Obtain data of partners (refer to project requirement 2, step 2- Utilize current CMP ACO Med insight to aggregate and stratify patients for population health utilizing health plan (payer) data (inclusive of Medicaid Salient data once pt. specific info is available) and EMR data rollout (Medent, eClinicalWorks, Allscripts, etc.).										
Task Step 2…Maximize usage of claims data, EMR data, and patient self-report data by partnering with payers and providers in data collection -- set up discussions with payers: Starting with obtaining Medicaid claims data from health plans, in particular, data for high risk Medicaid patients.										
Task Step 3…Engage CBOs in executive governing body; assess the CBO resources and capabilities; and engage them according to alignment with projects and work streams.										
Task Step 4…Develop and utilize a patient dashboard approach to deploy community health workers , care managers, social workers, and other resources as needed to augment primary care practice.										

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Task Step 5 ...Deploy mobile clinical transformation team (EMR specialists and QA specialists) to assist in identifying and addressing gaps in care and prioritize where the Medicaid population is the largest. Gaps will be closed through the use of registries, use of portal and secure messaging in reaching out to patients; the care management team will prioritize patients (and caregivers) and assist practices in tracking and interventions. Regional physician leads will work with practices in each county to improve practitioners engagement.										
Task Step 6…Staff trained on IDS protocol and processes by region utilizing CPWNY website, WebEx, clinical transformation teams and regional physicians.										
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	3	6	9	12	15	20	25
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	4	8	12	16	20	25	30
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	1	1	2	2	3	4	5
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	2	4	6	8	10	15	20
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	2	4	6	8	10	12	15
Task PPS uses alerts and secure messaging functionality.										
Task Step 1…Create inventory of Safety Net and non-Safety Net providers are signed on to HEALTHeLINK, whether they send complete CCD after encounter, whether they send/receive via HISP, whether they can do virtual record lookup. Determine the EMRs they are using.										

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Task Step 2…Roll out of partner agreements that stipulate the sharing of health information and use of the RHIO										
Task Step 3…In addition to agreements, HEALTHeLINK will be purchasing 500 authentication tokens for PPS practices that will make authentication for access to the RHIO information easier and no cost to the partner. This will enable providers to access information securely and easier.										
Task Step 4…HEALTHeLINK will provide a community wide patient event notification service that keys on multiple event types and is configurable to the practice/provider level										
Task Step 5…Build a directory that contains the DIRECT address of providers and practices across the community . This would facilitate the direct exchange of patient information between healthcare settings and would be readily accessible by any provider/user										
Task Step 6…Data exchange solution that enables Omni-directional communication between care providers and patients: a. Roll-out of patient portal to PPS partners without EMR= DY 1,Q 4; Roll-out to other PPS partners= DY 2, Q 4; Integrate MobileMD with RHIO (HEALTHeLINK) = DY 1, Q4; Integrate MobileMD with PPS EMR , first PPS EMR = DY2, Q4; Integrate with all other PPS EMRs such as behavioral health, SNF, home care= DY 3, Q4 (NOTE: MobileMD is an HIE that provides comprehensive data exchange solutions and will be directly integrated with the community-wide HEALTHeLINK RHIO/SHIN-NY).										
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	1	5	8	12	15	18	22	25	28
Task Step 1... Analyze current status of EMR systems used, the status of Meaningful Use (AUI, Stage 1, Stage 2, or none), and status of										

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PCMH (Level 3, 2, 1, in process, or none) by participating provider practices. Create a work plan and timelines for getting practices not yet at PCMH Level 3 and MU to achieve them both by end of DY3.										
Task Step2... Assign each PCP practice a Clinical Transformation Specialist to work with them and be their point of contact on EMR, MU, PCMH, and Population Health/Quality Outcome Measures. Need to hire additional personnel to take on additional practices and workload. Roll out will be in phases starting with those practices with the largest volume of Medicaid patients.										
Task Step 3... Understand EMR system capabilities and if they have the ability to meet MU/PCMH for those who are not currently there. If there are gaps in capabilities create a work plan and timeline for working with the vendor or possibly transitioning some practices to more "ready" vendors(those practices that need to transition to more " ready" vendors will need more time and will not be completed until DY 3, Q4)										
Task Step 4… Have 100% of practices on EMR systems that enable them to meet MU and PCMH										
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…Create and maintain patient registries from Practices EMRs. For practices who don't currently have EMR, do manual registry based on claims data to start with , and eventually merge them to EMR registry workflow.										
Task Step 2...Create data dictionary of registry elements										
Task Step 3...Ensure data is getting into the EMR via queryable fields										
Task Step 4…Data quality check and robust data aggregation /reporting										

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Task Step 5…Data analytics function in place										
Task Step 6…Appropriate clinical oversight /review in place										
Task Step 7…Maintain centralized patient registries that will be used to stratify patients by condition and by responsible providers. Prioritize by HCC (patient stratification on severity/complexity) and other coding methodologies to assist the practices in population health interventions.										
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	10	35	60	85	110	135	160	185	210
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...Analyze current status of EMR systems used, the status of Meaningful Use (AUI, Stage 1, Stage 2, or none), and status of PCMH (Level 3, 2, 1, in process, or none) by participating provider practices. Create a work plan and timelines for getting practices not yet at PCMH Level 3 and MU to achieve them both by end of DY3.										
Task Step 2...Assign each PCP practice a Clinical Transformation Specialist to work with them and be their point of contact on EMR, MU, PCMH, and Population Health/Quality Outcome Measures. Need to hire additional personnel to take on additional practices and workload										
Task Step 3...Create a survey or contact practices to understand practice readiness to engage in PCMH or MU activities (if not currently engaged). Create work plan for training and educating those who are ready. Create an intervention strategy to help										

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engage those who are not ready through the use of Regional Primary Care Leaders, Hospital leadership, and other resources yet to be determined (such as providing more care management assistance or behavioral health assistance to help the practice feel more comfortable with their ability to take on PCMH Project.)										
Task Step 4...Create educational training materials for Meaningful Use. Provide targeted education based on each practices needs, especially for those who did not meet MU on DY1, for either in person training, web based (WebEx), or user-group by EMR vendor training										
Task a. Provide education and training to greater than half practices on Meaningful Use										
Task b. Provide education and training to greater than 75% practices on Meaningful Use										
Task c. Provide education and training to 100% practices on Meaningful Use										
Task d. All practices on Meaningful Use by end of DY 3= Steps listed below that correspond with PCMH 2014 standards but focusing on EMR capabilities and practice use of these capabilities:										
Task Step 5…Improving quality ,safety , efficiency and reducing health disparities (these measures will help to provide better access to comprehensive patient data for patients health team; use evidence based order sets and Computer Order entry; apply clinical decision support at the point of care; generate list of patients who need care and use them to reach out to patients.)										
Task Step 6…Engage patients and families in their health care (these measures will provide patients and families with timely access to data; tools to make informed decisions and manage their health)										
Task Step 7…Improve care coordination (These measures will allow practices to exchange meaningful clinical information among a professional health care team)										
Task Step 8…Improve population and public health (these measures will allow physicians to communicate with public health agencies and better track of health information across communities)										

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Task Step 9…Ensure adequate privacy and security protections for personal health information (These measures will help ensure : the privacy & security protections for confidential health information through operating policies , procedures and technology; compliance with applicable law; and transparency of data sharing to the patient.										
Task Step 10...Create educational and training materials for Patient Centered Medical Home recognition. Create a series of classes (teaching of standards, leadership skills, project management skills, IT/EMR support) for practices not yet achieved PCMH to teach the steps of how to achieved Level 3 recognition. Find practices that have already achieved Level 3 that are willing to participate as mentors and leaders to other practices that have not yet achieved and connect them.										
Task a. Provide education and training to greater than half practices on PCMH										
Task b. Provide education and training to greater than 75% practices on PCMH										
Task c. Provide education and training to 100% practices on PCMH										
Task d. All Primary Care practices achieve PCMH by end of DY3==Steps listed below that are individualized to the assessment of each practice and has meaningful use standards embedded in the applicable standard:										
Task Step 11… Ensure PCMH policies and procedures in place with a process to review , revise and reapprove (templates are provided for office adaptation, customization)										
Task Step 12…Ability to run reports to track missed appointments, upcoming appointments, gaps in preventive care, gaps in chronic disease management, hospitalization and transitions of care documentation, care management interventions.										
Task Step 13…Appointment Access and availability reports completed (and follow policy). Enhance recruitment of providers based on access and availability report and CAHPS surveys through hospital and IPA recruitment offices										

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Task Step 14…Roles and job descriptions completed for practice team members in PCMH and training to PCMH as noted above										
Task Step 15…Evidence Based guidelines built into the EMR along with tools to manage patient care(care management including referrals to COBs, educational tools, follow up , motivational interviewing)										
Task Step 16…Assessment of diversity in the practice and ability to run quality metrics based on culture, language, and ethnicity										
Task Step 17…Track outreach to patients in attempts to close gaps in care(along with preferred methods of contact as stipulated by the patient)										
Task Step 18…Exchange of information (care coordination)-- reports to show timeliness of incoming and outgoing patient information.(referral agreements in place and information exchanged according to agreements and policy)										
Task Step 19…Quality improvement program in the office, utilizing Rapid Cycle Evaluation										
Task Step 20…Evaluation of usefulness of community referrals.										
Task Step 21…Medication management (monitors cost, best practice, allergies, interactions, e-scripts)										
Task Step 22... Set up a process for continued education and assistance with PCMH and Meaningful Use. PCMH renewals occur every three years, and meaningful use is yearly. So many practices will have to renew PCMH recognition during this time period, as well as continuing their MU attestations. We want to set up a process to ensure their continued success in the future. There are also standards in which you must show achievement during the interim years of recognition like the measurement and improvement of quality measures.										
Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.										
Task										

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Medicaid Managed Care contract(s) are in place that include value-based payments.										
Task Step 1...Assess current state of Medicaid Managed care contracts, compare with current value based payment arrangements for other products such as commercial or Medicare managed care.										
Task Step 2…Meet with major health plans to discuss establishing performance based contracts.										
Task Step 3…Develop additional performance /value contracts that incorporate financial and quality risk for Medicaid population.										
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…Establish monthly meetings with health plans to focus on medical management with actuarial/financial and medical/nursing staff discussing improvement initiatives , either separately or together .Catholic Medical Partners (CMP) has monthly meetings (rotating basis) with health plans reviewing utilization trends and discussing performance issues, return on investment, and payment reform. There is never an end date or completion date with healthplan meetings -- they will be ongoing but will add CPWNY partners to the table.										
Task Step 2… Currently CMP has risk arrangements and Value based contracts. We are working on with Fidelis (main product Medicaid) on Value based contracting . With existing contracts CPWNY will bring forth those partners interested in Value based contracting (ie Hospice Buffalo has expressed a desire to be included in talks for Palliative Care)										
Task Step 3…. Include key stakeholders in the meetings with MCOs as they express their interest in negotiating Value based contracts once data available indicating ROI.										
Task Step 4….Meetings to escalate to Monthly as needed if value based contracting for PPS is not on target r/t to agreement of										

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incentives, shared savings or risk arrangements.										
Task Step 5… Provide Executive Board with updates to Value Based Contracting progress on a quarterly basis										
Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.										
Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation										
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.										
Task Step 1...Develop a negotiating committee inclusive of representatives of our partners for discussions of value based contracts										
Task Step 2… CPWNY will utilize resources including a Contract Sub Committee and a Strategic Planning Sub Committee to engage impacted providers / partners and assist in the individual contracting done with HMO's.										
Task Step 3…CPWNY will use an existing shared savings compensation model and existing value based contracts for the establishment of value based agreements with the health plans.CPWNY will explore various VBP models such as total population, integrated primary care, acute care, and chronic care and payment methodologies. Plan the orderly implementation of VBP through the Strategic Planning Committee.										
Task Step 4… Insure that health plan data is available in a timely manner to all partners so action may be taken- CPWNY receives paid claims data and monitors cost and frequency of hospital inpatient and outpatient services , physician services, pharmacy and other expenses.										
Task Step 5…Insure the global budgets are risk adjusted for age and gender										
Task Step 6…Develop a stop-loss mechanism with the health plan contracts										

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Task Step 7…Review actuarial reports and trends with the PPS governance.										
Task Step 8…Compare utilization and cost to industry wide benchmarks										
Task Step 9…Align performance measures with community and industry standards utilizing a clinical integration program.										
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…Utilizing healthcare data analytics complete an assessment of our PPS attributed Medicaid members. Using clinical transformation team, extract data from EMRs - all Medicaid patients; sort by who has not been in office for 1 year or greater; by disease conditions (Cardiovascular , HTN, Renal, Diabetes, Behavioral health); impending doctor appointment; build in claims data to ascertain hospitalizations and ER visits to obtain holistic view of patient; Stratify population by the aforementioned and also segment by culture, ethnicity and language; Connect patients to health home (who also uses community health workers). Set up documentation in EMR to run reports on care management care plans, care transitions. To be overseen by CPWNY Clinical Transformation and CPWNY IT teams.										
Task Step 2… Identify and train community health workers and patient navigators- work with our CBO partners including our Health Homes to assist in developing a community health worker program.										
Task Step 3…Survey CBOs on their capabilities, value they bring for the Medicaid patient, hours of operation and after hours access, their role in meeting the needs of the Medicaid patient to avoid hospital usage as a first line health access component. Utilize social workers to make recommendations to connect partners with various CBOs , based on population needs of the provider.										

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Task Step 4…Each county will identify their community based partners, utilizing the Community Needs Assessment as a guide after the survey in step 3 is completed, and set up agreements/contracts regarding exchange of information and their committed help for the Medicaid patient.										
Task Step 5…Utilizing a behavioral health subcommittee, focus workgroup , draw on existing knowledge base of behavioral health providers regarding the needs and concerns of their patient base.Based on this information develop a strategy to engage patients.										
Task Step 6…CPWNY Care management team will assist practices, prioritizing outreach and developing a workflow on patient engagement, examining patient expressed barriers to seeking health care on an outpatient basis. Barriers may be related to lack of understanding, social, cultural, travel time, family dynamics, prioritization, etc. and utilize Community Based Organizations for overcoming these barriers.										

Project 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…..According to Thorpe and Ogden (1) An Integrated Delivery System is characterized by comprehensive services across the continuum of care and includes the fiollowing : 1. Patient focus; 2. Geographic coverage and rosters; 3. Performance Management; 4. Information Systems; 5. Organization culture and leadership ; 6. Physician integration ; 7. Governance Structure; Financial Management.The inclusion of all providers , institutions, payers, and CBOs:										

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Task Step 1 SUB STEPS: a. Align hospitals, physicians and other providers across the continuum , inclusive but not limited to behavioral health specialists , in governance meetings. Recognize that acute care is not the hub of the system and the primary care provider is. This includes but not limited to finance committee, IT/data committee and ad hoc committees.										
Task b. The delivery system is designed around the patient, not the provider. Adopt shared decision making tools throughout the continuum of care and utilize care managers to meet the needs of the complex patient.										
Task c. Adopt system wide evidence based guidelines, policies and procedures.										
Task d. Build consensus regarding a variety of performance measures and goals including access to care, clinical outcomes, functionality, satisfaction and value received and incentives.										
Task e. Create a process to that tracks provider performance compared to contract terms /requirements , including corrective action plans										
Task f. Establish a plan to monitor PPS provider performance periodically and report to the PPS governance, with corrective action and performance improvement initiatives, as needed.										
Task g. CEOs participate (through the governance board, in facilitating a network of healthcare delivery organizations and provide strategic management and leadership to their own organizations.										
Task h. Adopt a " no wrong door approach " policy and procedure to health care delivery, ensuring an individual can be treated , or referred to treatment , whether he or she seeks help for mental health problems, a substance abuse problem or general medical conditions.This would be reflected in educational trainings, PCMH rollout, health homes, and hospital alignments with outpatient care.										
Task i. IT integration will be crucial to success of the IDS: Initiate assessments of systems and identification of gaps that will be prioritized and remedied.										

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Task J. Complete full provider list of all PPS participants , defined by provider type, NPI and Practice name- post PPS provider network directory on web site. Maintain periodic audit trail report of log of changes to network list , periodic reports with changes to network list and contractual agreements.										
Task k. Develop a list of elements that will need to be part of each provider agreement/cotnract to develop draft contract										
Task l. Set up accountability agreements with partners (with behavioral health, ancillary providers, facilities, palliative care)as well as acute care , outpatient care, long term care, urgent care, home care, etc. Process of tracking agreements established.										
Task m. Create a process to track all executed provider contractual agreements.										
Task n. Engage key internal unit level PPS partners to participate in IDS project										
Task Step 2…Set up and maintain regular meetings /communication and involvement with all relevant stakeholders : (though there are target dates to sub steps meetings are continuous , especially when setting clinical integration metrics and informing of outcomes. SUB STEPS In relation to Step 2:										
Task a. Meet with Primary Care Providers - start with large Medicaid practices who need PCMH and communicate DSRIP initiatives utilizing physician lead , clinical transformation and enhanced care management team. (This is continuous)										
Task b. Meet with all small panel Medicaid practices utilizing Clinical Transformation team , Care Management team and Territory physicians (as needed) (This is continuous)										
Task c. Meet with Behavioral health through project involvement and Medical director as needed (this is continuous)										
Task d. Meet with post acute , long term care, community based service providers , social service organizations through project involvement, project leads. (this is continuous)										
Task e. Initiate meetings with payers on a monthly basis										

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Task f. Will use a variety of communication methods: webinars, emails, open forums, surveys, letters, Newsletters, and a fully functioning website with contacts for questions regarding our integrated network. A list of our network will be on the website with contact info.										
Task g. Communicate with other WNY PPS leadership to ensure no mixed messages on overlapping projects and present WNY as aligned and focused on the improvement of health care in the communities.										
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…Expand our current systems in place for ACO population health: MedInsight, Crimson, HEALTHeLINK. This provides the network and population management analytics and reporting application to monitor the sources of care for patients: Following sub steps refer to Step 1:										
Task a. Data Acquisition: inpatient data interfacing= DY 1, Q2; Ambulatory (hospital based interfacing) data interfacing = DY 1, Q2; Completion of physician practice interfacing = DY2, Q2										
Task b. User Acceptance testing: inpatient analytics - DY 1,Q2; Ambulatory (hospital based) analytics = DY2, Q2; physician practice (medical groups) analytics - DY 2, Q2										
Task Step 2 - Utilize current CMP ACO MedInsight to aggregate and stratify patients for population health utilizing health plan (payer) data (inclusive of Medicaid Salient data once pt. specific info is available) and EMR data rollout. (Medent, Clinical, Allscripts, etc.) --see Project requirement #6 Step 3 =Ensure data is getting										

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into the EMR via queryable fields										
Task Step 3…Social services link to HEALTHeLINK and other partners via Mirth Mail										
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…Our data analytics system is designed to identify gaps in care of the population and will be able to drill down to individual gaps in care. Obtain data of partners (refer to project requirement 2, step 2- Utilize current CMP ACO Med insight to aggregate and stratify patients for population health utilizing health plan (payer) data (inclusive of Medicaid Salient data once pt. specific info is available) and EMR data rollout (Medent, eClinicalWorks, Allscripts, etc.).										
Task Step 2…Maximize usage of claims data, EMR data, and patient self-report data by partnering with payers and providers in data collection -- set up discussions with payers: Starting with obtaining Medicaid claims data from health plans, in particular, data for high risk Medicaid patients.										
Task Step 3…Engage CBOs in executive governing body; assess the CBO resources and capabilities; and engage them according to alignment with projects and work streams.										
Task Step 4…Develop and utilize a patient dashboard approach to deploy community health workers , care managers, social										

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workers, and other resources as needed to augment primary care practice.										
Task Step 5 ...Deploy mobile clinical transformation team (EMR specialists and QA specialists) to assist in identifying and addressing gaps in care and prioritize where the Medicaid population is the largest. Gaps will be closed through the use of registries, use of portal and secure messaging in reaching out to patients; the care management team will prioritize patients (and caregivers) and assist practices in tracking and interventions. Regional physician leads will work with practices in each county to improve practitioners engagement.										
Task Step 6…Staff trained on IDS protocol and processes by region utilizing CPWNY website, WebEx, clinical transformation teams and regional physicians.										
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.	30	53	53	53	53	53	53	53	53	53
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	35	69	69	69	69	69	69	69	69	69
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	6	7	7	7	7	7	7	7	7	7
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	25	34	34	34	34	34	34	34	34	34
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	20	30	30	30	30	30	30	30	30	30
Task PPS uses alerts and secure messaging functionality.										
Task Step 1…Create inventory of Safety Net and non-Safety Net providers are signed on to HEALTHeLINK, whether they send complete CCD after encounter, whether they send/receive via										

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HISP, whether they can do virtual record lookup. Determine the EMRs they are using.										
Task Step 2…Roll out of partner agreements that stipulate the sharing of health information and use of the RHIO										
Task Step 3…In addition to agreements, HEALTHeLINK will be purchasing 500 authentication tokens for PPS practices that will make authentication for access to the RHIO information easier and no cost to the partner. This will enable providers to access information securely and easier.										
Task Step 4…HEALTHeLINK will provide a community wide patient event notification service that keys on multiple event types and is configurable to the practice/provider level										
Task Step 5…Build a directory that contains the DIRECT address of providers and practices across the community . This would facilitate the direct exchange of patient information between healthcare settings and would be readily accessible by any provider/user										
Task Step 6…Data exchange solution that enables Omni-directional communication between care providers and patients: a. Roll-out of patient portal to PPS partners without EMR= DY 1,Q 4; Roll-out to other PPS partners= DY 2, Q 4; Integrate MobileMD with RHIO (HEALTHeLINK) = DY 1, Q4; Integrate MobileMD with PPS EMR , first PPS EMR = DY2, Q4; Integrate with all other PPS EMRs such as behavioral health, SNF, home care= DY 3, Q4 (NOTE: MobileMD is an HIE that provides comprehensive data exchange solutions and will be directly integrated with the community-wide HEALTHeLINK RHIO/SHIN-NY).										
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.	32	53	53	53	53	53	53	53	53	53

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Task Step 1... Analyze current status of EMR systems used, the status of Meaningful Use (AUI, Stage 1, Stage 2, or none), and status of PCMH (Level 3, 2, 1, in process, or none) by participating provider practices. Create a work plan and timelines for getting practices not yet at PCMH Level 3 and MU to achieve them both by end of DY3.										
Task Step2... Assign each PCP practice a Clinical Transformation Specialist to work with them and be their point of contact on EMR, MU, PCMH, and Population Health/Quality Outcome Measures. Need to hire additional personnel to take on additional practices and workload. Roll out will be in phases starting with those practices with the largest volume of Medicaid patients.										
Task Step 3... Understand EMR system capabilities and if they have the ability to meet MU/PCMH for those who are not currently there. If there are gaps in capabilities create a work plan and timeline for working with the vendor or possibly transitioning some practices to more "ready" vendors(those practices that need to transition to more " ready" vendors will need more time and will not be completed until DY 3, Q4)										
Task Step 4… Have 100% of practices on EMR systems that enable them to meet MU and PCMH										
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…Create and maintain patient registries from Practices EMRs. For practices who don't currently have EMR, do manual registry based on claims data to start with , and eventually merge them to EMR registry workflow.										
Task Step 2...Create data dictionary of registry elements										
Task Step 3...Ensure data is getting into the EMR via queryable fields										
Task										

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Step 4…Data quality check and robust data aggregation /reporting										
Task Step 5…Data analytics function in place										
Task Step 6…Appropriate clinical oversight /review in place										
Task Step 7…Maintain centralized patient registries that will be used to stratify patients by condition and by responsible providers. Prioritize by HCC (patient stratification on severity/complexity) and other coding methodologies to assist the practices in population health interventions.										
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.	235	399	399	399	399	399	399	399	399	399
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...Analyze current status of EMR systems used, the status of Meaningful Use (AUI, Stage 1, Stage 2, or none), and status of PCMH (Level 3, 2, 1, in process, or none) by participating provider practices. Create a work plan and timelines for getting practices not yet at PCMH Level 3 and MU to achieve them both by end of DY3.										
Task Step 2...Assign each PCP practice a Clinical Transformation Specialist to work with them and be their point of contact on EMR, MU, PCMH, and Population Health/Quality Outcome Measures. Need to hire additional personnel to take on additional practices and workload										
Task Step 3...Create a survey or contact practices to understand practice readiness to engage in PCMH or MU activities (if not										

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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
currently engaged). Create work plan for training and educating those who are ready. Create an intervention strategy to help engage those who are not ready through the use of Regional Primary Care Leaders, Hospital leadership, and other resources yet to be determined (such as providing more care management assistance or behavioral health assistance to help the practice feel more comfortable with their ability to take on PCMH Project.)										
Task Step 4...Create educational training materials for Meaningful Use. Provide targeted education based on each practices needs, especially for those who did not meet MU on DY1, for either in person training, web based (WebEx), or user-group by EMR vendor training										
Task a. Provide education and training to greater than half practices on Meaningful Use										
Task b. Provide education and training to greater than 75% practices on Meaningful Use										
Task c. Provide education and training to 100% practices on Meaningful Use										
Task d. All practices on Meaningful Use by end of DY 3= Steps listed below that correspond with PCMH 2014 standards but focusing on EMR capabilities and practice use of these capabilities:										
Task Step 5…Improving quality ,safety , efficiency and reducing health disparities (these measures will help to provide better access to comprehensive patient data for patients health team; use evidence based order sets and Computer Order entry; apply clinical decision support at the point of care; generate list of patients who need care and use them to reach out to patients.)										
Task Step 6…Engage patients and families in their health care (these measures will provide patients and families with timely access to data; tools to make informed decisions and manage their health)										
Task Step 7…Improve care coordination (These measures will allow practices to exchange meaningful clinical information among a professional health care team)										
Task Step 8…Improve population and public health (these measures will allow physicians to communicate with public health agencies										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
and better track of health information across communities)										
Task Step 9…Ensure adequate privacy and security protections for personal health information (These measures will help ensure : the privacy & security protections for confidential health information through operating policies , procedures and technology; compliance with applicable law; and transparency of data sharing to the patient.										
Task Step 10...Create educational and training materials for Patient Centered Medical Home recognition. Create a series of classes (teaching of standards, leadership skills, project management skills, IT/EMR support) for practices not yet achieved PCMH to teach the steps of how to achieved Level 3 recognition. Find practices that have already achieved Level 3 that are willing to participate as mentors and leaders to other practices that have not yet achieved and connect them.										
Task a. Provide education and training to greater than half practices on PCMH										
Task b. Provide education and training to greater than 75% practices on PCMH										
Task c. Provide education and training to 100% practices on PCMH										
Task d. All Primary Care practices achieve PCMH by end of DY3==Steps listed below that are individualized to the assessment of each practice and has meaningful use standards embedded in the applicable standard:										
Task Step 11… Ensure PCMH policies and procedures in place with a process to review , revise and reapprove (templates are provided for office adaptation, customization)										
Task Step 12…Ability to run reports to track missed appointments, upcoming appointments, gaps in preventive care, gaps in chronic disease management, hospitalization and transitions of care documentation, care management interventions.										
Task Step 13…Appointment Access and availability reports completed (and follow policy). Enhance recruitment of providers based on access and availability report and CAHPS surveys through										

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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
hospital and IPA recruitment offices										
Task Step 14…Roles and job descriptions completed for practice team members in PCMH and training to PCMH as noted above										
Task Step 15…Evidence Based guidelines built into the EMR along with tools to manage patient care(care management including referrals to COBs, educational tools, follow up , motivational interviewing)										
Task Step 16…Assessment of diversity in the practice and ability to run quality metrics based on culture, language, and ethnicity										
Task Step 17…Track outreach to patients in attempts to close gaps in care(along with preferred methods of contact as stipulated by the patient)										
Task Step 18…Exchange of information (care coordination)-- reports to show timeliness of incoming and outgoing patient information.(referral agreements in place and information exchanged according to agreements and policy)										
Task Step 19…Quality improvement program in the office, utilizing Rapid Cycle Evaluation										
Task Step 20…Evaluation of usefulness of community referrals.										
Task Step 21…Medication management (monitors cost, best practice, allergies, interactions, e-scripts)										
Task Step 22... Set up a process for continued education and assistance with PCMH and Meaningful Use. PCMH renewals occur every three years, and meaningful use is yearly. So many practices will have to renew PCMH recognition during this time period, as well as continuing their MU attestations. We want to set up a process to ensure their continued success in the future. There are also standards in which you must show achievement during the interim years of recognition like the measurement and improvement of quality measures.										
Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish										

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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
value-based payment arrangements.										
Task Medicaid Managed Care contract(s) are in place that include value-based payments.										
Task Step 1...Assess current state of Medicaid Managed care contracts, compare with current value based payment arrangements for other products such as commercial or Medicare managed care.										
Task Step 2…Meet with major health plans to discuss establishing performance based contracts.										
Task Step 3…Develop additional performance /value contracts that incorporate financial and quality risk for Medicaid population.										
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…Establish monthly meetings with health plans to focus on medical management with actuarial/financial and medical/nursing staff discussing improvement initiatives , either separately or together .Catholic Medical Partners (CMP) has monthly meetings (rotating basis) with health plans reviewing utilization trends and discussing performance issues, return on investment, and payment reform. There is never an end date or completion date with healthplan meetings -- they will be ongoing but will add CPWNY partners to the table.										
Task Step 2… Currently CMP has risk arrangements and Value based contracts. We are working on with Fidelis (main product Medicaid) on Value based contracting . With existing contracts CPWNY will bring forth those partners interested in Value based contracting (ie Hospice Buffalo has expressed a desire to be included in talks for Palliative Care)										
Task Step 3…. Include key stakeholders in the meetings with MCOs as they express their interest in negotiating Value based contracts once data available indicating ROI.										

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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 4….Meetings to escalate to Monthly as needed if value based contracting for PPS is not on target r/t to agreement of incentives, shared savings or risk arrangements.										
Task Step 5… Provide Executive Board with updates to Value Based Contracting progress on a quarterly basis										
Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.										
Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation										
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.										
Task Step 1...Develop a negotiating committee inclusive of representatives of our partners for discussions of value based contracts										
Task Step 2… CPWNY will utilize resources including a Contract Sub Committee and a Strategic Planning Sub Committee to engage impacted providers / partners and assist in the individual contracting done with HMO's.										
Task Step 3…CPWNY will use an existing shared savings compensation model and existing value based contracts for the establishment of value based agreements with the health plans.CPWNY will explore various VBP models such as total population, integrated primary care, acute care, and chronic care and payment methodologies. Plan the orderly implementation of VBP through the Strategic Planning Committee.										
Task Step 4… Insure that health plan data is available in a timely manner to all partners so action may be taken- CPWNY receives paid claims data and monitors cost and frequency of hospital inpatient and outpatient services , physician services, pharmacy and other expenses.										
Task Step 5…Insure the global budgets are risk adjusted for age and gender										
Task										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Step 6…Develop a stop-loss mechanism with the health plan contracts										
Task Step 7…Review actuarial reports and trends with the PPS governance.										
Task Step 8…Compare utilization and cost to industry wide benchmarks										
Task Step 9…Align performance measures with community and industry standards utilizing a clinical integration program.										
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…Utilizing healthcare data analytics complete an assessment of our PPS attributed Medicaid members. Using clinical transformation team, extract data from EMRs - all Medicaid patients; sort by who has not been in office for 1 year or greater; by disease conditions (Cardiovascular , HTN, Renal, Diabetes, Behavioral health); impending doctor appointment; build in claims data to ascertain hospitalizations and ER visits to obtain holistic view of patient; Stratify population by the aforementioned and also segment by culture, ethnicity and language; Connect patients to health home (who also uses community health workers). Set up documentation in EMR to run reports on care management care plans, care transitions. To be overseen by CPWNY Clinical Transformation and CPWNY IT teams.										
Task Step 2… Identify and train community health workers and patient navigators- work with our CBO partners including our Health Homes to assist in developing a community health worker program.										
Task Step 3…Survey CBOs on their capabilities, value they bring for the Medicaid patient, hours of operation and after hours access, their role in meeting the needs of the Medicaid patient to avoid hospital usage as a first line health access component. Utilize										

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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
social workers to make recommendations to connect partners with various CBOs , based on population needs of the provider.										
Task Step 4…Each county will identify their community based partners, utilizing the Community Needs Assessment as a guide after the survey in step 3 is completed, and set up agreements/contracts regarding exchange of information and their committed help for the Medicaid patient.										
Task Step 5…Utilizing a behavioral health subcommittee, focus workgroup , draw on existing knowledge base of behavioral health providers regarding the needs and concerns of their patient base.Based on this information develop a strategy to engage patients.										
Task Step 6…CPWNY Care management team will assist practices, prioritizing outreach and developing a workflow on patient engagement, examining patient expressed barriers to seeking health care on an outpatient basis. Barriers may be related to lack of understanding, social, cultural, travel time, family dynamics, prioritization, etc. and utilize Community Based Organizations for overcoming these barriers.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.	
Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	
Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	
Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	
Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	
Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	
Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	For Milestone #10, task #4, this has been placed "on Hold" due to these two committee's have been combined into the Executive Committee.
Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	

Milestone Review Status

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

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Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

• Initially different providers will be at different states of readiness for meeting PCMH level 3 standards. This would limit the number of practices that are prepared manage patients according to DSRIP guidelines. We plan to utilize our current clinical transformation team to aide practices that have not yet achieved certification. Additional staff will be hired to address the influx of practices required to achieve certification. CPWNY will prioritize practices with the largest volume of Medicaid patients. CPWNY will utilize existing relationships with our health homes and safety net clinics to help manage patients and meet project requirements.

• There may be periods when many providers require support from the PPS to achieve common deadlines. This will create a short term demand on central resources that may not be equipped to handle the entire volume of providers at once. CPWNY will address this by starting early and prioritizing practices that require the most help. As deadlines approach, CPWNY will establish a call service to address questions about achieving requirements. CPWNY will hold group training sessions to touch multiple practices at once and provide additional resources to practices as needed. CPWNY will enlist the help of providers that have successfully met their deadlines to offer guidance to practices that are behind, reducing the burden on centralized staff. The executive governance board will review performance of all PPS providers for possible remediation.

• Key providers in a patient care pathway may not be part of the PPS's network. This may create a problem with ensuring that the provider has interest in meeting DSRIP goals when treating our patients. In our region, there are two PPS provider networks: CPWNY and Millennium Collaborative Care (MCC). As both PPS's are engaged in the ED Triage project, CPWNY will establish a mutual agreement with MCC to treat all patients according to DSRIP standards. CPWNY will develop IT infrastructure through the RHIE, Health-e-Link, which will allow CPWNY providers to exchange information with MCC providers in order to track patient progress across PPS's. For patients who see providers outside of either network, CPWNY will refer them to existing internal care management resources, such as our health homes, to ensure that the patients are receiving appropriate care, attending appointments, and meeting care plan goals.

• Some providers may resist adopting PPS-wide protocols. This would affect CPWNY's overall performance and hinder the quality of care provided to patients. As a federally recognized Accountable Care Organization, Catholic Medical Partners has experience engaging physicians in PPS-wide protocols related to quality of care and performance reporting. This is done through use of physician champions, performance incentives, providing necessary resources, and remediation programs for providers who fail to perform at the expected level. CPWNY will employ our existing and proven strategies going forward to ensure participation and engagement in PPS-wide protocols. The executive governance board will review performance of all PPS providers for possible remediation.

• Some providers may see an excess burden if they choose to implement DSRIP projects with only a subset of their patients. This may hinder provider engagement and lower performance. CPWNY will create an incentive program that rewards physicians for clinical performance and for physician engagement. CPWNY will create a policy that requires all Medicaid patients be treated according to the same standards, and will not discriminate based on their status as a member of our attributed population. CPWNY will provide resources such as care coordination, community health workers, and social workers to assist practices and alleviate the burden of DSRIP implementation.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	22,695

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
5,070	11,751	73.97%	4,136	51.78%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (15,887)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
dcao	Rosters	46_PMDL2715_1_3_20160128150404_CPWNY_Patient_List_for_2.b.iii_ED_Triage_DY1_Q3.pdf	CPWNY Patient List for project 2.b.iii ED Triage in DY1 Q3.	01/28/2016 03:04 PM

Narrative Text :

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

Regarding patient identifier information for project 2.b.iii: CPWNY provides CIN when possible. When CIN is not available we provider MCO information and MCO policy number. Patient names are provided from most partners to maximize traceability. The data collection process follows the approved CPWNY grant application and the approved CPWNY implementation plan.

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Establish ED care triage program for at-risk populations	Project	N/A	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Stand up program based on project requirements	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Step 1….Assess current ER utilization for potentially preventable ER visits by payer type Medicaid/Managed Medicaid and by level of severity (triage level 4 or 5), including high risk patients who have multiple preventable ER visits.	Project		Completed	07/01/2015	12/30/2015	07/01/2015	12/30/2015	12/31/2015	DY1 Q3
Task Step 2...Assess current ER Care Management capabilities, scope of work, hours of operation, staffing complement , etc. at each acute care site and the resources needed to achieve the target goals of reducing potentially preventable ER visits by 25% over 5 years. Determine exiting resources at each ER that can assist with diversion: social workers, Health home, care management staff.	Project		Completed	07/01/2015	12/30/2015	07/01/2015	12/30/2015	12/31/2015	DY1 Q3
Task Step 3….CPWNY's partner hospitals currently have protocols for ER triage for potentially preventable ER visits. CPWNY will assess the existing protocols and adapt the protocols to better suit the needs of Medicaid population.	Project		In Progress	08/01/2015	03/30/2016	08/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task Step 4….Develop protocols for ER triage for potentially preventable ER visits and referral process to PCMH practices and/or Health Home and other community resources.	Project		In Progress	08/01/2015	03/30/2016	08/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task Step 5...Commence with hiring/posting process for select clinical/non clinical personnel including social workers , patient navigators and health home outreach associates	Project		In Progress	08/01/2015	03/30/2016	08/01/2015	03/30/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 6….Train staff in identifying potentially preventable ER visits and in facilitating safe and effective referrals to PCMH, Health Home and other community resources.	Project		In Progress	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 7….Establish onsite health home outreach presence /capability in the ER setting for select high volume ER with initial focus on Sisters/Main Street and Mercy Buffalo.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 8….Establish open access for patients with participating CBOs for rapid turn around and follow through. Agreement between CPWNY and participating CBOs will reflect this expectation.	Project		In Progress	08/01/2015	03/30/2016	08/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task Step 9….Create/establish electronic data base /registry for the Medicaid patient cohort. The ER triage project team will work with the IT team to address the gaps in existing EMR systems in tracking Medicaid patients in ER.	Project		In Progress	09/01/2015	12/30/2016	09/01/2015	12/30/2016	12/31/2016	DY2 Q3
Task Step 10….Follow through with health home (weekly updates as needed) for patients diverted and referred to either health home or PCMH PCP practices.	Project		In Progress	10/01/2015	12/30/2016	10/01/2015	12/30/2016	12/31/2016	DY2 Q3
Task Step 11…Periodic assessment of success, failures, improvements needed utilizing process improvement techniques such as Rapid Cycle Improvement. (This activity is ongoing)	Project		In Progress	07/01/2015	03/30/2018	07/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Step. 12...Once established program successful after 6-9 months then roll out to other hospitals, one at a time. (steps 1-12)	Project		In Progress	01/01/2017	03/30/2018	01/01/2017	03/30/2018	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	Project	N/A	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	Provider	Safety Net Hospital	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Item a. (Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3.) will be addressed in the following steps:	Project		In Progress	09/01/2015	03/30/2016	09/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task Step 1... Analyze current status of EMR systems used, the status of Meaningful Use (AUI, Stage 1, Stage 2, or none), and status of PCMH (Level 3, 2, 1, in process, or none) by participating provider practices. Create a work plan and timelines for getting practices not yet at PCMH Level 3 and MU to achieve them both by end of DY3.	Project		In Progress	09/01/2015	12/30/2015	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2... Assign each PCP practice a Clinical Transformation Specialist to work with them and be their point of contact on EMR, MU, PCMH, and Population Health/Quality Outcome Measures. Need to hire additional personnel to take on additional practices and workload. Roll out will be in phases starting with those practices with the largest volume of Medicaid patients.	Project		In Progress	09/01/2015	12/30/2015	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3... Understand EMR system capabilities and if they have	Project		In Progress	09/01/2015	03/30/2018	09/01/2015	03/30/2018	03/31/2018	DY3 Q4

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DSRIP Implementation Plan Project

Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
the ability to meet MU/PCMH for those who are not currently there. If there are gaps in capabilities create a work plan and timeline for working with the vendor or possibly transitioning some practices to more "ready" vendors(those practices that need to transition to more " ready" vendors will need more time and will not be completed until DY 3, Q4)									
Task Step 4… Have 100% of practices on EMR systems that enable them to meet MU and PCMH	Project		In Progress	09/01/2015	03/30/2018	09/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task The following steps will address item b. and c. (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		In Progress	09/01/2015	03/30/2018	09/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Step 1... The ER Triage project team will collaborate with CPWNY's IT team to assess community primary care providers' and Health Home's existing notification capabilities.	Project		In Progress	09/01/2015	03/30/2016	09/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task Step 2... Establish procedures and policies on connectivity between ER and primary care providers; currently some of the CPWNY hospitals have real time notification to the Health Home and/or community primary care providers when a patient has presented into the ER that needs Health Home assistance.	Project		In Progress	09/01/2015	03/30/2016	09/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task Step 3... The ER Triage project team will conduct meetings and assessment with other CPWNY partner hospitals on their existing connectivity with Health Home and community primary care and existing ED triage procedures and policies.	Project		In Progress	09/01/2015	03/30/2016	09/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task Step 4... The ER Triage project team will develop plan to identify and address gaps to transform to real time notification to the Health Home based on existing best practices and nationally recognized guideline.	Project		In Progress	09/01/2015	03/30/2016	09/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task Efforts to understand EMR systems capabilities/readiness and ability to achieve /meet Medical Home, PCMH or APCM status	Project		In Progress	09/01/2015	03/30/2018	09/01/2015	03/30/2018	03/31/2018	DY3 Q4

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with focus on practices/groups/practitioners not yet there. This may include a written/formalized workplan, timeline with evaluating/ascertaining vendor readiness. Will evaluate moving some practices to vendors with more capabilities to achieve status as noted									
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	09/01/2015	03/30/2018	09/01/2015	03/30/2018	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	09/01/2015	03/30/2018	09/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task There are levels of patient navigators: Level 1 may be a lay healthcare worker or have some college , and work in the community or health care settings. They often work with patients during health screening and through the diagnostic process and may link patients to screening tests or provider health information. Level 1 also work with patients to identify and reduce barriers that keep patients from getting healthcare. A Level 2 patient navigator may be a nurse or a social worker with a BS or MS degree. Some Level 2 navigators may have less education but a lot of experience as patient navigators. These navigators work with patients in healthcare or community settings after patients receive a diagnosis , through treatment or disease management, into health maintenance, and sometimes at the end of life. Level 2 navigators may focus on behavior change, adjustment to life with a chronic illness or help clients maintain a healthy lifestyle. They address barriers to healthcare	Project		In Progress	09/01/2015	03/30/2018	09/01/2015	03/30/2018	03/31/2018	DY3 Q4

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, coordinate care, tailor health information to patient needs, and motivate clients to make healthy choices. (Level 2 patient navigators can also perform all functions of Level 1 as well) he following is CPWNY road map for use of patient navigators is:									
Task CPWNY has experience with patient navigators, Level 2 , in certain hospitals for patients other than Medicaid. The ER Triage project team, in collaboration with Health Home, will assess the capability of our partners and identify gaps in addressing the needs of Medicaid population.	Project		In Progress	09/01/2015	03/30/2016	09/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task CPWNY will develop procedures and protocols that develop flow when a patient needs a Level 1 or 2 patient navigator that will better address the needs of the Medicaid population.	Project		In Progress	09/01/2015	03/30/2018	09/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Produce a list of non emergent encounters eligible for triage to ascertain trends and issues (as stated in Milestone #1) time of day , frequent flyers, to help guide the facilitation of protocols established.(provide lists to patient navigators of PCMH offices that will accommodate patient appointments)	Project		In Progress	09/01/2015	03/30/2016	09/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task CPWNY will engage partners with successful patient navigation performance in providing patient navigation training programs that also meet cultural competency and health literacy requirements for patient trust and engagement.	Project		In Progress	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Based on assessments of Hospital partners and their existing resources , formulate a hiring/training plan with our selected CBOs to bridge resource gaps. Training program will specifically address improving Medicaid population's access to PCMH practices. Patient navigators will be trained to work along side with social workers to access community resources.	Project		In Progress	09/01/2015	03/30/2018	09/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Initial implementation at Mercy Hospital of Buffalo and Sisters of Charity Hospital. Competency to be in place for assisting the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need; assist the	Project		In Progress	09/01/2015	03/30/2016	09/01/2015	03/30/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
patient with identifying and accessing needed community support resources; assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).									
Task Deployment of on site health home outreach associates in the SOC and MHOB ER during peak hours of 11:00 am to 11:00 pm so as to support/encourage/promote health home enrollment	Project		In Progress	09/01/2015	03/30/2016	09/01/2015	03/30/2016	03/31/2016	DY1 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	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has protocols and operations in place to transport non-acute patients to appropriate care site. (Optional).	Provider	Safety Net Hospital	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Create/establish a system identification/system solution/system alert to identify that an risk patient is in the ED based on payer type and ER triage level of care (CPWNY's Partner Hospitals in the Catholic Health System currently have a system to identify ER utilization for potentially preventable ER visits by payer type --Need to expand to Medicaid/Managed Medicaid and by level of severity (triage level 4 or 5), including high risk patients who have multiple preventable ER visits.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Assess what all our hospital partners have in place , identify gaps in systems and utilize Rapid Cycle Evaluation method to process improve.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task ER Triage team (inclusive of CPWNY hospital partners) will work	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
on creation and establishment of a system wide /universal data base with reporting /analytic reporting capability. CPWNY's IT team will be involved in this endeavor.									
Task Data quality control with appropriate clinical oversight -adjust process based on the quality control oversight.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	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….Assess current ER utilization for potentially preventable ER visits by payer type Medicaid/Managed Medicaid and by level of severity (triage level 4 or 5), including high risk patients who have multiple preventable ER visits.										
Task Step 2...Assess current ER Care Management capabilities, scope of work, hours of operation, staffing complement , etc. at each acute care site and the resources needed to achieve the target goals of reducing potentially preventable ER visits by 25% over 5 years. Determine exiting resources at each ER that can assist with diversion: social workers, Health home, care management staff.										
Task Step 3….CPWNY's partner hospitals currently have protocols for ER triage for potentially preventable ER visits. CPWNY will assess the existing protocols and adapt the protocols to better suit the needs of Medicaid population.										
Task Step 4….Develop protocols for ER triage for potentially preventable ER visits and referral process to PCMH practices and/or Health Home and other community resources.										
Task Step 5...Commence with hiring/posting process for select clinical/non clinical personnel including social workers , patient navigators and health home outreach associates										
Task Step 6….Train staff in identifying potentially preventable ER visits										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
and in facilitating safe and effective referrals to PCMH, Health Home and other community resources.										
Task Step 7….Establish onsite health home outreach presence /capability in the ER setting for select high volume ER with initial focus on Sisters/Main Street and Mercy Buffalo.										
Task Step 8….Establish open access for patients with participating CBOs for rapid turn around and follow through. Agreement between CPWNY and participating CBOs will reflect this expectation.										
Task Step 9….Create/establish electronic data base /registry for the Medicaid patient cohort. The ER triage project team will work with the IT team to address the gaps in existing EMR systems in tracking Medicaid patients in ER.										
Task Step 10….Follow through with health home (weekly updates as needed) for patients diverted and referred to either health home or PCMH PCP practices.										
Task Step 11…Periodic assessment of success, failures, improvements needed utilizing process improvement techniques such as Rapid Cycle Improvement. (This activity is ongoing)										
Task Step. 12...Once established program successful after 6-9 months then roll out to other hospitals, one at a time. (steps 1-12)										
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	1	5	8	12	15	18	22	25	28
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note:										

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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
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	3	6	9	12	15	20	25
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	0	0	0	1	1	2	2	3	4	5
Task Item a. (Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3.) will be addressed in the following steps:										
Task Step 1... Analyze current status of EMR systems used, the status of Meaningful Use (AUI, Stage 1, Stage 2, or none), and status of PCMH (Level 3, 2, 1, in process, or none) by participating provider practices. Create a work plan and timelines for getting practices not yet at PCMH Level 3 and MU to achieve them both by end of DY3.										
Task Step 2... Assign each PCP practice a Clinical Transformation Specialist to work with them and be their point of contact on EMR, MU, PCMH, and Population Health/Quality Outcome Measures. Need to hire additional personnel to take on additional practices and workload. Roll out will be in phases starting with those practices with the largest volume of Medicaid patients.										
Task Step 3... Understand EMR system capabilities and if they have the ability to meet MU/PCMH for those who are not currently there. If there are gaps in capabilities create a work plan and timeline for working with the vendor or possibly transitioning some practices to more "ready" vendors(those practices that need to transition to more " ready" vendors will need more time and will not be completed until DY 3, Q4)										
Task Step 4… Have 100% of practices on EMR systems that enable them to meet MU and PCMH										
Task The following steps will address item b. and c. (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)										

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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 1... The ER Triage project team will collaborate with CPWNY's IT team to assess community primary care providers' and Health Home's existing notification capabilities.										
Task Step 2... Establish procedures and policies on connectivity between ER and primary care providers; currently some of the CPWNY hospitals have real time notification to the Health Home and/or community primary care providers when a patient has presented into the ER that needs Health Home assistance.										
Task Step 3... The ER Triage project team will conduct meetings and assessment with other CPWNY partner hospitals on their existing connectivity with Health Home and community primary care and existing ED triage procedures and policies.										
Task Step 4... The ER Triage project team will develop plan to identify and address gaps to transform to real time notification to the Health Home based on existing best practices and nationally recognized guideline.										
Task Efforts to understand EMR systems capabilities/readiness and ability to achieve /meet Medical Home, PCMH or APCM status with focus on practices/groups/practitioners not yet there. This may include a written/formalized workplan, timeline with evaluating/ascertaining vendor readiness. Will evaluate moving some practices to vendors with more capabilities to achieve status as noted										
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.										

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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 There are levels of patient navigators: Level 1 may be a lay healthcare worker or have some college , and work in the community or health care settings. They often work with patients during health screening and through the diagnostic process and may link patients to screening tests or provider health information. Level 1 also work with patients to identify and reduce barriers that keep patients from getting healthcare. A Level 2 patient navigator may be a nurse or a social worker with a BS or MS degree. Some Level 2 navigators may have less education but a lot of experience as patient navigators. These navigators work with patients in healthcare or community settings after patients receive a diagnosis , through treatment or disease management, into health maintenance, and sometimes at the end of life. Level 2 navigators may focus on behavior change, adjustment to life with a chronic illness or help clients maintain a healthy lifestyle. They address barriers to healthcare , coordinate care, tailor health information to patient needs, and motivate clients to make healthy choices. (Level 2 patient navigators can also perform all functions of Level 1 as well) he following is CPWNY road map for use of patient navigators is:										
Task CPWNY has experience with patient navigators, Level 2 , in certain hospitals for patients other than Medicaid. The ER Triage project team, in collaboration with Health Home, will assess the capability of our partners and identify gaps in addressing the needs of Medicaid population.										
Task CPWNY will develop procedures and protocols that develop flow when a patient needs a Level 1 or 2 patient navigator that will better address the needs of the Medicaid population.										
Task Produce a list of non emergent encounters eligible for triage to ascertain trends and issues (as stated in Milestone #1) time of day , frequent flyers, to help guide the facilitation of protocols established.(provide lists to patient navigators of PCMH offices that will accommodate patient appointments)										
Task CPWNY will engage partners with successful patient navigation performance in providing patient navigation training programs that also meet cultural competency and health literacy requirements for patient trust and engagement.										
Task Based on assessments of Hospital partners and their existing resources , formulate a hiring/training plan with our selected										

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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
CBOs to bridge resource gaps. Training program will specifically address improving Medicaid population's access to PCMH practices. Patient navigators will be trained to work along side with social workers to access community resources.										
Task Initial implementation at Mercy Hospital of Buffalo and Sisters of Charity Hospital. Competency to be in place for assisting the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need; assist the patient with identifying and accessing needed community support resources; assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).										
Task Deployment of on site health home outreach associates in the SOC and MHOB ER during peak hours of 11:00 am to 11:00 pm so as to support/encourage/promote health home enrollment										
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 Create/establish a system identification/system solution/system alert to identify that an risk patient is in the ED based on payer type and ER triage level of care (CPWNY's Partner Hospitals in the Catholic Health System currently have a system to identify ER utilization for potentially preventable ER visits by payer type --Need to expand to Medicaid/Managed Medicaid and by level of severity (triage level 4 or 5), including high risk patients who have multiple preventable ER visits.										
Task Assess what all our hospital partners have in place , identify gaps in systems and utilize Rapid Cycle Evaluation method to process										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
improve.										
Task ER Triage team (inclusive of CPWNY hospital partners) will work on creation and establishment of a system wide /universal data base with reporting /analytic reporting capability. CPWNY's IT team will be involved in this endeavor.										
Task Data quality control with appropriate clinical oversight -adjust process based on the quality control oversight.										

Project 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….Assess current ER utilization for potentially preventable ER visits by payer type Medicaid/Managed Medicaid and by level of severity (triage level 4 or 5), including high risk patients who have multiple preventable ER visits.										
Task Step 2...Assess current ER Care Management capabilities, scope of work, hours of operation, staffing complement , etc. at each acute care site and the resources needed to achieve the target goals of reducing potentially preventable ER visits by 25% over 5 years. Determine exiting resources at each ER that can assist with diversion: social workers, Health home, care management staff.										
Task Step 3….CPWNY's partner hospitals currently have protocols for ER triage for potentially preventable ER visits. CPWNY will assess the existing protocols and adapt the protocols to better suit the needs of Medicaid population.										
Task Step 4….Develop protocols for ER triage for potentially preventable ER visits and referral process to PCMH practices and/or Health Home and other community resources.										
Task Step 5...Commence with hiring/posting process for select clinical/non clinical personnel including social workers , patient navigators and health home outreach associates										

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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….Train staff in identifying potentially preventable ER visits and in facilitating safe and effective referrals to PCMH, Health Home and other community resources.										
Task Step 7….Establish onsite health home outreach presence /capability in the ER setting for select high volume ER with initial focus on Sisters/Main Street and Mercy Buffalo.										
Task Step 8….Establish open access for patients with participating CBOs for rapid turn around and follow through. Agreement between CPWNY and participating CBOs will reflect this expectation.										
Task Step 9….Create/establish electronic data base /registry for the Medicaid patient cohort. The ER triage project team will work with the IT team to address the gaps in existing EMR systems in tracking Medicaid patients in ER.										
Task Step 10….Follow through with health home (weekly updates as needed) for patients diverted and referred to either health home or PCMH PCP practices.										
Task Step 11…Periodic assessment of success, failures, improvements needed utilizing process improvement techniques such as Rapid Cycle Improvement. (This activity is ongoing)										
Task Step. 12...Once established program successful after 6-9 months then roll out to other hospitals, one at a time. (steps 1-12)										
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.	32	53	53	53	53	53	53	53	53	53

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 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	30	53	53	53	53	53	53	53	53	53
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	6	7	7	7	7	7	7	7	7	7
Task Item a. (Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3.) will be addressed in the following steps:										
Task Step 1... Analyze current status of EMR systems used, the status of Meaningful Use (AUI, Stage 1, Stage 2, or none), and status of PCMH (Level 3, 2, 1, in process, or none) by participating provider practices. Create a work plan and timelines for getting practices not yet at PCMH Level 3 and MU to achieve them both by end of DY3.										
Task Step 2... Assign each PCP practice a Clinical Transformation Specialist to work with them and be their point of contact on EMR, MU, PCMH, and Population Health/Quality Outcome Measures. Need to hire additional personnel to take on additional practices and workload. Roll out will be in phases starting with those practices with the largest volume of Medicaid patients.										
Task Step 3... Understand EMR system capabilities and if they have the ability to meet MU/PCMH for those who are not currently there. If there are gaps in capabilities create a work plan and timeline for working with the vendor or possibly transitioning some practices to more "ready" vendors(those practices that need to transition to more " ready" vendors will need more time and will not be completed until DY 3, Q4)										
Task Step 4… Have 100% of practices on EMR systems that enable them to meet MU and PCMH										
Task The following steps will address item b. and c. (b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c.										

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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
Ensure real time notification to a Health Home care manager as applicable)										
Task Step 1... The ER Triage project team will collaborate with CPWNY's IT team to assess community primary care providers' and Health Home's existing notification capabilities.										
Task Step 2... Establish procedures and policies on connectivity between ER and primary care providers; currently some of the CPWNY hospitals have real time notification to the Health Home and/or community primary care providers when a patient has presented into the ER that needs Health Home assistance.										
Task Step 3... The ER Triage project team will conduct meetings and assessment with other CPWNY partner hospitals on their existing connectivity with Health Home and community primary care and existing ED triage procedures and policies.										
Task Step 4... The ER Triage project team will develop plan to identify and address gaps to transform to real time notification to the Health Home based on existing best practices and nationally recognized guideline.										
Task Efforts to understand EMR systems capabilities/readiness and ability to achieve /meet Medical Home, PCMH or APCM status with focus on practices/groups/practitioners not yet there. This may include a written/formalized workplan, timeline with evaluating/ascertaining vendor readiness. Will evaluate moving some practices to vendors with more capabilities to achieve status as noted										
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										

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
is in place.										
Task There are levels of patient navigators: Level 1 may be a lay healthcare worker or have some college , and work in the community or health care settings. They often work with patients during health screening and through the diagnostic process and may link patients to screening tests or provider health information. Level 1 also work with patients to identify and reduce barriers that keep patients from getting healthcare. A Level 2 patient navigator may be a nurse or a social worker with a BS or MS degree. Some Level 2 navigators may have less education but a lot of experience as patient navigators. These navigators work with patients in healthcare or community settings after patients receive a diagnosis , through treatment or disease management, into health maintenance, and sometimes at the end of life. Level 2 navigators may focus on behavior change, adjustment to life with a chronic illness or help clients maintain a healthy lifestyle. They address barriers to healthcare , coordinate care, tailor health information to patient needs, and motivate clients to make healthy choices. (Level 2 patient navigators can also perform all functions of Level 1 as well) he following is CPWNY road map for use of patient navigators is:										
Task CPWNY has experience with patient navigators, Level 2 , in certain hospitals for patients other than Medicaid. The ER Triage project team, in collaboration with Health Home, will assess the capability of our partners and identify gaps in addressing the needs of Medicaid population.										
Task CPWNY will develop procedures and protocols that develop flow when a patient needs a Level 1 or 2 patient navigator that will better address the needs of the Medicaid population.										
Task Produce a list of non emergent encounters eligible for triage to ascertain trends and issues (as stated in Milestone #1) time of day , frequent flyers, to help guide the facilitation of protocols established.(provide lists to patient navigators of PCMH offices that will accommodate patient appointments)										
Task CPWNY will engage partners with successful patient navigation performance in providing patient navigation training programs that also meet cultural competency and health literacy requirements for patient trust and engagement.										

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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 Based on assessments of Hospital partners and their existing resources , formulate a hiring/training plan with our selected CBOs to bridge resource gaps. Training program will specifically address improving Medicaid population's access to PCMH practices. Patient navigators will be trained to work along side with social workers to access community resources.										
Task Initial implementation at Mercy Hospital of Buffalo and Sisters of Charity Hospital. Competency to be in place for assisting the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need; assist the patient with identifying and accessing needed community support resources; assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).										
Task Deployment of on site health home outreach associates in the SOC and MHOB ER during peak hours of 11:00 am to 11:00 pm so as to support/encourage/promote health home enrollment										
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 Create/establish a system identification/system solution/system alert to identify that an risk patient is in the ED based on payer type and ER triage level of care (CPWNY's Partner Hospitals in the Catholic Health System currently have a system to identify ER utilization for potentially preventable ER visits by payer type --Need to expand to Medicaid/Managed Medicaid and by level of severity (triage level 4 or 5), including high risk patients who have multiple preventable ER visits.										

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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 Assess what all our hospital partners have in place , identify gaps in systems and utilize Rapid Cycle Evaluation method to process improve.										
Task ER Triage team (inclusive of CPWNY hospital partners) will work on creation and establishment of a system wide /universal data base with reporting /analytic reporting capability. CPWNY's IT team will be involved in this endeavor.										
Task Data quality control with appropriate clinical oversight -adjust process based on the quality control oversight.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish ED care triage program for at-risk populations	
Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable	
For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	
Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)	
Use EHRs and other technical platforms to track all patients engaged in the project.	

Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

• Risk: Initially different providers will be at different states of readiness/completeness regarding meeting PCMH level 3 standards. This would limit the number of practices that are prepared to schedule and manage patients according to the project guidelines. Mitigation: CPWNY plans to utilize current clinical transformation team to target and aide practices that have not yet achieved their certification. Additional staff will be hired by this team to address the influx of practices required to achieve PCMH level 3 certification. CPWNY will prioritize and focus on practices with the largest volume of Medicaid patients. CPWNY will also utilize existing relationships with our health homes and safety net clinics to help manage patients and meet project requirements.

• Risk: As providers work towards meeting the timelines set by the PPS, there may be periods when many providers require support from the PPS to achieve common PPS-wide deadlines. This will create a short term demand on central resources that may not be equipped to handle the entire volume of providers at once. CPWNY will address this by starting early and prioritizing practices that require the most help and effort to achieve specific requirements. Mitigation: As widespread deadlines approach, CPWNY will establish a call service to address questions or concerns with achieving requirements. CPWNY will hold intensive group training sessions to touch multiple practices at once and provide additional resources to practices as needed. CPWNY will enlist the help of providers that have successfully met their deadlines to act as liaisons and offer guidance to practices that are behind, and reduce the burden on centralized staff. The executive governance board will review performance of all PPS providers for possible remediation.

• Risk: Some providers may resist/refuse adopting PPS-wide protocols. This would affect CPWNY's overall performance and hinder the quality of care provided to patients in the network. Mitigation: As a federally recognized Accountable Care Organization, Catholic Medical Partners has experience engaging physicians in PPS wide protocols related to quality of care and performance reporting. This is done through use of physician champions, performance incentives, providing necessary resources to our practices, and through remediation programs for providers who fail to perform at the expected level. CPWNY will employ these existing, and proven, strategies going forward to ensure participation and engagement in PPS-wide DSRIP protocols. The executive governance board will review performance of all PPS providers for possible remediation.

• Risk: Some providers may see an excess burden if they choose to implement DSRIP projects with only a subset of their patients. This may hinder provider engagement and lower performance. Mitigation: CPWNY will create an incentive program that rewards physicians for clinical performance and for physician engagement. CPWNY will also institute a policy that requires that all Medicaid patients be treated according to DSRIP project standards, and will not discriminate based on their status as a member of our attributed population. CPWNY will provide resources such as care coordination, community health workers, and social workers to assist practices and alleviate the burden of DSRIP implementation.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	11,740

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
3,467	5,815	123.83%	-1,119	49.53%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
dcao	Rosters	46_PMDL2815_1_3_20160126150421_CPWNY_Patient_List_for_2.b.iv_Care_Transitions_DY1_Q3.pdf	CPWNY Patient List for 2.b.iv Care Transitions DY1 Q3	01/26/2016 03:04 PM

Narrative Text :

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

CPWNY's definition of a care transition plan is a complete transition of care document from the hospital EMR including the following elements:
• Patient self-education instructions
• Follow-up appointment or instructions for scheduling a follow-up appointment
• Details of discharging medications for medication reconciliation
That is delivered to the patient and/or patient care giver or the next level of care provider.

Regarding patient identifier information for project 2.b.iv: CPWNY's hospital partners only track CIN for Medicaid Fee-For-Service patients. Managed Medicaid patients, which represent the majority of Medicaid population in Erie and Niagara County, are tracked by MCO insurance ID.

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We are able to query Managed Medicaid patients' CIN one at a time. Given the short turn-around time it is impractical to do so. Thus Q3 patient files will have either CIN or MCO insurance ID to trace to a specific patient if needed. Going forward it will be beneficial if NYS can provide monthly crosswalk file between CIN and MCO insurance ID; or if NYS can facilitate the MCOs to run CIN crosswalk for the PPS.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1… Establish a work group that includes home care partners, certified health home agencies, primary care physicians, and other CBO's, to determine CPWNY protocol. Members of this work group will be selected based on Medicaid volume, and their responsibility for discharge planning.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2…Established work group analyzes current PPS partner hospitals existing Care Transition models including staffing, hospital readmission rates within 30 days, and primary referral sources that are currently PCMH. Identify gaps in current discharge planning protocols.	Project		In Progress	08/15/2015	03/31/2016	08/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3…Review existing best practices for reducing hospital re-admissions.	Project		Completed	08/15/2015	12/31/2015	08/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4… Care Transitions project team will develop risk assessment process using Project Boost (8P readmission risk assessment methodology). Risk assessment process will be approved by Clinical Governance Committee (CGC).	Project		Completed	08/15/2015	12/31/2015	08/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 5… Roll out risk assessment process (including training,	Project		In Progress	12/31/2015	06/30/2016	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	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
culture competency, health literacy, and social support) to all participating hospitals.									
Task Step 6…Review existing care transitions protocols for the key clinical conditions represented in the readmission data. Utilize the Project Boost 8P readmission risk assessment methodology. Project Boost uses factors such as problems of medications, psychological status, physical limitations, health literacy, etc.	Project		Completed	08/15/2015	12/31/2015	08/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 7…Develop a Care Transition protocol for discharge planning and linkage to care management and PCMH practices. The protocol will focus on ensuring patients are seen 2-7 days after discharge. The protocol will also include active follow-up from health home and/or community health workers if patients do not successfully engage in 2-7 days. Included in this protocol is a process to screen patients for health home referrals and home care services.	Project		In Progress	01/02/2016	05/30/2016	01/02/2016	05/30/2016	06/30/2016	DY2 Q1
Task Step 8…Use existing Care Transition protocol as the base for developing the Care Transition Intervention Model, and adapt to the needs of Medicaid population.	Project		In Progress	01/02/2016	05/30/2016	01/02/2016	05/30/2016	06/30/2016	DY2 Q1
Task Step 9…Send draft protocol to Clinical Governance Committee for review and feedback	Project		In Progress	05/30/2016	09/30/2016	05/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 10…Finalize Care Transition Intervention Model (Approval from Clinical Governance Committee)	Project		In Progress	09/30/2016	12/23/2016	09/30/2016	12/23/2016	12/31/2016	DY2 Q3
Task Step 11…Develop a communication and implementation strategy for the Care Transition Intervention Model at all PPS Partner Hospitals	Project		In Progress	12/23/2016	03/30/2017	12/23/2016	03/30/2017	03/31/2017	DY2 Q4
Task Step 12…Monitor implementation of the care transitions protocol through training with attestation and self reportingto make sure the protocol is actively implemented. Periodic review of re-hospitalizations (to the same facility and all faculties) after implementation. (This action is ongoing)	Project		In Progress	12/23/2016	03/30/2017	12/23/2016	03/30/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 13…Use Rapid Cycle improvement method to monitor readmission over the duration of DSRIP. (this action is ongoing)	Project		In Progress	12/23/2016	03/30/2017	12/23/2016	03/30/2017	03/31/2017	DY2 Q4
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	Project	N/A	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Step 1…The PPS project management office, Catholic Medical Partners, currently has Medicaid risk contracts (with Value Based Payment metrics) with 3 payers and is working to develop risk contracts with 2 additional health plans. This would include the majority of Medicaid population attributed to CPWNY. Please note that Catholic Medical Partners project management team has had Value Based contracts based on successful collaborative relationships over the last 10 years.	Project		In Progress	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task Step 2… PPS will review existing risk contracts and conduct assessment of how to include PPS partners in existing and future risk contracts. Develop timeline to include PPS partners in the future.	Project		In Progress	04/01/2015	12/30/2016	04/01/2015	12/30/2016	12/31/2016	DY2 Q3
Task Step 3…Currently the health plans are providing to the PPS's Health Homes lists of potentially eligible patients to be enrolled in Health Homes. Currently PPS has 1500 patients enrolled and is working for enrolling another 1500 patients. Note: This will be	Project		In Progress	04/01/2015	12/30/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
ongoing enrollment process through the 5 years of DSRIP grant.									
Task Step 4…The PPS project management office meets quarterly with health plans to identify opportunities to improve utilization and enhance quality using both actuarial data from Milliman MedInsight and clinical metrics from sources such as NYS DOH QARR.	Project		In Progress	08/01/2015	12/30/2015	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5…The PPS project management office will review on periodic basis readmission trends for each managed care contract and will report results to the Care Transitions project team and all providers who are engaged in initiative to reduce re-admissions. (This action is ongoing)	Project		In Progress	08/01/2015	03/30/2018	08/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Step 6…The PPS project management office will provide readmission reports to each of the PPS's participating PCMH practices and Health Homes. (This action is ongoing)	Project		In Progress	12/30/2015	06/30/2016	12/30/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 7…PPS will use Rapid Cycle Improvement to provide PPS partners with trends of hospital readmission and will provide training and group sessions to share best practices. (this action will be ongoing)	Project		In Progress	12/30/2015	06/30/2016	12/30/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 10…Share the final version of CPWNY's PPS-wide Care Transition model for Medicaid with MCO's and Health Homes to ensure reduce redundancy and improve effectiveness	Project		In Progress	12/23/2016	03/30/2017	12/23/2016	03/30/2017	03/31/2017	DY2 Q4
Task Step 11…CPWNY will conduct periodic progress updates on the Care Transition model roll out and on relationship development with Health Homes, MCO and Fee-For-Service (this action is ongoing)	Project		In Progress	03/30/2017	03/30/2018	03/30/2017	03/30/2018	03/31/2018	DY3 Q4
Milestone #3 Ensure required social services participate in the project.	Project	N/A	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Required network social services, including medically tailored home food services, are provided in care transitions.	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task	Project		Completed	09/03/2015	12/30/2015	09/03/2015	12/30/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 1…Evaluate and analyze current social services used each PPS partner hospital for Care Transition Services. PPS will use the analysis to identify regional trends in readmissions will assess the capacity and adequacy of social services safety net in supporting PCMH practices in caring for patients and providing relevent data on utilization. Please note that we have used community needs assessment to identify the geographical areas where patients with the highest need reside and selected PPS partners in those areas.									
Task Step 2…Social service agencies will receive basic trainings on socio economic factors related to re-hospitalizations based on the Project Boost methodology. And PPS will provide trainings on the protocols we developed for Care Transitions. Please note that the Project Management Office currently has 3 social workers engaged in receiving referrals from the PPS network, as well as various existing hospital based Social Workers referring patients to social services. A referral process has been established and the team of social workers has established relationships with Meals on Wheels, Catholic Charities, Erie/Chautauqua/Niagara County Health Departments, Horizon Health Services, Health Homes, legal services, and participating behavioral health and substance abuse agencies.	Project		In Progress	09/30/2015	03/30/2016	09/30/2015	03/30/2016	03/31/2016	DY1 Q4
Task Step 3…Expand the Project Management Office's current services to other PPS partners especially in Chautauqua County, provide trainings.	Project		In Progress	09/30/2015	09/30/2016	09/30/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 4…PPS will monitor social service agencies' volume on periodic basis, which will be used to assess PPS's success in closing social economic gaps and to assess PPS's success in the future. The Project Advisory Committee will receive periodic reports. Monitoring in Erie County will be established sooner (DY1 Q4) due to the fact that the PMO has existing relationship with social service agencies..	Project		In Progress	12/30/2015	03/30/2017	12/30/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 5…Create a process for referrals including a documented	Project		In Progress	04/15/2016	03/30/2017	04/15/2016	03/30/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
list of social services available in the community and referral agreements between hospital partners and social service agencies that document processes and timelines.									
Task Step 6…CPWNY will work with relevant social services to conduct periodic assessment based on utilization reporting identified in the gap analysis (ie access to appropriate services through of implementation of referral process, e.g. referral volume, timely follow-up after referral, etc) (this action is ongoing)	Project		In Progress	03/30/2017	03/30/2018	03/30/2017	03/30/2018	03/31/2018	DY3 Q4
Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Hospital	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 1…Analyze current PPS partner hospitals care manager staffing models and processes. Review current job descriptions, training needs/gaps, and staffing levels. Determine if current processes include early notification of planned discharges.	Project		Completed	04/20/2015	09/30/2015	04/20/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…Review existing care manager protocols and create a work group including care management leads from each PPS partner hospitals to determine CPWNY protocol. Included in this protocol is a process to identify patients early in their	Project		Completed	08/02/2015	12/22/2015	08/02/2015	12/22/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
hospital stay (including when in the ER) for a planned discharge process, patient screening for additional referrals (health home, home care, BH, Palliative Care, social service needs. Also included is a documentation plan (Current electronic documentation, gaps, and plan for future needs)									
Task Step 3…Create and Send draft protocol from workgroup to Clinical Governance Committee for review and feedback	Project		In Progress	11/15/2015	12/30/2015	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4…Finalize Care Transition protocol for care managers (Approval from Clinical Governance Committee)	Project		In Progress	01/02/2016	03/30/2016	01/02/2016	03/30/2016	03/31/2016	DY1 Q4
Task Step 5…PPS will monitor the number of patients discharged per PPS participating hospital and assess whether the discharge process is consistent with the developed protocol and sufficient to handle patient volume. Periodic reports will be produced. (this action will be ongoing)	Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 6…Develop a training, communication and implementation strategy for the Care Management model.	Project		In Progress	04/15/2016	12/30/2016	04/15/2016	12/30/2016	12/31/2016	DY2 Q3
Task Step 7…The PPS will develop a highly reliable discharge planning process using a change management strategy / Six Sigma Method based upon the premises that proactive follow-up and risk mitigation is needed to reach the overall goal of reducing readmission by 25%. We will use the theme of "no patient left behind". The Project Management Office and Catholic Health System have Six Sigma training in place.	Project		In Progress	04/15/2016	03/10/2017	04/15/2016	03/10/2017	03/31/2017	DY2 Q4
Task Step 8…PPS will use Rapid Cycle Improvement and periodic reports to monitor results. Results will be communicated through the reporting system to governance boards and relevant providers. (this action will be ongoing)	Project		In Progress	04/15/2016	03/30/2017	04/15/2016	03/30/2017	03/31/2017	DY2 Q4
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4

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Task Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 1…Analyze current policies and procedures that are in place for documenting and exchanging care transition plans from patient medical record. Including who has access, how it Is transmitted to the patient and their care team (including their primary care provider)	Project		Completed	08/01/2015	09/29/2015	08/01/2015	09/29/2015	09/30/2015	DY1 Q2
Task Step 2…Determine each hospitals' and primary care center's referral network EMR interoperability capabilities (see IT Assessment)	Project		In Progress	08/15/2015	12/28/2015	08/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3…Review assessment and determine gaps for exchanging care transition plans between patients and primary care providers in a timely manner. CPWNY is developing our Crimson Care Management module in partnership with HEALTHeLINK which will have the capability to receive alerts when a patient is admitted, discharged, or presents at the ER at any hospital in our PPS region.	Project		In Progress	01/05/2016	06/30/2016	01/05/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 4…Convene work group to determine policy and procedure for exchanging care transition plans	Project		In Progress	03/01/2016	06/30/2016	03/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 5…Create and Send draft protocol from workgroup to Clinical Governance Committee (CGC) for review and feedback	Project		In Progress	02/10/2016	06/30/2016	02/10/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6…Finalize Care Transitions plan protocol (Approval from CGC)	Project		In Progress	02/28/2016	06/30/2016	02/28/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 7…Develop a training, communication and implementation strategy for the Care transition record exchange for each PPS partner hospital and primary care practice	Project		In Progress	08/02/2016	03/28/2017	08/02/2016	03/28/2017	03/31/2017	DY2 Q4
Task	Project		In Progress	04/15/2016	03/30/2017	04/15/2016	03/30/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 8…The PPS will develop a value based payment mission within the PPS using both process and outcome measures for the target population and metrics for both clinical and financial success. The PPS will develop a highly reliable discharge planning process using a change management strategy / Six Sigma Method based upon the premises that proactive follow-up and risk mitigation is needed to reach the overall goal of reducing readmission by 25%. We will use the theme of "no patient left behind". The Project Management Office and Catholic Health System have Six Sigma training in place.									
Milestone #6 Ensure that a 30-day transition of care period is established.	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Evaluate current PPS partners' existing Care Transition process including the current 30-day transition of care period.	Project		Completed	08/15/2015	12/31/2015	08/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task Review existing care transition care period and identify gaps where PPS partners are not following a 30 day transition of care period.	Project		In Progress	10/15/2015	03/28/2016	10/15/2015	03/28/2016	03/31/2016	DY1 Q4
Task Convene work group to establish procedures for practices to follow for 30 day transition of care period and monitoring including screening for patient at higher risk for re-admission.	Project		In Progress	04/03/2016	06/15/2016	04/03/2016	06/15/2016	06/30/2016	DY2 Q1
Task Create and Send draft procedure from work group to Clinical Governance Committee for review and feedback.	Project		In Progress	06/20/2016	09/28/2016	06/20/2016	09/28/2016	09/30/2016	DY2 Q2
Task Finalize 30 Day Care Transition period procedure (Approval from CGC)..	Project		In Progress	09/01/2016	12/20/2016	09/01/2016	12/20/2016	12/31/2016	DY2 Q3
Task Develop a training, communication and implementation strategy for the 30 day Care transition period.	Project		In Progress	01/04/2017	03/28/2017	01/04/2017	03/28/2017	03/31/2017	DY2 Q4
Task Step 7…The PPS will develop a value based payment mission within the PPS using both process and outcome measures for	Project		In Progress	04/15/2016	03/30/2017	04/15/2016	03/30/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
the target population and metrics for both clinical and financial success. The PPS will develop a highly reliable discharge planning process using a change management strategy / Six Sigma Method based upon the premises that proactive follow-up and risk mitigation is needed to reach the overall goal of reducing readmission by 25%. We will use the theme of "no patient left behind". The Project Management Office and Catholic Health System have Six Sigma training in place.									
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 1…Review IT assessment for all hospital partners including EMR platforms and identify where they currently document/identify discharged patients, care transition plans sent, and identify gaps in current documentation status of other necessary data fields in order to track project implementation progress. Our IT assessment indicates that all our PPS hospital partners are using EMR platforms and sharing with the local RHIO, HEALTHeLINK.	Project		In Progress	08/10/2015	12/28/2015	08/10/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2…Monitor and ensure the hospital partners are actively using the local RHIO, HEALTHeLINK.	Project		In Progress	01/05/2016	06/01/2016	01/05/2016	06/01/2016	06/30/2016	DY2 Q1
Task Step 3…Create work plan including hospital IT departments and/or care management departments to address and IT data documentation and reporting gaps at each hospital	Project		In Progress	01/05/2016	06/01/2016	01/05/2016	06/01/2016	06/30/2016	DY2 Q1
Task Step 4…Implement and communicate work plan to address and IT data documentation and reporting gaps at each hospital	Project		In Progress	07/06/2016	03/30/2017	07/06/2016	03/30/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Develop standardized protocols for a Care Transitions										

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Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.										
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.										
Task Step 1… Establish a work group that includes home care partners, certified health home agencies, primary care physicians, and other CBO's, to determine CPWNY protocol. Members of this work group will be selected based on Medicaid volume, and their responsibility for discharge planning.										
Task Step 2…Established work group analyzes current PPS partner hospitals existing Care Transition models including staffing, hospital readmission rates within 30 days, and primary referral sources that are currently PCMH. Identify gaps in current discharge planning protocols.										
Task Step 3…Review existing best practices for reducing hospital re-admissions.										
Task Step 4… Care Transitions project team will develop risk assessment process using Project Boost (8P readmission risk assessment methodology). Risk assessment process will be approved by Clinical Governance Committee (CGC).										
Task Step 5… Roll out risk assessment process (including training, culture competency, health literacy, and social support) to all participating hospitals.										
Task Step 6…Review existing care transitions protocols for the key clinical conditions represented in the readmission data. Utilize the Project Boost 8P readmission risk assessment methodology. Project Boost uses factors such as problems of medications, psychological status, physical limitations, health literacy, etc.										
Task Step 7…Develop a Care Transition protocol for discharge planning and linkage to care management and PCMH practices. The protocol will focus on ensuring patients are seen 2-7 days after discharge. The protocol will also include active follow-up from health home and/or community health workers if patients do not successfully engage in 2-7 days. Included in this protocol is a process to screen patients for health home referrals and home care services.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Step 8…Use existing Care Transition protocol as the base for developing the Care Transition Intervention Model, and adapt to the needs of Medicaid population.										
Task Step 9…Send draft protocol to Clinical Governance Committee for review and feedback										
Task Step 10…Finalize Care Transition Intervention Model (Approval from Clinical Governance Committee)										
Task Step 11…Develop a communication and implementation strategy for the Care Transition Intervention Model at all PPS Partner Hospitals										
Task Step 12…Monitor implementation of the care transitions protocol through training with attestation and self reportingto make sure the protocol is actively implemented. Periodic review of re-hospitalizations (to the same facility and all faculties) after implementation. (This action is ongoing)										
Task Step 13…Use Rapid Cycle improvement method to monitor readmission over the duration of DSRIP. (this action is ongoing)										
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.										
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.										
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.										
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.										
Task Step 1…The PPS project management office, Catholic Medical Partners, currently has Medicaid risk contracts (with Value Based Payment metrics) with 3 payers and is working to develop risk contracts with 2 additional health plans. This would include the										

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majority of Medicaid population attributed to CPWNY. Please note that Catholic Medical Partners project management team has had Value Based contracts based on successful collaborative relationships over the last 10 years.										
Task Step 2… PPS will review existing risk contracts and conduct assessment of how to include PPS partners in existing and future risk contracts. Develop timeline to include PPS partners in the future.										
Task Step 3…Currently the health plans are providing to the PPS's Health Homes lists of potentially eligible patients to be enrolled in Health Homes. Currently PPS has 1500 patients enrolled and is working for enrolling another 1500 patients. Note: This will be ongoing enrollment process through the 5 years of DSRIP grant.										
Task Step 4…The PPS project management office meets quarterly with health plans to identify opportunities to improve utilization and enhance quality using both actuarial data from Milliman MedInsight and clinical metrics from sources such as NYS DOH QARR.										
Task Step 5…The PPS project management office will review on periodic basis readmission trends for each managed care contract and will report results to the Care Transitions project team and all providers who are engaged in initiative to reduce re-admissions. (This action is ongoing)										
Task Step 6…The PPS project management office will provide readmission reports to each of the PPS's participating PCMH practices and Health Homes. (This action is ongoing)										
Task Step 7…PPS will use Rapid Cycle Improvement to provide PPS partners with trends of hospital readmission and will provide training and group sessions to share best practices. (this action will be ongoing)										
Task Step 10…Share the final version of CPWNY's PPS-wide Care Transition model for Medicaid with MCO's and Health Homes to ensure reduce redundancy and improve effectiveness										
Task Step 11…CPWNY will conduct periodic progress updates on the Care Transition model roll out and on relationship development										

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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
with Health Homes, MCO and Fee-For-Service (this action is ongoing)										
Milestone #3 Ensure required social services participate in the project.										
Task Required network social services, including medically tailored home food services, are provided in care transitions.										
Task Step 1…Evaluate and analyze current social services used each PPS partner hospital for Care Transition Services. PPS will use the analysis to identify regional trends in readmissions will assess the capacity and adequacy of social services safety net in supporting PCMH practices in caring for patients and providing relevent data on utilization. Please note that we have used community needs assessment to identify the geographical areas where patients with the highest need reside and selected PPS partners in those areas.										
Task Step 2…Social service agencies will receive basic trainings on socio economic factors related to re-hospitalizations based on the Project Boost methodology. And PPS will provide trainings on the protocols we developed for Care Transitions. Please note that the Project Management Office currently has 3 social workers engaged in receiving referrals from the PPS network, as well as various existing hospital based Social Workers referring patients to social services. A referral process has been established and the team of social workers has established relationships with Meals on Wheels, Catholic Charities, Erie/Chautauqua/Niagara County Health Departments, Horizon Health Services, Health Homes, legal services, and participating behavioral health and substance abuse agencies.										
Task Step 3…Expand the Project Management Office's current services to other PPS partners especially in Chautauqua County, provide trainings.										
Task Step 4…PPS will monitor social service agencies' volume on periodic basis, which will be used to assess PPS's success in closing social economic gaps and to assess PPS's success in the future. The Project Advisory Committee will receive periodic reports. Monitoring in Erie County will be established sooner (DY1 Q4) due to the fact that the PMO has existing relationship with social service agencies..										

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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…Create a process for referrals including a documented list of social services available in the community and referral agreements between hospital partners and social service agencies that document processes and timelines.										
Task Step 6…CPWNY will work with relevant social services to conduct periodic assessment based on utilization reporting identified in the gap analysis (ie access to appropriate services through of implementation of referral process, e.g. referral volume, timely follow-up after referral, etc) (this action is ongoing)										
Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.										
Task Policies and procedures are in place for early notification of planned discharges.	0	10	35	60	85	135	210	399	399	399
Task Policies and procedures are in place for early notification of planned discharges.	0	5	25	45	65	105	165	293	293	293
Task Policies and procedures are in place for early notification of planned discharges.	0	2	2	4	6	8	10	15	15	15
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.										
Task Step 1…Analyze current PPS partner hospitals care manager staffing models and processes. Review current job descriptions, training needs/gaps, and staffing levels. Determine if current processes include early notification of planned discharges.										
Task Step 2…Review existing care manager protocols and create a work group including care management leads from each PPS partner hospitals to determine CPWNY protocol. Included in this protocol is a process to identify patients early in their hospital stay (including when in the ER) for a planned discharge process, patient screening for additional referrals (health home, home care, BH, Palliative Care, social service needs. Also included is a documentation plan (Current electronic documentation, gaps, and plan for future needs)										

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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 3…Create and Send draft protocol from workgroup to Clinical Governance Committee for review and feedback										
Task Step 4…Finalize Care Transition protocol for care managers (Approval from Clinical Governance Committee)										
Task Step 5…PPS will monitor the number of patients discharged per PPS participating hospital and assess whether the discharge process is consistent with the developed protocol and sufficient to handle patient volume. Periodic reports will be produced. (this action will be ongoing)										
Task Step 6…Develop a training, communication and implementation strategy for the Care Management model.										
Task Step 7…The PPS will develop a highly reliable discharge planning process using a change management strategy / Six Sigma Method based upon the premises that proactive follow-up and risk mitigation is needed to reach the overall goal of reducing readmission by 25%. We will use the theme of "no patient left behind". The Project Management Office and Catholic Health System have Six Sigma training in place.										
Task Step 8…PPS will use Rapid Cycle Improvement and periodic reports to monitor results. Results will be communicated through the reporting system to governance boards and relevant providers. (this action will be ongoing)										
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.										
Task Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.										
Task Step 1…Analyze current policies and procedures that are in place for documenting and exchanging care transition plans from patient medical record. Including who has access, how it Is transmitted to the patient and their care team (including their primary care provider)										

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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 2…Determine each hospitals' and primary care center's referral network EMR interoperability capabilities (see IT Assessment)										
Task Step 3…Review assessment and determine gaps for exchanging care transition plans between patients and primary care providers in a timely manner. CPWNY is developing our Crimson Care Management module in partnership with HEALTHeLINK which will have the capability to receive alerts when a patient is admitted, discharged, or presents at the ER at any hospital in our PPS region.										
Task Step 4…Convene work group to determine policy and procedure for exchanging care transition plans										
Task Step 5…Create and Send draft protocol from workgroup to Clinical Governance Committee (CGC) for review and feedback										
Task Step 6…Finalize Care Transitions plan protocol (Approval from CGC)										
Task Step 7…Develop a training, communication and implementation strategy for the Care transition record exchange for each PPS partner hospital and primary care practice										
Task Step 8…The PPS will develop a value based payment mission within the PPS using both process and outcome measures for the target population and metrics for both clinical and financial success. The PPS will develop a highly reliable discharge planning process using a change management strategy / Six Sigma Method based upon the premises that proactive follow-up and risk mitigation is needed to reach the overall goal of reducing readmission by 25%. We will use the theme of "no patient left behind". The Project Management Office and Catholic Health System have Six Sigma training in place.										
Milestone #6 Ensure that a 30-day transition of care period is established.										
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.										
Task Evaluate current PPS partners' existing Care Transition process including the current 30-day transition of care period.										

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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 Review existing care transition care period and identify gaps where PPS partners are not following a 30 day transition of care period.										
Task Convene work group to establish procedures for practices to follow for 30 day transition of care period and monitoring including screening for patient at higher risk for re-admission.										
Task Create and Send draft procedure from work group to Clinical Governance Committee for review and feedback.										
Task Finalize 30 Day Care Transition period procedure (Approval from CGC)..										
Task Develop a training, communication and implementation strategy for the 30 day Care transition period.										
Task Step 7…The PPS will develop a value based payment mission within the PPS using both process and outcome measures for the target population and metrics for both clinical and financial success. The PPS will develop a highly reliable discharge planning process using a change management strategy / Six Sigma Method based upon the premises that proactive follow-up and risk mitigation is needed to reach the overall goal of reducing readmission by 25%. We will use the theme of "no patient left behind". The Project Management Office and Catholic Health System have Six Sigma training in place.										
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1…Review IT assessment for all hospital partners including EMR platforms and identify where they currently document/identify discharged patients, care transition plans sent, and identify gaps in current documentation status of other necessary data fields in order to track project implementation progress. Our IT assessment indicates that all our PPS hospital partners are using EMR platforms and sharing with the local RHIO, HEALTHeLINK.										
Task										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Step 2…Monitor and ensure the hospital partners are actively using the local RHIO, HEALTHeLINK.										
Task Step 3…Create work plan including hospital IT departments and/or care management departments to address and IT data documentation and reporting gaps at each hospital										
Task Step 4…Implement and communicate work plan to address and IT data documentation and reporting gaps at each hospital										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.										
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.										
Task Step 1… Establish a work group that includes home care partners, certified health home agencies, primary care physicians, and other CBO's, to determine CPWNY protocol. Members of this work group will be selected based on Medicaid volume, and their responsibility for discharge planning.										
Task Step 2…Established work group analyzes current PPS partner hospitals existing Care Transition models including staffing, hospital readmission rates within 30 days, and primary referral sources that are currently PCMH. Identify gaps in current discharge planning protocols.										
Task Step 3…Review existing best practices for reducing hospital re-admissions.										
Task Step 4… Care Transitions project team will develop risk assessment process using Project Boost (8P readmission risk assessment methodology). Risk assessment process will be approved by Clinical Governance Committee (CGC).										
Task Step 5… Roll out risk assessment process (including training, culture competency, health literacy, and social support) to all participating hospitals.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Step 6…Review existing care transitions protocols for the key clinical conditions represented in the readmission data. Utilize the Project Boost 8P readmission risk assessment methodology. Project Boost uses factors such as problems of medications, psychological status, physical limitations, health literacy, etc.										
Task Step 7…Develop a Care Transition protocol for discharge planning and linkage to care management and PCMH practices. The protocol will focus on ensuring patients are seen 2-7 days after discharge. The protocol will also include active follow-up from health home and/or community health workers if patients do not successfully engage in 2-7 days. Included in this protocol is a process to screen patients for health home referrals and home care services.										
Task Step 8…Use existing Care Transition protocol as the base for developing the Care Transition Intervention Model, and adapt to the needs of Medicaid population.										
Task Step 9…Send draft protocol to Clinical Governance Committee for review and feedback										
Task Step 10…Finalize Care Transition Intervention Model (Approval from Clinical Governance Committee)										
Task Step 11…Develop a communication and implementation strategy for the Care Transition Intervention Model at all PPS Partner Hospitals										
Task Step 12…Monitor implementation of the care transitions protocol through training with attestation and self reportingto make sure the protocol is actively implemented. Periodic review of re-hospitalizations (to the same facility and all faculties) after implementation. (This action is ongoing)										
Task Step 13…Use Rapid Cycle improvement method to monitor readmission over the duration of DSRIP. (this action is ongoing)										
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.										
Task										

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A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.										
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.										
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.										
Task Step 1…The PPS project management office, Catholic Medical Partners, currently has Medicaid risk contracts (with Value Based Payment metrics) with 3 payers and is working to develop risk contracts with 2 additional health plans. This would include the majority of Medicaid population attributed to CPWNY. Please note that Catholic Medical Partners project management team has had Value Based contracts based on successful collaborative relationships over the last 10 years.										
Task Step 2… PPS will review existing risk contracts and conduct assessment of how to include PPS partners in existing and future risk contracts. Develop timeline to include PPS partners in the future.										
Task Step 3…Currently the health plans are providing to the PPS's Health Homes lists of potentially eligible patients to be enrolled in Health Homes. Currently PPS has 1500 patients enrolled and is working for enrolling another 1500 patients. Note: This will be ongoing enrollment process through the 5 years of DSRIP grant.										
Task Step 4…The PPS project management office meets quarterly with health plans to identify opportunities to improve utilization and enhance quality using both actuarial data from Milliman MedInsight and clinical metrics from sources such as NYS DOH QARR.										
Task Step 5…The PPS project management office will review on periodic basis readmission trends for each managed care contract and will report results to the Care Transitions project team and all providers who are engaged in initiative to reduce re-admissions. (This action is ongoing)										
Task Step 6…The PPS project management office will provide										

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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
readmission reports to each of the PPS's participating PCMH practices and Health Homes. (This action is ongoing)										
Task Step 7…PPS will use Rapid Cycle Improvement to provide PPS partners with trends of hospital readmission and will provide training and group sessions to share best practices. (this action will be ongoing)										
Task Step 10…Share the final version of CPWNY's PPS-wide Care Transition model for Medicaid with MCO's and Health Homes to ensure reduce redundancy and improve effectiveness										
Task Step 11…CPWNY will conduct periodic progress updates on the Care Transition model roll out and on relationship development with Health Homes, MCO and Fee-For-Service (this action is ongoing)										
Milestone #3 Ensure required social services participate in the project.										
Task Required network social services, including medically tailored home food services, are provided in care transitions.										
Task Step 1…Evaluate and analyze current social services used each PPS partner hospital for Care Transition Services. PPS will use the analysis to identify regional trends in readmissions will assess the capacity and adequacy of social services safety net in supporting PCMH practices in caring for patients and providing relevent data on utilization. Please note that we have used community needs assessment to identify the geographical areas where patients with the highest need reside and selected PPS partners in those areas.										
Task Step 2…Social service agencies will receive basic trainings on socio economic factors related to re-hospitalizations based on the Project Boost methodology. And PPS will provide trainings on the protocols we developed for Care Transitions. Please note that the Project Management Office currently has 3 social workers engaged in receiving referrals from the PPS network, as well as various existing hospital based Social Workers referring patients to social services. A referral process has been established and the team of social workers has established relationships with Meals on Wheels, Catholic Charities, Erie/Chautauqua/Niagara County Health Departments, Horizon Health Services, Health Homes, legal services, and participating										

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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
behavioral health and substance abuse agencies.										
Task Step 3…Expand the Project Management Office's current services to other PPS partners especially in Chautauqua County, provide trainings.										
Task Step 4…PPS will monitor social service agencies' volume on periodic basis, which will be used to assess PPS's success in closing social economic gaps and to assess PPS's success in the future. The Project Advisory Committee will receive periodic reports. Monitoring in Erie County will be established sooner (DY1 Q4) due to the fact that the PMO has existing relationship with social service agencies..										
Task Step 5…Create a process for referrals including a documented list of social services available in the community and referral agreements between hospital partners and social service agencies that document processes and timelines.										
Task Step 6…CPWNY will work with relevant social services to conduct periodic assessment based on utilization reporting identified in the gap analysis (ie access to appropriate services through of implementation of referral process, e.g. referral volume, timely follow-up after referral, etc) (this action is ongoing)										
Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.										
Task Policies and procedures are in place for early notification of planned discharges.	399	399	399	399	399	399	399	399	399	399
Task Policies and procedures are in place for early notification of planned discharges.	293	293	293	293	293	293	293	293	293	293
Task Policies and procedures are in place for early notification of planned discharges.	15	15	15	15	15	15	15	15	15	15
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.										

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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…Analyze current PPS partner hospitals care manager staffing models and processes. Review current job descriptions, training needs/gaps, and staffing levels. Determine if current processes include early notification of planned discharges.										
Task Step 2…Review existing care manager protocols and create a work group including care management leads from each PPS partner hospitals to determine CPWNY protocol. Included in this protocol is a process to identify patients early in their hospital stay (including when in the ER) for a planned discharge process, patient screening for additional referrals (health home, home care, BH, Palliative Care, social service needs. Also included is a documentation plan (Current electronic documentation, gaps, and plan for future needs)										
Task Step 3…Create and Send draft protocol from workgroup to Clinical Governance Committee for review and feedback										
Task Step 4…Finalize Care Transition protocol for care managers (Approval from Clinical Governance Committee)										
Task Step 5…PPS will monitor the number of patients discharged per PPS participating hospital and assess whether the discharge process is consistent with the developed protocol and sufficient to handle patient volume. Periodic reports will be produced. (this action will be ongoing)										
Task Step 6…Develop a training, communication and implementation strategy for the Care Management model.										
Task Step 7…The PPS will develop a highly reliable discharge planning process using a change management strategy / Six Sigma Method based upon the premises that proactive follow-up and risk mitigation is needed to reach the overall goal of reducing readmission by 25%. We will use the theme of "no patient left behind". The Project Management Office and Catholic Health System have Six Sigma training in place.										
Task Step 8…PPS will use Rapid Cycle Improvement and periodic reports to monitor results. Results will be communicated through the reporting system to governance boards and relevant providers. (this action will be ongoing)										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.										
Task Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.										
Task Step 1…Analyze current policies and procedures that are in place for documenting and exchanging care transition plans from patient medical record. Including who has access, how it Is transmitted to the patient and their care team (including their primary care provider)										
Task Step 2…Determine each hospitals' and primary care center's referral network EMR interoperability capabilities (see IT Assessment)										
Task Step 3…Review assessment and determine gaps for exchanging care transition plans between patients and primary care providers in a timely manner. CPWNY is developing our Crimson Care Management module in partnership with HEALTHeLINK which will have the capability to receive alerts when a patient is admitted, discharged, or presents at the ER at any hospital in our PPS region.										
Task Step 4…Convene work group to determine policy and procedure for exchanging care transition plans										
Task Step 5…Create and Send draft protocol from workgroup to Clinical Governance Committee (CGC) for review and feedback										
Task Step 6…Finalize Care Transitions plan protocol (Approval from CGC)										
Task Step 7…Develop a training, communication and implementation strategy for the Care transition record exchange for each PPS partner hospital and primary care practice										
Task Step 8…The PPS will develop a value based payment mission within the PPS using both process and outcome measures for										

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the target population and metrics for both clinical and financial success. The PPS will develop a highly reliable discharge planning process using a change management strategy / Six Sigma Method based upon the premises that proactive follow-up and risk mitigation is needed to reach the overall goal of reducing readmission by 25%. We will use the theme of "no patient left behind". The Project Management Office and Catholic Health System have Six Sigma training in place.										
Milestone #6 Ensure that a 30-day transition of care period is established.										
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.										
Task Evaluate current PPS partners' existing Care Transition process including the current 30-day transition of care period.										
Task Review existing care transition care period and identify gaps where PPS partners are not following a 30 day transition of care period.										
Task Convene work group to establish procedures for practices to follow for 30 day transition of care period and monitoring including screening for patient at higher risk for re-admission.										
Task Create and Send draft procedure from work group to Clinical Governance Committee for review and feedback.										
Task Finalize 30 Day Care Transition period procedure (Approval from CGC)..										
Task Develop a training, communication and implementation strategy for the 30 day Care transition period.										
Task Step 7…The PPS will develop a value based payment mission within the PPS using both process and outcome measures for the target population and metrics for both clinical and financial success. The PPS will develop a highly reliable discharge planning process using a change management strategy / Six Sigma Method based upon the premises that proactive follow-up and risk mitigation is needed to reach the overall goal of reducing readmission by 25%. We will use the theme of "no patient left behind". The Project Management Office and Catholic Health System have Six Sigma training in place.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #7 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…Review IT assessment for all hospital partners including EMR platforms and identify where they currently document/identify discharged patients, care transition plans sent, and identify gaps in current documentation status of other necessary data fields in order to track project implementation progress. Our IT assessment indicates that all our PPS hospital partners are using EMR platforms and sharing with the local RHIO, HEALTHeLINK.										
Task Step 2…Monitor and ensure the hospital partners are actively using the local RHIO, HEALTHeLINK.										
Task Step 3…Create work plan including hospital IT departments and/or care management departments to address and IT data documentation and reporting gaps at each hospital										
Task Step 4…Implement and communicate work plan to address and IT data documentation and reporting gaps at each hospital										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	
Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Ensure required social services participate in the project.	
Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	
Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	
Ensure that a 30-day transition of care period is established.	
Use EHRs and other technical platforms to track all patients engaged in the project.	

Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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Project 2.c.ii – Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services

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

Instructions :

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

• Provider participation in telemedicine consultations requires a comprehensive credentialing process. This could create a problem for CPWNY where the time it takes for our participating providers to achieve the appropriate credentials will be too long to meet initial patient demand and achieve patient engagement targets. To mitigate this problem, while our local providers are undergoing the process of achieving the appropriate credentials, CPWNY will contract with turnkey vendors to facilitate consultations by connecting with available providers across the country. CPWNY will choose a vendor with expertise in addressing challenges of differing licensure/credentialing standards across different states. Over the timeline of the grant, if we do not reach the necessary volume of local providers interested and successful in achieving these credentials, these contracts with turnkey vendors will be renewed to supplement care based on patient demand.

• Currently, there is limited reimbursement infrastructure for telemedicine consultations. This creates a problem with engaging providers to participate in consultations if they are unsure about how they will be paid for their service. To ensure the sustainability of this project, CPWNY will then work with local health plans and Medicaid Managed Care Organizations to negotiate and develop a payment infrastructure for telemedicine consultations that is sufficient to encourage physician engagement. CPWNY will engage providers and request physician input in the development of a sustainable payment model.

• For the initial implementation, there is concern that providers may not have the appropriate IT infrastructure or technological capabilities to participate in telemedicine consultations. CPWNY will work with our information technology team to build exchange capacity between different provider sites. CPWNY will contract with turnkey vendors to help facilitate the development of appropriate IT infrastructure in a timely manner. Technologies will be rolled out gradually based on practices with high volume of Medicaid patients accessing these services and patients with acute conditions.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	13,862

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
0	0	0.00%	840	0.00%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (840)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
dcao	Documentation/Certification	46_PMDL3515_1_3_20160126152229_2.c.ii_Telemedicine_Narrative.pdf	Narrative for project 2.c.ii patient engagement status.	01/26/2016 03:23 PM

Narrative Text :

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

Community Partners of WNY has no patient engagement numbers to report for this quarter. This is because we are working with an outside vendor, Specialists on Call, to do the telemedicine consultations and it has taken time to get the services ready to go live. We have signed our contract and identified a pilot site, WCA Hospital, to roll out the project. WCA Hospital has also signed a contract with the vendor and is in the process of credentialing the physicians that will be providing consultations. The credentialing process has not finished by the end of DY1 Q3.
After credentialing process, we will train providers from the pilot site on how to use the technology. Once they are trained we will begin engaging patients in telemedicine consults. The program is expected to go live in DY1 Q4.

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Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its actively engaged commitments for DY1Q3. The documentation does not support the reported actively engaged numbers.

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement telemedicine services, aimed at reducing avoidable hospital use by increasing patient access to services not otherwise available and/or increasing specialty expertise of primary care providers and their staff in order to increase availability of scarce specialty services.	Project	N/A	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Telemedicine service implemented, based on evaluation of impact to underserved areas including, but not limited to: - analysis of the availability of broadband access in the geographic area being served - gaps in services - geographic areas where PPS lacks resources and telemedicine will be used to increase the reach of these patients - why telemedicine is the best alternative to provide these services - challenges expected and plan to pro-actively resolve - plan for long term sustainability	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Perform a community-wide assessment to determine highest need for telemedicine and potential gaps, which can assist in the reduction of preventable admissions/readmissions. This is in accordance with the goals to reduce improper utilization by 25% in 5 years. The WNY region has identified gaps such as critical care, acute neurology assessment, and behavioral health consultations. In addition, our goal is to triage patients to appropriate level of care through telemedicine consults and thus facilitate patient transfers as needed.	Project		Completed	04/01/2015	04/01/2015	04/01/2015	04/01/2015	06/30/2015	DY1 Q1
Task CPWNY will assess existing telemedicine capabilities and issue	Project		Completed	04/01/2015	04/15/2015	04/01/2015	04/15/2015	06/30/2015	DY1 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
telemedicine RFPs to outside vendors.									
Task Telemedicine vendor selected by CPWNY EGB based on vendor's capability of addressing identified gaps in services. Specialist on Call-NY Telemedicine TPP (SOC) was selected.	Project		Completed	04/15/2015	05/15/2015	04/15/2015	05/15/2015	06/30/2015	DY1 Q1
Task Contract negotiations between SOC and CPWNY. Contract developed by SOC and under review by CPWNY's legal team and Women's Christian Association Hospital, which is the first pilot site for rolling out the telemedicine project.	Project		Completed	05/30/2015	07/15/2015	05/30/2015	07/15/2015	09/30/2015	DY1 Q2
Task Contract to be signed by CPWNY for the initial and ongoing implementation of the telemedicine project. WCA to review and sign contract for the individual services to be provided in the areas identified as gaps in care for this institution. There will be a 120-day implementation period following signing	Project		Completed	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Needs for connectivity, interoperability, credentialing, reporting, and other required elements of the telemedicine project will be coordinated with CPWNY's participating partners and outside vendors.	Project		Completed	05/15/2015	09/30/2015	05/15/2015	09/30/2015	09/30/2015	DY1 Q2
Task Provide communication and training to participating providers at WCA hospital on Specialists on Call regarding equipment and clinical protocols for the provision of medical services.	Project		Completed	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task CPWNY will conduct periodic assessment of the progress in implementing the telemedicine project and produce reports and newsletters. CPWNY will utilize Rapid Cycle Improvement and PDSA methodology for continuous improvement. Note: ongoing activity.	Project		In Progress	03/30/2016	03/30/2018	03/30/2016	03/30/2018	03/31/2018	DY3 Q4
Milestone #2 Provide equipment specifications and rationale for equipment choice (including cost of acquisition, maintenance and sustainability of service).	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Equipment specifications (meeting certified standards for interoperability and communications) and rationale documented.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Telemedicine workstations leased from SOC based on their experience and on call network for ICU, neurology and psychiatry	Project		Completed	07/15/2015	10/01/2015	07/15/2015	10/01/2015	12/31/2015	DY1 Q3
Task Implementation including equipment, clinical protocol , IT installation and training is $55,000 per hospital (one time fee) plus monthly maintenance of $750 per month. Equipment choice (Rubbermaid Telemedicine cart with Cisco SX20 video codec or Polycom Group 500) is specified by SOC, which will provide continuous maintenance.	Project		Completed	07/15/2015	10/01/2015	07/15/2015	10/01/2015	12/31/2015	DY1 Q3
Task CPWNY will engage in discussions with health plans to develop additional strategic initiatives that will enhance the sustainability of the project, including additional reimbursement for these services.	Project		In Progress	07/15/2015	09/30/2016	07/15/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #3 Define service area and participating providers, with clear delineation between telemedicine hub sites versus spoke sites.	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Service area, delineated between spoke and hub sites, defined.	Provider	Spoke Sites	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Service area, delineated between spoke and hub sites, defined.	Provider	Hub Sites	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Perform assessment of areas in our counties (Chautauqua, Erie and Niagara, Orleans) in high need of telemedicine services. Reach out to other hospitals to identify their specific needs and initiate implementation of additional telemedicine sites.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Begin roll out in Chautauqua County, starting with Women's Christian Association hospital, due to high patient demand and provider interest.	Project		In Progress	06/01/2015	12/30/2015	06/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize agreements with WCA hospital. CPWNY will work on additional agreements with Brooks Memorial Hospital in Chautauqua County, Mount St Mary's Hospital in Niagara County, Medina Hospital in Orleans County, Westfield Hospital in Chautauqua County, and Bertrand Chaffee Hospital in Erie County.	Project		In Progress	07/01/2015	03/30/2016	07/01/2015	03/30/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task SOC is a turn key operation with a robust on-call network. To create a uniform process, they will act as the "hub" for our providers to obtain services. The spokes will be our rural hospitals and providers.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #4 Procure service agreements for provision of telemedicine services such as specialty services, participating primary care and nurse triage monitoring.	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Service agreements in place for provision of telemedicine services.	Provider	Spoke Sites	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Service agreements in place for provision of telemedicine services.	Provider	Hub Sites	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Service agreements, which outline specific protocols for the provision of medical services, are developed for WCA Hospital, Brooks Memorial Hospital, Mount St Mary's Hospital, and Bertrand Chaffe Hospital with all related costs and relevant services identified. The agreements are developed based on SOC's standard service protocol and are edited to incorporate the specific needs of CPWNY's participating hospitals.	Project		In Progress	06/01/2015	03/30/2016	06/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task Agreements will be approved by the CPWNY EGB and specific hospital agreements will be reviewed and approved in coordination with participating hospitals.	Project		In Progress	06/01/2015	03/30/2016	06/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task Communicate the terms of the service agreements and provider contracts to participating providers.	Project		In Progress	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task The Medical Directors of each institution participating in the project will coordinate the implementation, credentialing, and integration of the services with their respective medical staff.	Project		In Progress	08/01/2015	09/30/2016	08/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #5 Develop standard service protocols, as well as consent and confidentiality standards meeting all federal and state requirements.	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Telemedicine service, consent, and confidentiality protocols developed to meet federal and state requirements for: - patient eligibility - appointment availability - medical record protocols - educational standards - continuing education credits									
Task Work with Specialists on Call and the CPWNY Clinical Governance Committee will review and approve standard service protocols and standards on consent and confidentiality that will be HIPAA-compliant.	Project		Completed	06/01/2015	12/30/2015	06/01/2015	12/30/2015	12/31/2015	DY1 Q3
Task SOC will ensure that their approved physicians are licensed in NYS. Participating hospitals will credential SOC physicians within their medical staff.	Project		Completed	07/15/2015	12/30/2015	07/15/2015	12/30/2015	12/31/2015	DY1 Q3
Task Hospital to use SOC clinical protocols and requirements for effective record exchange and provide appropriate documentation regarding the encounter.	Project		Completed	07/15/2015	12/30/2015	07/15/2015	12/30/2015	12/31/2015	DY1 Q3
Task Timeline for accessing the on call physician will be established by contractual agreements with SOC.	Project		Completed	07/15/2015	09/30/2015	07/15/2015	09/30/2015	09/30/2015	DY1 Q2
Task In coordination with the local hospital medical staff leadership, CPWNY will provide communication and training to participating providers on standard service protocols.	Project		Completed	07/15/2015	12/30/2015	07/15/2015	12/30/2015	12/31/2015	DY1 Q3
Task Assessment executed and reviewed to determine effectiveness of the program and make improvements. SOC is Joint Commission regulated and adheres to proper quality guidelines.	Project		In Progress	01/01/2016	12/30/2016	01/01/2016	12/30/2016	12/31/2016	DY2 Q3
Milestone #6 Coordinate with Medicaid Managed Care Organizations to develop and ensure service authorization and payment strategies are in place to support sustainability of patient care uses.	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Service authorization and payment strategies developed, in	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
concert with Medicaid Managed Care companies.									
Task CPWNY's PMO has existing value-based risk contract relationship with local Medicaid Managed Care Organizations. CPWNY will leverage existing relationships to develop service authorizations and payment strategies to address the needs of Medicaid population.	Project		Completed	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3
Task Convene meetings with local health plans and Managed Care Organizations to discuss payment arrangements and authorization.	Project		Completed	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3
Task Finalize payment agreements with major health plans and Managed Care Organizations for provision of telemedicine services.	Project		In Progress	07/01/2015	01/30/2016	07/01/2015	01/30/2016	03/31/2016	DY1 Q4
Task Payment agreements approved by the EGB and the Finance Committee.	Project		In Progress	01/01/2016	03/30/2016	01/01/2016	03/30/2016	03/31/2016	DY1 Q4
Task Meet periodically with the MMCOs to review and improve agreements. (This action is ongoing)	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Include in service agreements provisions for the exchange of clinical information. Identify SOC capabilities for tracking and follow-up.	Project		Completed	07/15/2015	12/30/2015	07/15/2015	12/30/2015	12/31/2015	DY1 Q3
Task Review IT assessment to identify interoperability capabilities between SOC and CPWNY providers and between the local RHIO, HEALTHeLINK.	Project		In Progress	07/15/2015	03/30/2016	07/15/2015	03/30/2016	03/31/2016	DY1 Q4
Task Work with HEALTHeLINK and the IT team to develop interoperability and patient tracking capability.	Project		In Progress	07/15/2015	03/30/2016	07/15/2015	03/30/2016	03/31/2016	DY1 Q4
Task	Project		In Progress	07/15/2015	03/30/2017	07/15/2015	03/30/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
CPWNY will require participating hospitals to report utilization of patients engaged in this project. (This action is ongoing)									

Project 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 telemedicine services, aimed at reducing avoidable hospital use by increasing patient access to services not otherwise available and/or increasing specialty expertise of primary care providers and their staff in order to increase availability of scarce specialty services.										
Task Telemedicine service implemented, based on evaluation of impact to underserved areas including, but not limited to: - analysis of the availability of broadband access in the geographic area being served - gaps in services - geographic areas where PPS lacks resources and telemedicine will be used to increase the reach of these patients - why telemedicine is the best alternative to provide these services - challenges expected and plan to pro-actively resolve - plan for long term sustainability										
Task Perform a community-wide assessment to determine highest need for telemedicine and potential gaps, which can assist in the reduction of preventable admissions/readmissions. This is in accordance with the goals to reduce improper utilization by 25% in 5 years. The WNY region has identified gaps such as critical care, acute neurology assessment, and behavioral health consultations. In addition, our goal is to triage patients to appropriate level of care through telemedicine consults and thus facilitate patient transfers as needed.										
Task CPWNY will assess existing telemedicine capabilities and issue telemedicine RFPs to outside vendors.										
Task Telemedicine vendor selected by CPWNY EGB based on vendor's capability of addressing identified gaps in services. Specialist on Call-NY Telemedicine TPP (SOC) was selected.										
Task Contract negotiations between SOC and CPWNY. Contract										

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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
developed by SOC and under review by CPWNY's legal team and Women's Christian Association Hospital, which is the first pilot site for rolling out the telemedicine project.										
Task Contract to be signed by CPWNY for the initial and ongoing implementation of the telemedicine project. WCA to review and sign contract for the individual services to be provided in the areas identified as gaps in care for this institution. There will be a 120-day implementation period following signing										
Task Needs for connectivity, interoperability, credentialing, reporting, and other required elements of the telemedicine project will be coordinated with CPWNY's participating partners and outside vendors.										
Task Provide communication and training to participating providers at WCA hospital on Specialists on Call regarding equipment and clinical protocols for the provision of medical services.										
Task CPWNY will conduct periodic assessment of the progress in implementing the telemedicine project and produce reports and newsletters. CPWNY will utilize Rapid Cycle Improvement and PDSA methodology for continuous improvement. Note: ongoing activity.										
Milestone #2 Provide equipment specifications and rationale for equipment choice (including cost of acquisition, maintenance and sustainability of service).										
Task Equipment specifications (meeting certified standards for interoperability and communications) and rationale documented.										
Task Telemedicine workstations leased from SOC based on their experience and on call network for ICU, neurology and psychiatry										
Task Implementation including equipment, clinical protocol , IT installation and training is $55,000 per hospital (one time fee) plus monthly maintenance of $750 per month. Equipment choice (Rubbermaid Telemedicine cart with Cisco SX20 video codec or Polycom Group 500) is specified by SOC, which will provide continuous maintenance.										
Task CPWNY will engage in discussions with health plans to develop additional strategic initiatives that will enhance the sustainability of the project, including additional reimbursement for these										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
services.										
Milestone #3 Define service area and participating providers, with clear delineation between telemedicine hub sites versus spoke sites.										
Task Service area, delineated between spoke and hub sites, defined.	0	0	1	2	3	4	10	21	21	21
Task Service area, delineated between spoke and hub sites, defined.	0	0	1	1	1	1	2	3	3	3
Task Perform assessment of areas in our counties (Chautauqua, Erie and Niagara, Orleans) in high need of telemedicine services. Reach out to other hospitals to identify their specific needs and initiate implementation of additional telemedicine sites.										
Task Begin roll out in Chautauqua County, starting with Women's Christian Association hospital, due to high patient demand and provider interest.										
Task Finalize agreements with WCA hospital. CPWNY will work on additional agreements with Brooks Memorial Hospital in Chautauqua County, Mount St Mary's Hospital in Niagara County, Medina Hospital in Orleans County, Westfield Hospital in Chautauqua County, and Bertrand Chaffee Hospital in Erie County.										
Task SOC is a turn key operation with a robust on-call network. To create a uniform process, they will act as the "hub" for our providers to obtain services. The spokes will be our rural hospitals and providers.										
Milestone #4 Procure service agreements for provision of telemedicine services such as specialty services, participating primary care and nurse triage monitoring.										
Task Service agreements in place for provision of telemedicine services.	0	0	1	2	3	4	10	21	21	21
Task Service agreements in place for provision of telemedicine services.	0	0	1	1	1	1	2	3	3	3
Task Service agreements, which outline specific protocols for the provision of medical services, are developed for WCA Hospital, Brooks Memorial Hospital, Mount St Mary's Hospital, and Bertrand Chaffe Hospital with all related costs and relevant										

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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
services identified. The agreements are developed based on SOC's standard service protocol and are edited to incorporate the specific needs of CPWNY's participating hospitals.										
Task Agreements will be approved by the CPWNY EGB and specific hospital agreements will be reviewed and approved in coordination with participating hospitals.										
Task Communicate the terms of the service agreements and provider contracts to participating providers.										
Task The Medical Directors of each institution participating in the project will coordinate the implementation, credentialing, and integration of the services with their respective medical staff.										
Milestone #5 Develop standard service protocols, as well as consent and confidentiality standards meeting all federal and state requirements.										
Task Telemedicine service, consent, and confidentiality protocols developed to meet federal and state requirements for: - patient eligibility - appointment availability - medical record protocols - educational standards - continuing education credits										
Task Work with Specialists on Call and the CPWNY Clinical Governance Committee will review and approve standard service protocols and standards on consent and confidentiality that will be HIPAA-compliant.										
Task SOC will ensure that their approved physicians are licensed in NYS. Participating hospitals will credential SOC physicians within their medical staff.										
Task Hospital to use SOC clinical protocols and requirements for effective record exchange and provide appropriate documentation regarding the encounter.										
Task Timeline for accessing the on call physician will be established by contractual agreements with SOC.										
Task In coordination with the local hospital medical staff leadership, CPWNY will provide communication and training to participating										

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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 on standard service protocols.										
Task Assessment executed and reviewed to determine effectiveness of the program and make improvements. SOC is Joint Commission regulated and adheres to proper quality guidelines.										
Milestone #6 Coordinate with Medicaid Managed Care Organizations to develop and ensure service authorization and payment strategies are in place to support sustainability of patient care uses.										
Task Service authorization and payment strategies developed, in concert with Medicaid Managed Care companies.										
Task CPWNY's PMO has existing value-based risk contract relationship with local Medicaid Managed Care Organizations. CPWNY will leverage existing relationships to develop service authorizations and payment strategies to address the needs of Medicaid population.										
Task Convene meetings with local health plans and Managed Care Organizations to discuss payment arrangements and authorization.										
Task Finalize payment agreements with major health plans and Managed Care Organizations for provision of telemedicine services.										
Task Payment agreements approved by the EGB and the Finance Committee.										
Task Meet periodically with the MMCOs to review and improve agreements. (This action is ongoing)										
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Include in service agreements provisions for the exchange of clinical information. Identify SOC capabilities for tracking and follow-up.										
Task Review IT assessment to identify interoperability capabilities										

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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
between SOC and CPWNY providers and between the local RHIO, HEALTHeLINK.										
Task Work with HEALTHeLINK and the IT team to develop interoperability and patient tracking capability.										
Task CPWNY will require participating hospitals to report utilization of patients engaged in this project. (This action is ongoing)										

Project 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 telemedicine services, aimed at reducing avoidable hospital use by increasing patient access to services not otherwise available and/or increasing specialty expertise of primary care providers and their staff in order to increase availability of scarce specialty services.										
Task Telemedicine service implemented, based on evaluation of impact to underserved areas including, but not limited to: - analysis of the availability of broadband access in the geographic area being served - gaps in services - geographic areas where PPS lacks resources and telemedicine will be used to increase the reach of these patients - why telemedicine is the best alternative to provide these services - challenges expected and plan to pro-actively resolve - plan for long term sustainability										
Task Perform a community-wide assessment to determine highest need for telemedicine and potential gaps, which can assist in the reduction of preventable admissions/readmissions. This is in accordance with the goals to reduce improper utilization by 25% in 5 years. The WNY region has identified gaps such as critical care, acute neurology assessment, and behavioral health consultations. In addition, our goal is to triage patients to appropriate level of care through telemedicine consults and thus facilitate patient transfers as needed.										
Task CPWNY will assess existing telemedicine capabilities and issue telemedicine RFPs to outside vendors.										
Task Telemedicine vendor selected by CPWNY EGB based on										

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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
vendor's capability of addressing identified gaps in services. Specialist on Call-NY Telemedicine TPP (SOC) was selected.										
Task Contract negotiations between SOC and CPWNY. Contract developed by SOC and under review by CPWNY's legal team and Women's Christian Association Hospital, which is the first pilot site for rolling out the telemedicine project.										
Task Contract to be signed by CPWNY for the initial and ongoing implementation of the telemedicine project. WCA to review and sign contract for the individual services to be provided in the areas identified as gaps in care for this institution. There will be a 120-day implementation period following signing										
Task Needs for connectivity, interoperability, credentialing, reporting, and other required elements of the telemedicine project will be coordinated with CPWNY's participating partners and outside vendors.										
Task Provide communication and training to participating providers at WCA hospital on Specialists on Call regarding equipment and clinical protocols for the provision of medical services.										
Task CPWNY will conduct periodic assessment of the progress in implementing the telemedicine project and produce reports and newsletters. CPWNY will utilize Rapid Cycle Improvement and PDSA methodology for continuous improvement. Note: ongoing activity.										
Milestone #2 Provide equipment specifications and rationale for equipment choice (including cost of acquisition, maintenance and sustainability of service).										
Task Equipment specifications (meeting certified standards for interoperability and communications) and rationale documented.										
Task Telemedicine workstations leased from SOC based on their experience and on call network for ICU, neurology and psychiatry										
Task Implementation including equipment, clinical protocol , IT installation and training is $55,000 per hospital (one time fee) plus monthly maintenance of $750 per month. Equipment choice (Rubbermaid Telemedicine cart with Cisco SX20 video codec or Polycom Group 500) is specified by SOC, which will provide continuous maintenance.										

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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 CPWNY will engage in discussions with health plans to develop additional strategic initiatives that will enhance the sustainability of the project, including additional reimbursement for these services.										
Milestone #3 Define service area and participating providers, with clear delineation between telemedicine hub sites versus spoke sites.										
Task Service area, delineated between spoke and hub sites, defined.	21	21	21	21	21	21	21	21	21	21
Task Service area, delineated between spoke and hub sites, defined.	3	3	3	3	3	3	3	3	3	3
Task Perform assessment of areas in our counties (Chautauqua, Erie and Niagara, Orleans) in high need of telemedicine services. Reach out to other hospitals to identify their specific needs and initiate implementation of additional telemedicine sites.										
Task Begin roll out in Chautauqua County, starting with Women's Christian Association hospital, due to high patient demand and provider interest.										
Task Finalize agreements with WCA hospital. CPWNY will work on additional agreements with Brooks Memorial Hospital in Chautauqua County, Mount St Mary's Hospital in Niagara County, Medina Hospital in Orleans County, Westfield Hospital in Chautauqua County, and Bertrand Chaffee Hospital in Erie County.										
Task SOC is a turn key operation with a robust on-call network. To create a uniform process, they will act as the "hub" for our providers to obtain services. The spokes will be our rural hospitals and providers.										
Milestone #4 Procure service agreements for provision of telemedicine services such as specialty services, participating primary care and nurse triage monitoring.										
Task Service agreements in place for provision of telemedicine services.	21	21	21	21	21	21	21	21	21	21
Task Service agreements in place for provision of telemedicine services.	3	3	3	3	3	3	3	3	3	3
Task Service agreements, which outline specific protocols for the										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
provision of medical services, are developed for WCA Hospital, Brooks Memorial Hospital, Mount St Mary's Hospital, and Bertrand Chaffe Hospital with all related costs and relevant services identified. The agreements are developed based on SOC's standard service protocol and are edited to incorporate the specific needs of CPWNY's participating hospitals.										
Task Agreements will be approved by the CPWNY EGB and specific hospital agreements will be reviewed and approved in coordination with participating hospitals.										
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Milestone #5 Develop standard service protocols, as well as consent and confidentiality standards meeting all federal and state requirements.										
Task Telemedicine service, consent, and confidentiality protocols developed to meet federal and state requirements for: - patient eligibility - appointment availability - medical record protocols - educational standards - continuing education credits										
Task Work with Specialists on Call and the CPWNY Clinical Governance Committee will review and approve standard service protocols and standards on consent and confidentiality that will be HIPAA-compliant.										
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Task Timeline for accessing the on call physician will be established by contractual agreements with SOC.										

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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 In coordination with the local hospital medical staff leadership, CPWNY will provide communication and training to participating providers on standard service protocols.										
Task Assessment executed and reviewed to determine effectiveness of the program and make improvements. SOC is Joint Commission regulated and adheres to proper quality guidelines.										
Milestone #6 Coordinate with Medicaid Managed Care Organizations to develop and ensure service authorization and payment strategies are in place to support sustainability of patient care uses.										
Task Service authorization and payment strategies developed, in concert with Medicaid Managed Care companies.										
Task CPWNY's PMO has existing value-based risk contract relationship with local Medicaid Managed Care Organizations. CPWNY will leverage existing relationships to develop service authorizations and payment strategies to address the needs of Medicaid population.										
Task Convene meetings with local health plans and Managed Care Organizations to discuss payment arrangements and authorization.										
Task Finalize payment agreements with major health plans and Managed Care Organizations for provision of telemedicine services.										
Task Payment agreements approved by the EGB and the Finance Committee.										
Task Meet periodically with the MMCOs to review and improve agreements. (This action is ongoing)										
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Include in service agreements provisions for the exchange of clinical information. Identify SOC capabilities for tracking and follow-up.										

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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 Review IT assessment to identify interoperability capabilities between SOC and CPWNY providers and between the local RHIO, HEALTHeLINK.										
Task Work with HEALTHeLINK and the IT team to develop interoperability and patient tracking capability.										
Task CPWNY will require participating hospitals to report utilization of patients engaged in this project. (This action is ongoing)										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement telemedicine services, aimed at reducing avoidable hospital use by increasing patient access to services not otherwise available and/or increasing specialty expertise of primary care providers and their staff in order to increase availability of scarce specialty services.	
Provide equipment specifications and rationale for equipment choice (including cost of acquisition, maintenance and sustainability of service).	
Define service area and participating providers, with clear delineation between telemedicine hub sites versus spoke sites.	
Procure service agreements for provision of telemedicine services such as specialty services, participating primary care and nurse triage monitoring.	
Develop standard service protocols, as well as consent and confidentiality standards meeting all federal and state requirements.	
Coordinate with Medicaid Managed Care Organizations to develop and ensure service authorization and payment strategies are in place to support sustainability of patient care uses.	

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Prescribed Milestones Narrative Text

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

Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

• Risk: It is not financially viable to hire therapists and psychiatric providers in rural practices exclusively for DSRIP patients. This could limit access to integrated care. Mitigation: CPWNY will institute a policy that all patients are treated according to DSRIP standards, and will not discriminate by insurance or DSRIP status. Therapists and psychiatric providers will be shared by multiple primary care offices. Satellite clinics will be embedded in primary care practices so both Medicaid and commercial insurance can be billed, or enhanced rapid access referral process will be in place. CPWNY will off-set the difference between Medicaid and commercial rates to support BH services.
• Risk: Staff and providers may not understand the projects and may be reluctant to perform necessary roles. Mitigation: CPWNY will ensure that all organizations are trained in the goals of DSRIP and roles of the organization and their staff. Catholic Medical Partners has experience engaging physicians in quality improvement and performance reporting through physician champions, performance incentives, providing resources, and remediation for providers who fail to perform. CPWNY will employ these strategies to ensure engagement in DSRIP protocols. The executive governance board will review performance for possible remediation.
• Risk: Lack of care coordination technology and lack of integration of medical and social services. OPWDD services & medical services have separate systems and rules. Without a care coordination system there will be limited continuity for OPWDD individuals. Mitigation: CPWNY will invest in care coordination technology to allow communication between providers, individuals and natural supports. New technology will include ability to track information on habilitative and medical services. CPWNY will ensure that all agencies have EHR access with linkage to the data warehouse. In the event of limited resources, CPWNY will use our health homes, which have capacity for managing and tracking both health and social services, to refer OPWDD individuals.
• Risk: Lack of interoperable EMRs between PCPs and behavioral health providers. This could create a barrier for coordination and secure exchanges between providers. Mitigation: CPWNY will partner with HealtheLink and instruct practices to utilize their functionality for direct exchange of patient data. This includes capability for Bi-directional exchange of CCD/CCDA data. CPWNY plans to develop infrastructure either through HealtheLink or individual EMRs for exchange of information between all network providers.
• Risk: Difficulty in engaging patients. Lack of participation is a liability for performance. Mitigation: CPWNY will train PCPs and behavioral health providers in the social and structural determinants of health. CPWNY will use peer health coaches and telephone reminders to engage patients. CPWNY will enlist experienced partners in the development of wellness programs. Appointment scheduling will consider patient schedules and transportation to ensure compliance. CPWNY providers will engage patient family members to create a familiar support network.
• Risk: Lack of standardized protocols for identifying patients in need of primary care and behavioral health services. This may create differences in patient classification and treatment across providers and inhibit continuity of care. Mitigation: CPWNY will establish PPS-wide protocols for classifying patients and developing care plans. CPWNY will provide training of PCPs in motivational interviewing and behavioral health treatment. Behavioral health staff will be trained in fundamentals of diabetes, hypertension, obesity, and nutrition. PCPs will be trained to use Screening, Brief Intervention, and Referral to Treatment (SBIRT) and Patient Health Questionnaire (PQH9) protocols for screening and evaluation.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	64,468

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
6,275	12,273	29.29%	29,631	19.04%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (41,904)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
dcao	Rosters	46_PMDL3715_1_3_20160201115735_CPWNY_Patient_List_for_3.a.i_Primary_Care_&_BH_Model_2_DY1_Q3.pdf	CPWNY Patient List for 3.a.i Primary Care & BH Model 2 DY1 Q3	02/01/2016 11:58 AM
dcao	Rosters	46_PMDL3715_1_3_20160201115602_CPWNY_Patient_List_for_3.a.i_Primary_Care_&_BH_Model_1_DY1_Q3.pdf	CPWNY Patient List for 3.a.i Primary Care & BH Model 1 DY1 Q3	02/01/2016 11:56 AM

Narrative Text :

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

CPWNY chose to implement Model 1 and Model 2 for project 3.a.i. Following the DSRIP guideline of "preventive care screening based on nationally-accepted best practices", CPWNY defines "appropriate preventive care screenings that include mental health/substance abuse" in Model 1 as:

In the 12-month rolling look-back period (look-back period for DY1 Q1 is 7/1/2014 – 6/30/2015; look-back period for DY1 Q2 is 10/1/2014 –

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9/30/2015; look-back period for DY1 Q3 is 1/1/2015 – 12/31/2015) patient had at least one depression screening and at least one of the following preventive care screening:
• BMI screening
• Breast cancer screening
• Cervical cancer screening
• Colorectal cancer screening
• Fall risk screening
• LDL screening
• Pneumococcal screening
We report Model 1 patient list (4,278 patients) and Model 2 patient list (8,183 patients) in two separated files. The total number of engaged patients in Project 3.a.i, de-duplicated between Model 1 and Model 2, is 12,273 for DY1 Q3.

CPWNY's patient engagement numbers for project 3.a.i in DY1 Q1 and Q2 are underestimated due to the following reasons:
• Model 1 Patient lists are only collected from a limited number of PCP practices. CPWNY is in the process to roll out IT integration and data collection effort to other partners.
• Data are incomplete for the most recent two months in Model 1. Thus Model 1 patients engaged in November or December 2015 are not reportable at this time.

Regarding patient identifier: We provide CIN for all patients engaged in Model 2. We provide CIN or MCO policy number for the majority of patients engaged in Model 1. There is a small number of Medicaid patients in Model 1 that we don't have CIN or MCO policy number. Those patients are traceable via last name, first name, and provider group name.

Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its actively engaged commitments for DY1Q3. The documentation does not support the reported actively engaged numbers.

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Model 1	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Behavioral health services are co-located within PCMH/APC practices and are available.		Provider	Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…The project management office (PMO) staff will identify from participating providers lists primary care practices and licensed mental health, behavioral health, and substance abuse organizations across the Community Partner's of WNY geographic areas and coordinate with Millennium Collaborative Care PPS as to which primary care providers and licensed mental health, behavioral health, and substance abuse providers are in both PPS's.		Project		Completed	08/01/2015	09/30/2015	08/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…PMO staff, with a cover letter detailing the kinds of support Community Partners could provide their practice, survey the identified primary care practices who are exclusively in the Community Partner's PPS as to their PCMH/NCQA Level or Advanced Primary Care status, percentage of current Medicaid patients served, their current ability to accept new Medicaid patients, EHR status		Project		In Progress	08/01/2015	03/31/2018	08/01/2015	03/31/2018	03/31/2018	DY3 Q4

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and vendor, CCD capacity to receive and send records, relationship with HealtheLink RHIO, current behavioral health capacity if any, status of current use of PHQ9 and SBIRT screenings, and willingness to discuss possible integration of a satellite mental health or behavioral health (including substance abuse) clinic within their practice site (Article 28 outpatient primary care clinics are currently unable by regulation to integrate a satellite Article 31 mental and behavioral health clinic unless there is a completely separate entrance and separate waiting room making this approach to integration not feasible). The PMO has contacted the regional Department of Health Commissioner for assistance in overcoming this barrier. (Will start with high volume Medicaid practices and roll out survey in increments.)										
Task Step 3…CPWNY PMO and Millennium Collaborative Care designated staff will send a joint cover letter and Survey to those primary practices which are in both the Millennium and Community Partner PPS's to identify available support and ask for the same information as in Step 2		Project		In Progress	08/01/2015	03/31/2018	08/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 4...With a cover letter detailing the kinds of support available in CPWNY, with representation from Article 31 (e.g. Spectrum) partners, will survey the identified licensed mental health/CD agencies exclusively aligned with Community Partners PPS as to current experience with satellite clinic integration into primary care sites, willingness to consider satellite clinic integration into primary care sites, EHR status and vendor, HealtheLink RHIO experience/relationship, CCD and /or MIRTH mail capacity to receive and send records if any, current status/use of PHQ9 and SBIRT screenings, current capacity to provide primary care services within their existing MH clinics. (roll out in increments based on CNA)		Project		In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task		Project		In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Step 5…CPWNY, with representation from Article 31 partners, and Millennium Collaborative Care designated staff will send a joint cover letter and Survey to those licensed mental health providers which are in both the Millennium and Community Partner PPS's identifying PPS support available and asking for the same information as in Step 3.										
Task Step 6…CPWNY, with representation from Article 31 partners, and Millennium Collaborative Care designated staff will jointly determine if the restrictions on integrating Article 31 clinics into Article 28 outpatient primary care facilities identified above are DOH regulations or Federal regulations. If DOH regulations jointly seek a waiver. If waiver not feasible explore the feasibility of the Article 28 clinics being able (if not already so) to hire their own mental or behavioral health (including substance abuse) professional and what supports would be needed to do so from respective PPS's if the Article 28 was in both PPS's. Survey solely or jointly by both PPS's as appropriate the Article 28's for the same information as in Steps 2 or 3.		Project		In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7…Hold geographically accessible planning meetings for primary care and behavioral health providers who expressed via survey interest in proceeding toward integrated services.. Meetings will be led by teams consisting of physician, mental health leaders and CPWNY central office representatives Include Millennium Collaborative Care representatives to address those providers who will be serving patients from both PPS's. Initiate outreach to PCP's by physician ambassadors from CPWNY and CPWNY mental health ambassadors to mental health providers to engage those providers who either did not respond to surveys or declined interest. Discuss their obstacles to participation and how CPWNY can help to resolve obstacles and engage their active		Project		In Progress	08/01/2015	03/31/2018	08/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
participation in the project through a shadowing visit to existing sites that have integrated behavioral health with primary care. Continue quarterly planning meetings throughout the project to support a learning community approach. Maintain regional meetings for providers throughout the project										
Task Step 8… CPWNY will use a variety of integration models to achieve the goals of this project. These include 1. embedding a mental or behavioral health provider from an Article 31 partner community based organization into a primary care site; 2. building evidence based behavioral health and substance abuse screening tools into the PCMH work flow; 3. facilitating same day access and referral to a geographically accessible behavioral health or substance abuse service for patients identified as in need.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 9...For practices that do not have a behavioral health provider physically located in the primary care practice, "warm transfers" will be facilitated in person by an available member of the PCP office to behavioral health/substance abuse providers located close by or in the same building, or via a scheduled conference call with participating behavioral health/substance abuse providers, primary care physicians, and the patient.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 10…Finalize contracts/MOU's with participating PCP's and behavioral health and substance abuse providers that outlines their commitment to participate in developing and operationalizing integrated services within the CPWNY PPS or, as appropriate, CPWNY and Millennium PPS's if members of both PPS's. Coordinate content of the contracts/MOU's between PPS's to standardize expectations. (incremental roll out - start with high volume practices and high need areas based on Community Needs Assessment)		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Task Step 11…Analyze current status of EMR systems used for both PCP's and Behavioral health/substance abuse provider practices, the status of Meaningful Use (AUI, Stage 1, Stage 2, or none), and status of PCMH (Level 3, 2, 1, in process, or none) by participating provider practices. Create a work plan and timeline for getting PCP practices not yet at PCMH Level 3 and MU to achieve them both by end of DY3.		Project		In Progress	09/01/2015	12/31/2015	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 12...Assign each PCP practice a Clinical Transformation Specialist to work with them and be their point of contact on EMR, MU, PCMH, and Population Health/Quality Outcome Measures. Need to hire additional personnel to take on additional practices and workload		Project		In Progress	09/01/2015	12/31/2015	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 13..Create a targeted survey or contact practices to understand practice readiness to engage in PCMH or MU activities (if not currently engaged). Create a work plan for training and educating those who are ready. Create an intervention strategy to help engage those who are not ready through the use of Regional Primary Care Leaders, Hospital leadership, and other resources yet to be determined (such as providing more care management assistance or behavioral health assistance to help the practice feel more comfortable with their ability to take on PCMH recognition)		Project		In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 14...Create educational training materials for Meaningful Use. Provide targeted education based on each practices' need, especially for those who did not meet MU on DY1, for either in person training, web based (WebEx), or user-group by EMR vendor training		Project		In Progress	06/01/2015	03/31/2018	06/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 14.a. *Provide education and training to greater than half of		Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
practices on Meaningful Use										
Task 14.b. *Provide education and training to greater than 75% practices on Meaningful Use		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 14.c *Provide education and training to 100% practices on Meaningful Use		Project		In Progress	07/01/2015	06/30/2017	07/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 14.d *All practices on Meaningful Use by end of DY 3= Steps listed below that correspond with 2014 standards but focusing on EMR capabilities and practice use of these capabilities:		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 15… Improving quality, safety , efficiency and reducing health disparities (these measures will help to provide better access to comprehensive patient data for patient's health team; use evidence based order sets and Computer Order entry; apply clinical decision support at the point of care; generate list of patients who need care and use them to reach out to patients.)		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 16…Engage patients and families in their health care (these measures will provide patients and families with timely access to data; tools to make informed decisions and manage their health)		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 17… Improve care coordination (These measures will allow practices to exchange meaningful clinical information among a professional health care team)		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 18… Improve population and public health (these measures will allow physicians to communicate with public health agencies and better track of health information across communities)		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 19…Ensure adequate privacy and security protections for personal health information (These		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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measures will help ensure : the privacy & security protections for confidential health information through operating policies , procedures and technology; compliance with applicable law; and transparency of data sharing to the patient.										
Task Step 20…Create education and training materials for PCMH recognition. Create a series of classes focused on teaching of standards, leadership skills, project management skills, IT/EMR support) for practices not yet achieved PCMH to teach the steps on how to achieve level 3 recognition. Find practices that have already achieved level 3 recognition that are willing to act as mentors and leaders to other practices who have not yet achieved level 3 and connect them.		Project		In Progress	06/01/2015	09/30/2016	06/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 20.a *Provide education and training to greater than half practices on PCMH		Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 20.b *Provide education and training to greater than 75% practices on PCMH		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 20.c *Provide education and training to 100% practices on PCMH		Project		In Progress	07/01/2015	06/30/2017	07/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 20.d * All Primary Care practices achieve PCMH by end of DY3==Steps listed below that are individualized to the assessment of each practice and has meaningful use standards embedded in the applicable standard:		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 21…Insure PCMH policies and procedures are in place with a process to review , revise and re-approve (templates are provided for office adaptation, customization)		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 22…Ability to run reports to track missed		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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appointments, upcoming appointments, gaps in preventive care, gaps in chronic disease management, hospitalization and transitions of care documentation, and care management interventions.										
Task Step 23…Appointment Access and availability reports completed (and follow policy). Enhance recruitment of providers based on access and availability report and CAHPS surveys through hospital and IPA recruitment offices		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 24…Roles and job descriptions completed for practice team members in PCMH and training to PCMH as noted above		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 25…Evidence Based guidelines built into the EMR along with tools to manage patient care (care management including referrals to CBOs, educational tools, follow up, motivational interviewing)		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 26…Assessment of diversity in the practice and ability to run quality metrics based on culture, language, and ethnicity		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 27…Track outreach to patients in attempts to close gaps in care (along with preferred methods of contact as stipulated by the patient)		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 28…Exchange of information (care coordination)--reports to show timeliness of incoming and outgoing patient information.(referral agreements in place and information exchanged according to agreements and policy)		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 29…Quality improvement program in the office, utilizing Rapid Cycle Evaluation		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Task Step 30…Evaluation of usefulness of community referrals.		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 31…Medication management (monitors cost, best practice, allergies, interactions, e-scripts)		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 32... Set up a process for continued education and assistance with PCMH and Meaningful Use. PCMH renewals occur every three years, and meaningful use is yearly. So many practices will have to renew PCMH recognition during this time period, as well as continuing their MU attestations. We want to set up a process to ensure their continued success in the future. There are also standards in which you must show achievement during the interim years of recognition like the measurement and improvement of quality measures.		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 33…For primary care practices whose Medicaid patient percentages are too low to support an integrated mental or behavioral health (including substance abuse) satellite clinic, collaborative care agreements will be developed with the assistance of the PPS (or PPSs as appropriate) with geographically accessible licensed mental health clinics and behavioral health and substance abuse providers. Evidence based protocols will be codified in MOU's that define the respective responsibilities of both the PCP and BH provider. Protocols in the MOU will include same day/next day access for patients referred by the PCP, concurrent exchange of patient treatment information through CCD's or MIRTH mail as available, connectivity by both PPSs with HEALTHeLINK RHIO to support exchange of treatment information, and regular communication to coordinate treatment plans and medication management. Clinical transformation specialists will meet quarterly with providers and their leadership to support the collaborative care relationship and provide problem solving as necessary. (ongoing)		Project		In Progress	03/31/2016	09/30/2016	03/31/2016	09/30/2016	09/30/2016	DY2 Q2

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Task Step 34… CPWNY is aware that services rendered by an Article 31 provider within an Article 28 facility are not billable to Medicaid. CPWNY is exploring mitigation options such as deploying social worker in Article 28 facility to facilitate warm handoff of patients.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	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	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1..CPWNY Clinical transformation specialists in collaboration with Millennium Collaborative Care Project Manager will develop agreements between each PCP and the integrating BH providers (embedded Article 31 satellite clinic or collaborative care model) utilizing SAMSHA evidence based guidelines provided by the PPS to establish clear written protocols on warm hand-offs of patients, team meeting participation of BH and PCP providers with inclusion of support staff/practice managers, case conferences on more complex patient needs, spontaneous curbside consultation between PCP and BH providers on patient needs, exchange of clinical treatment record information (CCD's or secure MIRTH mail), coordinated care plans including agreements on prescribing practices and coordination, warm hand-offs back to the referring physician at the conclusion of BH treatment including medication needs going forward as well as resolving the often perceived power differentials between physicians and behavioral health providers in		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4

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DSRIP Implementation Plan Project

Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

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order to promote true integration of service delivery versus simply co-location. Evidence based practices above will be coordinated with Millennium Collaborative Care where PCPs are members of both PPSs so services are delivered and integrated under one set of evidence based standards.										
Task Step 2.. Existing PMO care advisors are trained in motivational interviewing and brief interventions, which are key parts of the PMO's Care Management Program. The PMO currently utilizes social workers and nurses who have been trained and have a proven competency. As CPWNY rolls out the integrated model and as new staff are brought in, CPWNY will utilize the "train the trainer" program to train additional primary care and behavioral health staff on brief interventions and motivational interviewing.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 3..Clinical transformation specialists from CPWNY (and Millennium Collaborative Care Project Manager as indicated by dual membership in both PPS's) will meet with each integrated PCP/satellite BH site staff and leadership, each collaborative PCP/BH relationship staff and leadership, and each PCP/BH collaborative relationship with a NP providing primary care services within the BH clinic at least quarterly to mutually assess and problem solve where necessary the established evidence based protocols that support integrated/collaborative treatment and practice.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4... Quarterly meetings between clinical transformation team and participating behavioral health/mental health/substance abuse sites will include progress on implementation, status of adoption of clinical protocols, and discussion of risks and barriers to implementation. Clinical transformation team will assess progress and help practices to address risks and identify potential for improvements. (This action will be ongoing)		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task		Project		In Progress	09/01/2015	07/01/2016	09/01/2015	07/01/2016	09/30/2016	DY2 Q2

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Step 5... The respective PPS Health Home provider (CPWNY's Health Home provider within its PPS is Health Home Partners of WNY) will meet with PPS PCPs and BH licensed providers to educate all of the respective practitioners about the care coordination support and engagement Health Homes can provide eligible patients and how expedited referrals can be made, as well as clarifying the role differentiation between on site PCP nurse care coordinators and community based "boots on the ground" health home care coordinators.										
Task Step 6…CPWNY Care Coordination team (and jointly with Millennium Collaborative Care Project Coordinator as appropriate) will assist PCP and BH practices in prioritizing outreach and developing a workflow on patient engagement, examining patient expressed barriers to seeking healthcare on an outpatient basis. Barriers may be related to a lack of understanding, social, cultural, travel time, transportation needs, family dynamics, prioritization, stigma associated with mental health treatment, etc. and utilize health home care coordinators for eligible patients and Community Based Organizations to overcome these barriers.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Model 1	Project	N/A	In Progress	09/01/2015	03/31/2018	09/01/2015	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	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Screenings are documented in Electronic Health Record.		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	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		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4

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those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…PCP's and BH practices jointly surveyed by CPWNY & Millennium Collaborative Care as to which preventive screenings are currently routinely being used for patients in both PCP's and BH practices.		Project		On Hold	09/01/2015	12/31/2015	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 2...CPWNY's 3.a.i project team in collaboration with Millennium Collaborative Care Project Manager will identify best practice physical health preventive care screenings to be adopted across both PPS's PCP's in addition to PHQ9 and SBIRT screenings for both PCP's and behavioral health (including substance abuse) practices. The CPWNY project team in collaboration with the Behavioral Health partners will assess and select appropriate SBIRT tools to be used and obtain approval from CPWNY's clinical governance committee.		Project		In Progress	09/01/2015	12/31/2015	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3…A joint PPS (CPWNY & Millennium) training plan will be developed for both PCP and behavioral health practices to support the adoption of best practice screenings where there are current gaps within identified PCP's and behavioral health (including substance abuse) providers. Training plan includes educating practices on the billing codes for PHQ9 and SBIRT screens as many practices are unaware of ability to bill for these screens and absence of billing is a barrier.		Project		In Progress	09/01/2015	12/31/2015	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4…CPWNY Clinical Integration teams and Millennium Collaborative Care will jointly assist in training to PCP's and behavioral health (including substance abuse) providers participating in both PPS's and CPWNY Clinical Transformation teams will assist in providing the same		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4

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training to providers uniquely in the CPWNY PPS. As CPWNY rolls out the integrated model and as new staff are brought in, CPWNY will utilize the "train the trainer" program to train additional primary care and behavioral health staff on brief interventions and motivational interviewing.										
Task Step 5...All screenings are required to have documentation in provider EMR's.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6..Clinical integration training teams (with Millennium Collaborative Care counterparts for joint PPS membership) will incorporate reviews of screening protocols and implementation with periodic technical assistance meetings with providers.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7..CPWNY 3.a.i project team will assess and develop reporting metrics and outcome measures including usefulness of community referrals, medication management and adherence, effectiveness of patient outreach, and quality metrics based on culture, language, and ethnicity. The project team will utilize Rapid Cycle Improvement method for continuous improvement.(assessment is implemented in increments and ongoing)		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 1	Project	N/A	In Progress	09/01/2015	03/31/2017	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	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Utilizing healthcare data analytics, complete an assessment of our PPS attributed Medicaid members.		Project		In Progress	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Task Step 2…The clinical transformation team will assist practices in extracting data from EMRs on their Medicaid patients; sort by who has not been in office for 1 year or greater; and impending doctor appointment by disease conditions (Cardiovascular , HTN, Renal, Diabetes, Behavioral health)		Project		In Progress	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3… Assess the population from claims data to ascertain hospitalizations and ER visits to obtain holistic view of patient; stratify population by the aforementioned and also segment by culture, ethnicity and language.		Project		In Progress	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 4… CPWNY's PMO has existing referral relationship with our partner Health Home for eligible patients. The 3.a.i project team will assess the current workflow and develop a protocol for connecting eligible patients to the PPS's health home, Health Home Partners of WNY. CPWNY will extract data for further tracking from Health Home GSI Care Coordination software for health home enrolled patients.		Project		In Progress	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 5…Utilizing data extracted, CPWNY's Clinical Transformation team and IT team with help practices to identify targeted patients and establish patient registries for managing patient care and milestone reporting. The target population for patient registries and tracking will include but not limited to conditions such as depression, substance abuse, and/or overlapping co-morbid with diabetes and cardiac disease.		Project		In Progress	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6… Work with the information technology team to integrate behavioral health status and alerts into the medical record. This process involves obtaining a consent from the patient at the primary care site and at the behavioral health site. Once the consents are both in		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4

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place, information can be shared through HEALTHeLINK direct exchange or through mirth mail. (Defined process must be in place to ensure that no downstream sharing of patient behavioral health [title 42] information takes place)										
Task Step 7… Set up documentation in EMRs to run reports on care management care plans, care transitions, preventive PCP and BH screenings etc. To be overseen by CPWNY Clinical Transformation and CPWNY IT teams.		Project		In Progress	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Co-locate primary care services at behavioral health sites.	Model 2	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…The project management office (PMO) staff will identify from participating provider lists primary care practices and licensed mental health, behavioral health, and substance abuse provider organizations across the Community Partner's of WNY geographic areas and coordinate with Millennium Collaborative Care PPS to identify which primary care providers and licensed mental health, behavioral health, and substance abuse providers are in both PPS's.		Project		Completed	08/01/2015	09/30/2015	08/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…PMO staff, with a cover letter detailing the kinds of support Community Partners could provide their practice, will survey the identified primary care practices who are exclusively in the Community Partner's PPS as to their PCMH/NCQA Level or Advanced Primary Care status,		Project		In Progress	08/01/2015	03/31/2018	08/01/2015	03/31/2018	03/31/2018	DY3 Q4

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percentage of current Medicaid patients served, their current ability to accept new Medicaid patients, EHR status and vendor, CCD capacity to receive and send records, relationship with HealtheLink RHIO, current behavioral health/mental health/substance abuse capacity if any, status of current use of PHQ9 and SBIRT screenings, and willingness to discuss possible integration of a satellite mental health, behavioral health, or substance abuse clinic within their practice site (Article 28 outpatient primary care clinics are currently unable by regulation to integrate a satellite Article 31 clinic unless there is a completely separate entrance and separate waiting room making this approach to integration not feasible). The PMO has contacted the regional Department of Health Commissioner for assistance in overcoming this barrier. (Will start with high volume Medicaid practices and roll out survey in increments.)										
Task Step 3…CPWNY PMO and Millennium Collaborative Care designated staff will send a joint cover letter and Survey to those primary care practices which are in both the MCC and Community Partner PPS's identifying available support and asking for the same information as in Step 2		Project		In Progress	08/01/2015	03/31/2018	08/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 4...With a cover letter detailing the kinds of support available in the CPWNY PPS network, with representation from Article 31 (e.g. Spectrum) partners, will survey the identified licensed mental health/CD agencies exclusively aligned with Community Partners PPS as to current experience and capacity to provide primary care services within existing mental health, behavioral health, and substance abuse clinics, EHR status and vendor, HealtheLink RHIO experience/relationship, CCD and /or MIRTH mail capacity to receive and send records if any, current status/use of PHQ9 and SBIRT screenings. (roll out in increments based on CNA)		Project		In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Task Step 5…CPWNY, with representation from Article 31 partners, and Millennium Collaborative Care designated staff will send a joint cover letter and Survey to those licensed mental health, behavioral health, and substance abuse providers which are in both the Millennium Collaborative Care and Community Partner PPSs identifying PPS support available and asking for the same information as in Step 3.		Project		In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6…CPWNY, with representation from Article 31 partners, and Millennium Collaborative Care designated staff will jointly determine if the restrictions on integrating Article 31 clinics into Article 28 outpatient primary care facilities identified above are DOH regulations or Federal regulations. If DOH regulations, jointly seek a waiver. If waiver not feasible explore the feasibility of the Article 28 clinics being able (if not already so) to hire their own MH professional and what support would be needed to do so from respective PPS's if the Article 28 was in both PPS's. Survey solely or jointly by both PPS's as appropriate the Article 28's for the same information as in Steps 2 or 3.		Project		In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7…Hold geographically accessible planning meetings for primary care and behavioral health providers who expressed via survey interest in proceeding toward integrated services.. Meetings will be led by teams consisting of physician, mental health leaders and CPWNY central office representatives. Include Millennium Collaborative Care representatives to address those providers who will be serving patients from both PPSs. Initiate outreach to PCPs by physician ambassadors from CPWNY and CPWNY mental health ambassadors to mental health providers to engage those providers who either did not respond to surveys or declined interest. Discuss their obstacles to participation and how CPWNY		Project		In Progress	08/01/2015	03/31/2018	08/01/2015	03/31/2018	03/31/2018	DY3 Q4

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can help to resolve obstacles and engage their active participation in the project through a shadowing visit to existing sites that have integrated behavioral health with primary care. Continue quarterly planning meetings throughout the project to support a leaning community approach. Maintain regional meetings for providers throughout the project										
Task Step 8…CPWNY will work with Millennium PPS to integrate advanced care management services into Article 31 organizations and other mental health, behavioral health, and substance abuse sites to promote improvements and key health indicators that are targeted to be achieved for the behavioral health populations.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 9…Finalize contracts/MOU's with participating PCP's and BH providers that outlines their commitment to participate in developing and operationalizing integrated services within the CPWNY PPS or, as appropriate, CPWNY and Millennium PPSs if members of both PPS's. Coordinate content of the contracts/MOU's between PPS's to standardize expectations. (incremental roll out - start with high volume practices and high need areas based on Community Needs Assessment)		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 10…Analyze current status of EMR systems used for both PCP's and behavioral health, mental health, and substance abuse provider practices, the status of Meaningful Use (AUI, Stage 1, Stage 2, or none), and status of PCMH (Level 3, 2, 1, in process, or none) by participating provider practices. Create a work plan and timeline for getting PCP practices not yet at PCMH Level 3 and MU to achieve them both by end of DY3.		Project		In Progress	09/01/2015	12/31/2015	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task		Project		In Progress	09/01/2015	12/31/2015	09/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Step 11...Assign each PCP practice a Clinical Transformation Specialist to work with them and be their point of contact on EMR, MU, PCMH, and Population Health/Quality Outcome Measures. Need to hire additional personnel to take on additional practices and workload										
Task Step 12..Create a targeted survey or contact practices to understand practice readiness to engage in PCMH or MU activities (if not currently engaged). Create work plan for training and educating those who are ready. Create an intervention strategy to help engage those who are not ready through the use of Regional Primary Care Leaders, Hospital leadership, and other resources yet to be determined (such as providing more care management assistance or behavioral health assistance to help the practice feel more comfortable with their ability to take on PCMH recognition)		Project		In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 13...Create educational training materials for Meaningful Use. Provide targeted education based on each practices needs, especially for those who did not meet MU on DY1, for either in person training, web based (WebEx), or user-group by EMR vendor training		Project		In Progress	06/01/2015	03/31/2018	06/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 13.a. *Provide education and training to greater than half of practices on Meaningful Use		Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 13.b. *Provide education and training to greater than 75% practices on Meaningful Use		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 13.c *Provide education and training to 100% practices on Meaningful Use		Project		In Progress	07/01/2015	06/30/2017	07/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 13.d *All practices on Meaningful Use by end of DY 3= Steps listed below that correspond with 2014 standards but focusing on EMR capabilities and practice use of these capabilities:		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Task Step 14…Improving quality, safety , efficiency and reducing health disparities (these measures will help to provide better access to comprehensive patient data for patients health team; use evidence based order sets and Computer Order entry; apply clinical decision support at the point of care; generate list of patients who need care and use them to reach out to patients.)		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 15…Engage patients and families in their health care (these measures will provide patients and families with timely access to data; tools to make informed decisions and manage their health)		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 16…Improve care coordination (These measures will allow practices to exchange meaningful clinical information among a professional health care team)		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 17…Improve population and public health (these measures will allow physicians to communicate with public health agencies and better track of health information across communities)		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 18…Ensure adequate privacy and security protections for personal health information (These measures will help ensure: the privacy & security protections for confidential health information through operating policies , procedures and technology; compliance with applicable law; and transparency of data sharing to the patient.		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 19…Create education and training materials for PCMH recognition. Create a series of classes focused on teaching of standards, leadership skills, project management skills, IT/EMR support) for practices not yet achieved PCMH to teach the steps on how to achieve level		Project		In Progress	06/01/2015	03/31/2018	06/01/2015	03/31/2018	03/31/2018	DY3 Q4

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3 recognition. Find practices that have already achieved level 3 recognition that are willing to act as mentors and leaders to other practices who have not yet achieved level 3 and connect them.										
Task 19.a *Provide education and training to greater than half practices on PCMH		Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 19.b *Provide education and training to greater than 75% practices on PCMH		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 19.c *Provide education and training to 100% practices on PCMH		Project		In Progress	07/01/2015	06/30/2017	07/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 19.d * All Primary Care practices achieve PCMH by end of DY3==Steps listed below that are individualized to the assessment of each practice and has meaningful use standards embedded in the applicable standard:		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 20…Insure PCMH policies and procedures in place with a process to review, revise and re-approve (templates are provided for office adaptation, customization)		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 21…Ability to run reports to track missed appointments, upcoming appointments, gaps in preventive care, gaps in chronic disease management, hospitalization and transitions of care documentation, and care management interventions.		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 22…Appointment Access and availability reports completed (and follow policy). Enhance recruitment of providers based on access and availability report and CAHPS surveys through hospital and IPA recruitment offices		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 23…Roles and job descriptions completed for practice team members in PCMH and training to PCMH as		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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noted above										
Task Step 24…Evidence Based guidelines built into the EMR along with tools to manage patient care (care management including referrals to CBOs, educational tools, follow up , motivational interviewing)		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 25... The PPS leadership and clinical transformation staff will ensure that participating behavioral health/mental health/substance abuse sites will meet article 31 certification requirements for medical screening and follow up and are aligned with the DSRIP outcome metrics.		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 26…Assessment of diversity in the practice and ability to run quality metrics based on culture, language, and ethnicity		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 27…Track outreach to patients in attempts to close gaps in care (along with preferred methods of contact as stipulated by the patient)		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 28…Exchange of information (care coordination)--reports to show timeliness of incoming and outgoing patient information.(referral agreements in place and information exchanged according to agreements and policy)		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 29…Quality improvement program in the office, utilizing Rapid Cycle Evaluation		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 30…Evaluation of usefulness of community referrals.		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 31…Medication management (monitors cost, best practice, allergies, interactions, e-scripts)		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 32... Set up a process for continued education and		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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DSRIP Implementation Plan Project

Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
assistance with PCMH and Meaningful Use. PCMH renewals occur every three years, and meaningful use is yearly. So many practices will have to renew PCMH recognition during this time period, as well as continuing their MU attestations. We want to set up a process to ensure their continued success in the future. There are also standards in which you must show achievement during the interim years of recognition like the measurement and improvement of quality measures.										
Task Step 33... CPWNY will Use the results of the joint survey with MCC to identify primary care providers willing to accept patients identified with medical needs at behavioral health sites.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 34…For behavioral health, mental health, and substance abuse providers who choose to integrate primary care services into their practice collaborative care agreements will be developed with the assistance of the PPS (or PPS's as appropriate)with geographically accessible primary care providers and mobile nurse practitioners. Evidence based protocols will be codified in MOU's that define the respective responsibilities of both the PCP and BH/MH/substance abuse provider. Protocols in the MOU will include same day/next day access for patients referred by the behavioral health/mental health/substance abuse provider including but not limited to scheduled conference calls between collaborative providers and the patient to discuss conditions and treatment plans. Concurrent exchange of patient treatment information through CCD's or MIRTH mail as available, connectivity by both with HEALTHeLINK RHIO to support exchange of treatment information, and regular communication to coordinate treatment plans and medication management. Clinical transformation specialists will meet quarterly with providers and their leadership teams to support the collaborative care relationship and		Project		In Progress	03/31/2016	09/30/2016	03/31/2016	09/30/2016	09/30/2016	DY2 Q2

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provide problem solving as necessary. (ongoing)										
Task Step 35…To support the provision of primary care services within licensed MH clinics the PPS (or PPS's s appropriate to clinics in both PPS's) will fund the hiring of nurse practitioners to be attached to a collaborative PCP, whose role will be to spend one day a week on average at five different high volume Medicaid BH clinics to provide basic primary care screening, preventive medicine and medication management in collaboration with the BH/MH/substance abuse therapist and psychiatric provider as indicated. The population to be served are those Medicaid patients of the behavioral health/mental health/substance abuse clinic who refuse to be linked to a PCP practice. The NP will have a collaborative agreement with the host PCP to support their practice with this population. The PPS (or PPS's) will also fund, where none is available, a LPN nurse at each licensed behavioral health/mental health/substance abuse clinic to support basic health screening, wellness education and follow-up for both the NP and psychiatric providers. This collaborative relationship between the PCP and the behavioral health/mental health/substance abuse clinic will be supported by both a detailed MOU with defined protocols and an assigned clinical transformation specialist from CPWNY who will hold, at a minimum, quarterly meetings with the PCP and behavioral health/mental health/substance abuse practitioners/leadership with the assigned NP to assess the experience for patients and providers and support problem solving as needed.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 36... NP will be hired to provide primary care assessments to patients who are lost to contact with their primary care provider and following that will be linked to a primary care site. In addition the participating behavioral health/mental health/ substance abuse providers will have embedded nurse care coordinators to assist in supporting		Project		In Progress	09/01/2015	03/30/2018	09/01/2015	03/30/2018	03/31/2018	DY3 Q4

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the patients and ensuring follow up and continuation of their care plan.										
Task Step 37…. Eligible patients will be referred to health home. (This action is ongoing)		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 2	Project	N/A	In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1.. CPWNY Clinical transformation specialists in collaboration with Millennium Collaborative Care Project Manager will develop agreements between PCPs and the integrating BH providers (embedded Article 31 satellite clinic or collaborative care model) utilizing SAMSHA evidence based guidelines provided by the PPS to establish clear written protocols on warm hand-offs of patients, team meeting participation of BH and PCP providers with inclusion of support staff/practice managers, case conferences on more complex patient needs, spontaneous curbside consultation between PCP and BH providers on patient needs, exchange of clinical treatment record information (CCD's or secure MIRTH mail), coordinated care plans including agreements on prescribing practices and coordination, warm hand-offs back to the referring physician at the conclusion of BH treatment including medication needs going forward as well as resolving the often perceived power differentials between physicians and behavioral health providers in order to promote true integration of service delivery versus		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4

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simply co-location. Evidence based practices above will be coordinated with Millennium where PCPs are members of both PPSs so services are delivered and integrated under one set of evidence based standards.										
Task Step 2.. Existing PMO care advisors are trained in motivational interviewing and brief interventions, which are key parts of the PMO's Care Management Program. The PMO currently utilizes social workers and nurses who have been trained and have a proven competency. As CPWNY rolls out the integrated model and as new staff are brought in, CPWNY will utilize the "train the trainer" model to train additional primary care and behavioral health staff on brief interventions and motivational interviewing.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 3..Clinical transformation specialists from CPWNY (and Millennium Collaborative Care Project Manager as indicated by dual membership in both PPS's) will meet with each integrated PCP/satellite BH site staff and leadership, each collaborative PCP/BH relationship staff and leadership, and each PCP/BH collaborative relationship with a NP providing primary care services within the BH clinic at least quarterly to mutually assess and problem solve where necessary the established evidence based protocols that support integrated/collaborative treatment and practice.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4..Quarterly meetings between clinical transformation team and participating behavioral health/mental health/substance abuse sites will include progress on implementation, status of adoption of clinical protocols, and discussion of risks and barriers to implementation. Clinical transformation team will assess progress and help practices to address risks and identify potential for improvements. (This action is ongoing)		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5.. The respective PPS Health Home provider		Project		In Progress	09/01/2015	07/01/2016	09/01/2015	07/01/2016	09/30/2016	DY2 Q2

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(CPWNY's Health Home provider within its PPS is Health Home Partners of WNY) will meet with PPS PCPs and BH licensed providers to educate the respective practitioners about the care coordination support and engagement Health Homes can provide eligible patients and how expedited referrals can be made, as well as clarifying the role differentiation between on site PCP nurse care coordinators and community based "boots on the ground" health home care coordinators.										
Task Step 6…CPWNY Care Coordination team (and jointly with Millennium Collaborative Care Project Coordinator as appropriate) will assist PCP and BH practices in prioritizing outreach and developing a workflow for patient engagement, and examining patient expressed barriers to seeking healthcare on an outpatient basis. Barriers may be related to a lack of understanding, social, cultural, travel time, transportation needs, family dynamics, prioritization, stigma associated with mental health treatment, etc. and utilize health home care coordinators for eligible patients and Community Based Organizations for overcome these barriers.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Model 2	Project	N/A	In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Screenings are documented in Electronic Health Record.		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	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		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4

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those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…PCP's and behavioral health/mental health/substance abuse practices jointly surveyed by CPWNY & Millennium as to which preventive screenings are currently being implemented routinely for patients in both PCP's and behavioral health/mental health/substance abuse practices.		Project		On Hold	09/01/2015	12/31/2015	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 2...CPWNY's 3.a.i project team in collaboration with Millennium Project Manager identify best practice physical health preventive care screenings to be adopted across both PPS's PCP's in addition to PHQ9 and SBIRT screenings for both PCP's and behavioral health/mental health/substance abuse practices. The CPWNY project team in collaboration with the BH partners will assess and select appropriate SBIRT tools to be used and obtain approval from CPWNY's clinical governance committee.		Project		In Progress	09/01/2015	12/31/2015	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3…A joint PPS (CPWNY & Millennium) training plan will be developed for both PCP and behavioral health/mental health/substance abuse practices to support the adoption of best practice screenings where there are current gaps within identified PCP's and behavioral health/mental health/substance abuse providers. Training plan includes educating practices on the billing codes for PHQ9 and SBIRT screens as many practices are unaware of ability to bill for these screens and absence of billing is a barrier.		Project		In Progress	09/01/2015	12/31/2015	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4…CPWNY Clinical Integration teams and Millennium jointly assist in training PCPs and behavioral health/mental health/substance abuse providers participating in both		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4

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PPSs and CPWNY Clinical Transformation teams will provide the same training to providers uniquely in the CPWNY PPS. As CPWNY rolls out the integrated model and as new staff are brought in, CPWNY will utilize the "train the trainer" model to train additional primary care and behavioral health staff on brief interventions and motivational interviewing.										
Task Step 5...All screenings are required documentation in provider EMR's.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6..Clinical integration training teams (with Millennium Collaborative Care counterparts for joint PPS membership) will incorporate reviews of screening protocols and implementation with periodic technical assistance meetings with providers.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7..CPWNY 3.a.i project team will assess and develop reporting metrics and outcome measures including usefulness of community referrals, medication management and adherence, effectiveness of patient outreach, and quality metrics based on culture, language, and ethnicity. The project team will utilize Rapid Cycle Improvement method for continuous improvement.(assessment is implemented in increments and ongoing)		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 2	Project	N/A	In Progress	09/01/2015	03/31/2017	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	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Utilizing healthcare data analytics complete an		Project		In Progress	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
assessment of our PPS attributed Medicaid members.										
Task Step 2…Using clinical transformation team, assist practices in extracting data from EMRs on their Medicaid patients; sort by who has not been in office for 1 year or greater; and impending doctor appointment by disease conditions (Cardiovascular , HTN, Renal, Diabetes, Behavioral health)		Project		In Progress	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3… Assess the population from claims data to ascertain hospitalizations and ER visits to obtain holistic view of patient; stratify population by the aforementioned and also segment by culture, ethnicity and language.		Project		In Progress	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 4… CPWNY's PMO has an existing referral relationship with our partner Health Home for eligible patients. The 3.a.i project team will assess the current workflow and develop protocol for connecting eligible patients to PPS's health home, Health Home Partners of WNY. CPWNY will extract data for further tracking from Health Home GSI Care Coordination software for health home enrolled patients.		Project		In Progress	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 5…Utilizing data extracted, CPWNY's Clinical Transformation team and IT team will assist practices in identifying targeted patients and establishing patient registries for managing patient care and milestone reporting. The target population for patient registries and tracking will include but not be limited to conditions such as depression, substance abuse, and/or overlapping co-morbid with diabetes and cardiac disease.		Project		In Progress	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6… Work with the information technology team to integrate behavioral health status and alerts into the medical record. This process involves obtaining a consent from the patient at the primary care site and at the behavioral health site. Once the consents are both in		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4

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place, information can be shared through HEALTHeLINK direct exchange or through mirth mail. (Defined process must be in place to ensure that no downstream sharing of patient behavioral health [title 42] information takes place)										
Task Step 7… Set up documentation in EMRs to run reports on care management care plans, care transitions, preventive PCP and BH screenings etc. To be overseen by CPWNY Clinical Transformation and CPWNY IT teams.		Project		In Progress	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Implement IMPACT Model at Primary Care Sites.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has implemented IMPACT Model at Primary Care Sites.		Provider	Practitioner - Primary Care Provider (PCP)	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Policies and procedures include process for consulting with Psychiatrist.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation,		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task All IMPACT participants in PPS have a designated Psychiatrist.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #13 Measure outcomes as required in the IMPACT Model.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #14 Provide "stepped care" as required by the IMPACT Model.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Co-locate behavioral health services at primary care practice										

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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	10	35	60	85	110	135	160	185	210
Task Behavioral health services are co-located within PCMH/APC practices and are available.	0	0	5	10	15	20	25	30	35	40
Task Step 1…The project management office (PMO) staff will identify from participating providers lists primary care practices and licensed mental health, behavioral health, and substance abuse organizations across the Community Partner's of WNY geographic areas and coordinate with Millennium Collaborative Care PPS as to which primary care providers and licensed mental health, behavioral health, and substance abuse providers are in both PPS's.										
Task Step 2…PMO staff, with a cover letter detailing the kinds of support Community Partners could provide their practice, survey the identified primary care practices who are exclusively in the Community Partner's PPS as to their PCMH/NCQA Level or Advanced Primary Care status, percentage of current Medicaid patients served, their current ability to accept new Medicaid patients, EHR status and vendor, CCD capacity to receive and send records, relationship with HealtheLink RHIO, current behavioral health capacity if any, status of current use of PHQ9 and SBIRT screenings, and willingness to discuss possible integration of a satellite mental health or behavioral health (including substance abuse) clinic within their practice site (Article 28 outpatient primary care clinics are currently unable by regulation to integrate a satellite Article 31 mental and behavioral health clinic unless there is a completely separate entrance and separate waiting room making this approach to integration not feasible). The PMO has contacted the regional Department of Health Commissioner for assistance in overcoming this barrier. (Will start with high volume Medicaid practices and roll out survey in increments.)										
Task Step 3…CPWNY PMO and Millennium Collaborative Care designated staff will send a joint cover letter and Survey to those										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
primary practices which are in both the Millennium and Community Partner PPS's to identify available support and ask for the same information as in Step 2										
Task Step 4...With a cover letter detailing the kinds of support available in CPWNY, with representation from Article 31 (e.g. Spectrum) partners, will survey the identified licensed mental health/CD agencies exclusively aligned with Community Partners PPS as to current experience with satellite clinic integration into primary care sites, willingness to consider satellite clinic integration into primary care sites, EHR status and vendor, HealtheLink RHIO experience/relationship, CCD and /or MIRTH mail capacity to receive and send records if any, current status/use of PHQ9 and SBIRT screenings, current capacity to provide primary care services within their existing MH clinics. (roll out in increments based on CNA)										
Task Step 5…CPWNY, with representation from Article 31 partners, and Millennium Collaborative Care designated staff will send a joint cover letter and Survey to those licensed mental health providers which are in both the Millennium and Community Partner PPS's identifying PPS support available and asking for the same information as in Step 3.										
Task Step 6…CPWNY, with representation from Article 31 partners, and Millennium Collaborative Care designated staff will jointly determine if the restrictions on integrating Article 31 clinics into Article 28 outpatient primary care facilities identified above are DOH regulations or Federal regulations. If DOH regulations jointly seek a waiver. If waiver not feasible explore the feasibility of the Article 28 clinics being able (if not already so) to hire their own mental or behavioral health (including substance abuse) professional and what supports would be needed to do so from respective PPS's if the Article 28 was in both PPS's. Survey solely or jointly by both PPS's as appropriate the Article 28's for the same information as in Steps 2 or 3.										
Task Step 7…Hold geographically accessible planning meetings for primary care and behavioral health providers who expressed via survey interest in proceeding toward integrated services.. Meetings will be led by teams consisting of physician, mental health leaders and CPWNY central office representatives Include Millennium Collaborative Care representatives to address those providers who will be serving patients from both										

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

DSRIP Implementation Plan Project

Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
PPS's. Initiate outreach to PCP's by physician ambassadors from CPWNY and CPWNY mental health ambassadors to mental health providers to engage those providers who either did not respond to surveys or declined interest. Discuss their obstacles to participation and how CPWNY can help to resolve obstacles and engage their active participation in the project through a shadowing visit to existing sites that have integrated behavioral health with primary care. Continue quarterly planning meetings throughout the project to support a learning community approach. Maintain regional meetings for providers throughout the project										
Task Step 8… CPWNY will use a variety of integration models to achieve the goals of this project. These include 1. embedding a mental or behavioral health provider from an Article 31 partner community based organization into a primary care site; 2. building evidence based behavioral health and substance abuse screening tools into the PCMH work flow; 3. facilitating same day access and referral to a geographically accessible behavioral health or substance abuse service for patients identified as in need.										
Task Step 9...For practices that do not have a behavioral health provider physically located in the primary care practice, "warm transfers" will be facilitated in person by an available member of the PCP office to behavioral health/substance abuse providers located close by or in the same building, or via a scheduled conference call with participating behavioral health/substance abuse providers, primary care physicians, and the patient.										
Task Step 10…Finalize contracts/MOU's with participating PCP's and behavioral health and substance abuse providers that outlines their commitment to participate in developing and operationalizing integrated services within the CPWNY PPS or, as appropriate, CPWNY and Millennium PPS's if members of both PPS's. Coordinate content of the contracts/MOU's between PPS's to standardize expectations. (incremental roll out - start with high volume practices and high need areas based on Community Needs Assessment)										
Task Step 11…Analyze current status of EMR systems used for both PCP's and Behavioral health/substance abuse provider practices, the status of Meaningful Use (AUI, Stage 1, Stage 2, or none), and status of PCMH (Level 3, 2, 1, in										

Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
process, or none) by participating provider practices. Create a work plan and timeline for getting PCP practices not yet at PCMH Level 3 and MU to achieve them both by end of DY3.										
Task Step 12...Assign each PCP practice a Clinical Transformation Specialist to work with them and be their point of contact on EMR, MU, PCMH, and Population Health/Quality Outcome Measures. Need to hire additional personnel to take on additional practices and workload										
Task Step 13..Create a targeted survey or contact practices to understand practice readiness to engage in PCMH or MU activities (if not currently engaged). Create a work plan for training and educating those who are ready. Create an intervention strategy to help engage those who are not ready through the use of Regional Primary Care Leaders, Hospital leadership, and other resources yet to be determined (such as providing more care management assistance or behavioral health assistance to help the practice feel more comfortable with their ability to take on PCMH recognition)										
Task Step 14...Create educational training materials for Meaningful Use. Provide targeted education based on each practices' need, especially for those who did not meet MU on DY1, for either in person training, web based (WebEx), or user-group by EMR vendor training										
Task 14.a. *Provide education and training to greater than half of practices on Meaningful Use										
Task 14.b. *Provide education and training to greater than 75% practices on Meaningful Use										
Task 14.c *Provide education and training to 100% practices on Meaningful Use										
Task 14.d *All practices on Meaningful Use by end of DY 3= Steps listed below that correspond with 2014 standards but focusing on EMR capabilities and practice use of these capabilities:										
Task Step 15… Improving quality, safety , efficiency and reducing health disparities (these measures will help to provide better access to comprehensive patient data for patient's health team;										

Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
use evidence based order sets and Computer Order entry; apply clinical decision support at the point of care; generate list of patients who need care and use them to reach out to patients.)										
Task Step 16…Engage patients and families in their health care (these measures will provide patients and families with timely access to data; tools to make informed decisions and manage their health)										
Task Step 17… Improve care coordination (These measures will allow practices to exchange meaningful clinical information among a professional health care team)										
Task Step 18… Improve population and public health (these measures will allow physicians to communicate with public health agencies and better track of health information across communities)										
Task Step 19…Ensure adequate privacy and security protections for personal health information (These measures will help ensure : the privacy & security protections for confidential health information through operating policies , procedures and technology; compliance with applicable law; and transparency of data sharing to the patient.										
Task Step 20…Create education and training materials for PCMH recognition. Create a series of classes focused on teaching of standards, leadership skills, project management skills, IT/EMR support) for practices not yet achieved PCMH to teach the steps on how to achieve level 3 recognition. Find practices that have already achieved level 3 recognition that are willing to act as mentors and leaders to other practices who have not yet achieved level 3 and connect them.										
Task 20.a *Provide education and training to greater than half practices on PCMH										
Task 20.b *Provide education and training to greater than 75% practices on PCMH										
Task 20.c *Provide education and training to 100% practices on PCMH										
Task 20.d * All Primary Care practices achieve PCMH by end of DY3==Steps listed below that are individualized to the assessment of each practice and has meaningful use standards										

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DSRIP Implementation Plan Project

Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
embedded in the applicable standard:										
Task Step 21…Insure PCMH policies and procedures are in place with a process to review , revise and re-approve (templates are provided for office adaptation, customization)										
Task Step 22…Ability to run reports to track missed appointments, upcoming appointments, gaps in preventive care, gaps in chronic disease management, hospitalization and transitions of care documentation, and care management interventions.										
Task Step 23…Appointment Access and availability reports completed (and follow policy). Enhance recruitment of providers based on access and availability report and CAHPS surveys through hospital and IPA recruitment offices										
Task Step 24…Roles and job descriptions completed for practice team members in PCMH and training to PCMH as noted above										
Task Step 25…Evidence Based guidelines built into the EMR along with tools to manage patient care (care management including referrals to CBOs, educational tools, follow up, motivational interviewing)										
Task Step 26…Assessment of diversity in the practice and ability to run quality metrics based on culture, language, and ethnicity										
Task Step 27…Track outreach to patients in attempts to close gaps in care (along with preferred methods of contact as stipulated by the patient)										
Task Step 28…Exchange of information (care coordination)-- reports to show timeliness of incoming and outgoing patient information.(referral agreements in place and information exchanged according to agreements and policy)										
Task Step 29…Quality improvement program in the office, utilizing Rapid Cycle Evaluation										
Task Step 30…Evaluation of usefulness of community referrals.										
Task Step 31…Medication management (monitors cost, best practice,										

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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
allergies, interactions, e-scripts)										
Task Step 32... Set up a process for continued education and assistance with PCMH and Meaningful Use. PCMH renewals occur every three years, and meaningful use is yearly. So many practices will have to renew PCMH recognition during this time period, as well as continuing their MU attestations. We want to set up a process to ensure their continued success in the future. There are also standards in which you must show achievement during the interim years of recognition like the measurement and improvement of quality measures.										
Task Step 33…For primary care practices whose Medicaid patient percentages are too low to support an integrated mental or behavioral health (including substance abuse) satellite clinic, collaborative care agreements will be developed with the assistance of the PPS (or PPSs as appropriate) with geographically accessible licensed mental health clinics and behavioral health and substance abuse providers. Evidence based protocols will be codified in MOU's that define the respective responsibilities of both the PCP and BH provider. Protocols in the MOU will include same day/next day access for patients referred by the PCP, concurrent exchange of patient treatment information through CCD's or MIRTH mail as available, connectivity by both PPSs with HEALTHeLINK RHIO to support exchange of treatment information, and regular communication to coordinate treatment plans and medication management. Clinical transformation specialists will meet quarterly with providers and their leadership to support the collaborative care relationship and provide problem solving as necessary. (ongoing)										
Task Step 34… CPWNY is aware that services rendered by an Article 31 provider within an Article 28 facility are not billable to Medicaid. CPWNY is exploring mitigation options such as deploying social worker in Article 28 facility to facilitate warm handoff of patients.										
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.										

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Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project 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 Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.										
Task Step 1..CPWNY Clinical transformation specialists in collaboration with Millennium Collaborative Care Project Manager will develop agreements between each PCP and the integrating BH providers (embedded Article 31 satellite clinic or collaborative care model) utilizing SAMSHA evidence based guidelines provided by the PPS to establish clear written protocols on warm hand-offs of patients, team meeting participation of BH and PCP providers with inclusion of support staff/practice managers, case conferences on more complex patient needs, spontaneous curbside consultation between PCP and BH providers on patient needs, exchange of clinical treatment record information (CCD's or secure MIRTH mail), coordinated care plans including agreements on prescribing practices and coordination, warm hand-offs back to the referring physician at the conclusion of BH treatment including medication needs going forward as well as resolving the often perceived power differentials between physicians and behavioral health providers in order to promote true integration of service delivery versus simply co-location. Evidence based practices above will be coordinated with Millennium Collaborative Care where PCPs are members of both PPSs so services are delivered and integrated under one set of evidence based standards.										
Task Step 2.. Existing PMO care advisors are trained in motivational interviewing and brief interventions, which are key parts of the PMO's Care Management Program. The PMO currently utilizes social workers and nurses who have been trained and have a proven competency. As CPWNY rolls out the integrated model and as new staff are brought in, CPWNY will utilize the "train the trainer" program to train additional primary care and behavioral health staff on brief interventions and motivational interviewing.										
Task Step 3..Clinical transformation specialists from CPWNY (and Millennium Collaborative Care Project Manager as indicated by dual membership in both PPS's) will meet with each integrated PCP/satellite BH site staff and leadership, each collaborative PCP/BH relationship staff and leadership, and each PCP/BH collaborative relationship with a NP providing primary care services within the BH clinic at least quarterly to mutually assess and problem solve where necessary the established evidence										

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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
based protocols that support integrated/collaborative treatment and practice.										
Task Step 4... Quarterly meetings between clinical transformation team and participating behavioral health/mental health/substance abuse sites will include progress on implementation, status of adoption of clinical protocols, and discussion of risks and barriers to implementation. Clinical transformation team will assess progress and help practices to address risks and identify potential for improvements. (This action will be ongoing)										
Task Step 5... The respective PPS Health Home provider (CPWNY's Health Home provider within its PPS is Health Home Partners of WNY) will meet with PPS PCPs and BH licensed providers to educate all of the respective practitioners about the care coordination support and engagement Health Homes can provide eligible patients and how expedited referrals can be made, as well as clarifying the role differentiation between on site PCP nurse care coordinators and community based "boots on the ground" health home care coordinators.										
Task Step 6…CPWNY Care Coordination team (and jointly with Millennium Collaborative Care Project Coordinator as appropriate) will assist PCP and BH practices in prioritizing outreach and developing a workflow on patient engagement, examining patient expressed barriers to seeking healthcare on an outpatient basis. Barriers may be related to a lack of understanding, social, cultural, travel time, transportation needs, family dynamics, prioritization, stigma associated with mental health treatment, etc. and utilize health home care coordinators for eligible patients and Community Based Organizations to overcome these barriers.										
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,										

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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
SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	0	10	35	60	85	110	135	160	185	210
Task Step 1…PCP's and BH practices jointly surveyed by CPWNY & Millennium Collaborative Care as to which preventive screenings are currently routinely being used for patients in both PCP's and BH practices.										
Task Step 2...CPWNY's 3.a.i project team in collaboration with Millennium Collaborative Care Project Manager will identify best practice physical health preventive care screenings to be adopted across both PPS's PCP's in addition to PHQ9 and SBIRT screenings for both PCP's and behavioral health (including substance abuse) practices. The CPWNY project team in collaboration with the Behavioral Health partners will assess and select appropriate SBIRT tools to be used and obtain approval from CPWNY's clinical governance committee.										
Task Step 3…A joint PPS (CPWNY & Millennium) training plan will be developed for both PCP and behavioral health practices to support the adoption of best practice screenings where there are current gaps within identified PCP's and behavioral health (including substance abuse) providers. Training plan includes educating practices on the billing codes for PHQ9 and SBIRT screens as many practices are unaware of ability to bill for these screens and absence of billing is a barrier.										
Task Step 4…CPWNY Clinical Integration teams and Millennium Collaborative Care will jointly assist in training to PCP's and behavioral health (including substance abuse) providers participating in both PPS's and CPWNY Clinical Transformation teams will assist in providing the same training to providers uniquely in the CPWNY PPS. As CPWNY rolls out the integrated model and as new staff are brought in, CPWNY will utilize the "train the trainer" program to train additional primary care and behavioral health staff on brief interventions and motivational interviewing.										
Task Step 5...All screenings are required to have documentation in provider EMR's.										

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Task Step 6..Clinical integration training teams (with Millennium Collaborative Care counterparts for joint PPS membership) will incorporate reviews of screening protocols and implementation with periodic technical assistance meetings with providers.										
Task Step 7..CPWNY 3.a.i project team will assess and develop reporting metrics and outcome measures including usefulness of community referrals, medication management and adherence, effectiveness of patient outreach, and quality metrics based on culture, language, and ethnicity. The project team will utilize Rapid Cycle Improvement method for continuous improvement.(assessment is implemented in increments and ongoing)										
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…Utilizing healthcare data analytics, complete an assessment of our PPS attributed Medicaid members.										
Task Step 2…The clinical transformation team will assist practices in extracting data from EMRs on their Medicaid patients; sort by who has not been in office for 1 year or greater; and impending doctor appointment by disease conditions (Cardiovascular , HTN, Renal, Diabetes, Behavioral health)										
Task Step 3… Assess the population from claims data to ascertain hospitalizations and ER visits to obtain holistic view of patient; stratify population by the aforementioned and also segment by culture, ethnicity and language.										
Task Step 4… CPWNY's PMO has existing referral relationship with our partner Health Home for eligible patients. The 3.a.i project team will assess the current workflow and develop a protocol for connecting eligible patients to the PPS's health home, Health Home Partners of WNY. CPWNY will extract data for further tracking from Health Home GSI Care Coordination software for										

Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
health home enrolled patients.										
Task Step 5…Utilizing data extracted, CPWNY's Clinical Transformation team and IT team with help practices to identify targeted patients and establish patient registries for managing patient care and milestone reporting. The target population for patient registries and tracking will include but not limited to conditions such as depression, substance abuse, and/or overlapping co-morbid with diabetes and cardiac disease.										
Task Step 6… Work with the information technology team to integrate behavioral health status and alerts into the medical record. This process involves obtaining a consent from the patient at the primary care site and at the behavioral health site. Once the consents are both in place, information can be shared through HEALTHeLINK direct exchange or through mirth mail. (Defined process must be in place to ensure that no downstream sharing of patient behavioral health [title 42] information takes place)										
Task Step 7… Set up documentation in EMRs to run reports on care management care plans, care transitions, preventive PCP and BH screenings etc. To be overseen by CPWNY Clinical Transformation and CPWNY IT teams.										
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	10	35	60	85	110	135	160	185	210
Task Primary care services are co-located within behavioral Health practices and are available.	0	10	35	60	85	110	135	160	185	210
Task Primary care services are co-located within behavioral Health practices and are available.	0	0	5	10	15	20	25	30	35	40
Task Step 1…The project management office (PMO) staff will identify from participating provider lists primary care practices and licensed mental health, behavioral health, and substance abuse provider organizations across the Community Partner's of WNY geographic areas and coordinate with Millennium Collaborative Care PPS to identify which primary care providers and licensed mental health, behavioral health, and substance abuse providers are in both PPS's.										

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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 2…PMO staff, with a cover letter detailing the kinds of support Community Partners could provide their practice, will survey the identified primary care practices who are exclusively in the Community Partner's PPS as to their PCMH/NCQA Level or Advanced Primary Care status, percentage of current Medicaid patients served, their current ability to accept new Medicaid patients, EHR status and vendor, CCD capacity to receive and send records, relationship with HealtheLink RHIO, current behavioral health/mental health/substance abuse capacity if any, status of current use of PHQ9 and SBIRT screenings, and willingness to discuss possible integration of a satellite mental health, behavioral health, or substance abuse clinic within their practice site (Article 28 outpatient primary care clinics are currently unable by regulation to integrate a satellite Article 31 clinic unless there is a completely separate entrance and separate waiting room making this approach to integration not feasible). The PMO has contacted the regional Department of Health Commissioner for assistance in overcoming this barrier. (Will start with high volume Medicaid practices and roll out survey in increments.)										
Task Step 3…CPWNY PMO and Millennium Collaborative Care designated staff will send a joint cover letter and Survey to those primary care practices which are in both the MCC and Community Partner PPS's identifying available support and asking for the same information as in Step 2										
Task Step 4...With a cover letter detailing the kinds of support available in the CPWNY PPS network, with representation from Article 31 (e.g. Spectrum) partners, will survey the identified licensed mental health/CD agencies exclusively aligned with Community Partners PPS as to current experience and capacity to provide primary care services within existing mental health, behavioral health, and substance abuse clinics, EHR status and vendor, HealtheLink RHIO experience/relationship, CCD and /or MIRTH mail capacity to receive and send records if any, current status/use of PHQ9 and SBIRT screenings. (roll out in increments based on CNA)										
Task Step 5…CPWNY, with representation from Article 31 partners, and Millennium Collaborative Care designated staff will send a joint cover letter and Survey to those licensed mental health,										

Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project 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, and substance abuse providers which are in both the Millennium Collaborative Care and Community Partner PPSs identifying PPS support available and asking for the same information as in Step 3.										
Task Step 6…CPWNY, with representation from Article 31 partners, and Millennium Collaborative Care designated staff will jointly determine if the restrictions on integrating Article 31 clinics into Article 28 outpatient primary care facilities identified above are DOH regulations or Federal regulations. If DOH regulations, jointly seek a waiver. If waiver not feasible explore the feasibility of the Article 28 clinics being able (if not already so) to hire their own MH professional and what support would be needed to do so from respective PPS's if the Article 28 was in both PPS's. Survey solely or jointly by both PPS's as appropriate the Article 28's for the same information as in Steps 2 or 3.										
Task Step 7…Hold geographically accessible planning meetings for primary care and behavioral health providers who expressed via survey interest in proceeding toward integrated services.. Meetings will be led by teams consisting of physician, mental health leaders and CPWNY central office representatives. Include Millennium Collaborative Care representatives to address those providers who will be serving patients from both PPSs. Initiate outreach to PCPs by physician ambassadors from CPWNY and CPWNY mental health ambassadors to mental health providers to engage those providers who either did not respond to surveys or declined interest. Discuss their obstacles to participation and how CPWNY can help to resolve obstacles and engage their active participation in the project through a shadowing visit to existing sites that have integrated behavioral health with primary care. Continue quarterly planning meetings throughout the project to support a leaning community approach. Maintain regional meetings for providers throughout the project										
Task Step 8…CPWNY will work with Millennium PPS to integrate advanced care management services into Article 31 organizations and other mental health, behavioral health, and substance abuse sites to promote improvements and key health indicators that are targeted to be achieved for the behavioral health populations.										
Task Step 9…Finalize contracts/MOU's with participating PCP's and BH providers that outlines their commitment to participate in										

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developing and operationalizing integrated services within the CPWNY PPS or, as appropriate, CPWNY and Millennium PPSs if members of both PPS's. Coordinate content of the contracts/MOU's between PPS's to standardize expectations. (incremental roll out - start with high volume practices and high need areas based on Community Needs Assessment)										
Task Step 10…Analyze current status of EMR systems used for both PCP's and behavioral health, mental health, and substance abuse provider practices, the status of Meaningful Use (AUI, Stage 1, Stage 2, or none), and status of PCMH (Level 3, 2, 1, in process, or none) by participating provider practices. Create a work plan and timeline for getting PCP practices not yet at PCMH Level 3 and MU to achieve them both by end of DY3.										
Task Step 11...Assign each PCP practice a Clinical Transformation Specialist to work with them and be their point of contact on EMR, MU, PCMH, and Population Health/Quality Outcome Measures. Need to hire additional personnel to take on additional practices and workload										
Task Step 12..Create a targeted survey or contact practices to understand practice readiness to engage in PCMH or MU activities (if not currently engaged). Create work plan for training and educating those who are ready. Create an intervention strategy to help engage those who are not ready through the use of Regional Primary Care Leaders, Hospital leadership, and other resources yet to be determined (such as providing more care management assistance or behavioral health assistance to help the practice feel more comfortable with their ability to take on PCMH recognition)										
Task Step 13...Create educational training materials for Meaningful Use. Provide targeted education based on each practices needs, especially for those who did not meet MU on DY1, for either in person training, web based (WebEx), or user-group by EMR vendor training										
Task 13.a. *Provide education and training to greater than half of practices on Meaningful Use										
Task 13.b. *Provide education and training to greater than 75% practices on Meaningful Use										

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Task 13.c *Provide education and training to 100% practices on Meaningful Use										
Task 13.d *All practices on Meaningful Use by end of DY 3= Steps listed below that correspond with 2014 standards but focusing on EMR capabilities and practice use of these capabilities:										
Task Step 14…Improving quality, safety , efficiency and reducing health disparities (these measures will help to provide better access to comprehensive patient data for patients health team; use evidence based order sets and Computer Order entry; apply clinical decision support at the point of care; generate list of patients who need care and use them to reach out to patients.)										
Task Step 15…Engage patients and families in their health care (these measures will provide patients and families with timely access to data; tools to make informed decisions and manage their health)										
Task Step 16…Improve care coordination (These measures will allow practices to exchange meaningful clinical information among a professional health care team)										
Task Step 17…Improve population and public health (these measures will allow physicians to communicate with public health agencies and better track of health information across communities)										
Task Step 18…Ensure adequate privacy and security protections for personal health information (These measures will help ensure: the privacy & security protections for confidential health information through operating policies , procedures and technology; compliance with applicable law; and transparency of data sharing to the patient.										
Task Step 19…Create education and training materials for PCMH recognition. Create a series of classes focused on teaching of standards, leadership skills, project management skills, IT/EMR support) for practices not yet achieved PCMH to teach the steps on how to achieve level 3 recognition. Find practices that have already achieved level 3 recognition that are willing to act as mentors and leaders to other practices who have not yet achieved level 3 and connect them.										
Task 19.a *Provide education and training to greater than half										

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practices on PCMH										
Task 19.b *Provide education and training to greater than 75% practices on PCMH										
Task 19.c *Provide education and training to 100% practices on PCMH										
Task 19.d * All Primary Care practices achieve PCMH by end of DY3==Steps listed below that are individualized to the assessment of each practice and has meaningful use standards embedded in the applicable standard:										
Task Step 20…Insure PCMH policies and procedures in place with a process to review, revise and re-approve (templates are provided for office adaptation, customization)										
Task Step 21…Ability to run reports to track missed appointments, upcoming appointments, gaps in preventive care, gaps in chronic disease management, hospitalization and transitions of care documentation, and care management interventions.										
Task Step 22…Appointment Access and availability reports completed (and follow policy). Enhance recruitment of providers based on access and availability report and CAHPS surveys through hospital and IPA recruitment offices										
Task Step 23…Roles and job descriptions completed for practice team members in PCMH and training to PCMH as noted above										
Task Step 24…Evidence Based guidelines built into the EMR along with tools to manage patient care (care management including referrals to CBOs, educational tools, follow up , motivational interviewing)										
Task Step 25... The PPS leadership and clinical transformation staff will ensure that participating behavioral health/mental health/substance abuse sites will meet article 31 certification requirements for medical screening and follow up and are aligned with the DSRIP outcome metrics.										
Task Step 26…Assessment of diversity in the practice and ability to run quality metrics based on culture, language, and ethnicity										

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Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project 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 27…Track outreach to patients in attempts to close gaps in care (along with preferred methods of contact as stipulated by the patient)										
Task Step 28…Exchange of information (care coordination)-- reports to show timeliness of incoming and outgoing patient information.(referral agreements in place and information exchanged according to agreements and policy)										
Task Step 29…Quality improvement program in the office, utilizing Rapid Cycle Evaluation										
Task Step 30…Evaluation of usefulness of community referrals.										
Task Step 31…Medication management (monitors cost, best practice, allergies, interactions, e-scripts)										
Task Step 32... Set up a process for continued education and assistance with PCMH and Meaningful Use. PCMH renewals occur every three years, and meaningful use is yearly. So many practices will have to renew PCMH recognition during this time period, as well as continuing their MU attestations. We want to set up a process to ensure their continued success in the future. There are also standards in which you must show achievement during the interim years of recognition like the measurement and improvement of quality measures.										
Task Step 33... CPWNY will Use the results of the joint survey with MCC to identify primary care providers willing to accept patients identified with medical needs at behavioral health sites.										
Task Step 34…For behavioral health, mental health, and substance abuse providers who choose to integrate primary care services into their practice collaborative care agreements will be developed with the assistance of the PPS (or PPS's as appropriate)with geographically accessible primary care providers and mobile nurse practitioners. Evidence based protocols will be codified in MOU's that define the respective responsibilities of both the PCP and BH/MH/substance abuse provider. Protocols in the MOU will include same day/next day access for patients referred by the behavioral health/mental health/substance abuse provider including but not limited to scheduled conference calls between collaborative providers and										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
the patient to discuss conditions and treatment plans. Concurrent exchange of patient treatment information through CCD's or MIRTH mail as available, connectivity by both with HEALTHeLINK RHIO to support exchange of treatment information, and regular communication to coordinate treatment plans and medication management. Clinical transformation specialists will meet quarterly with providers and their leadership teams to support the collaborative care relationship and provide problem solving as necessary. (ongoing)										
Task Step 35…To support the provision of primary care services within licensed MH clinics the PPS (or PPS's s appropriate to clinics in both PPS's) will fund the hiring of nurse practitioners to be attached to a collaborative PCP, whose role will be to spend one day a week on average at five different high volume Medicaid BH clinics to provide basic primary care screening, preventive medicine and medication management in collaboration with the BH/MH/substance abuse therapist and psychiatric provider as indicated. The population to be served are those Medicaid patients of the behavioral health/mental health/substance abuse clinic who refuse to be linked to a PCP practice. The NP will have a collaborative agreement with the host PCP to support their practice with this population. The PPS (or PPS's) will also fund, where none is available, a LPN nurse at each licensed behavioral health/mental health/substance abuse clinic to support basic health screening, wellness education and follow-up for both the NP and psychiatric providers. This collaborative relationship between the PCP and the behavioral health/mental health/substance abuse clinic will be supported by both a detailed MOU with defined protocols and an assigned clinical transformation specialist from CPWNY who will hold, at a minimum, quarterly meetings with the PCP and behavioral health/mental health/substance abuse practitioners/leadership with the assigned NP to assess the experience for patients and providers and support problem solving as needed.										
Task Step 36... NP will be hired to provide primary care assessments to patients who are lost to contact with their primary care provider and following that will be linked to a primary care site. In addition the participating behavioral health/mental health/ substance abuse providers will have embedded nurse care coordinators to assist in supporting the patients and ensuring follow up and continuation of their care plan.										
Task										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Step 37…. Eligible patients will be referred to health home. (This action is ongoing)										
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.										
Task Step 1.. CPWNY Clinical transformation specialists in collaboration with Millennium Collaborative Care Project Manager will develop agreements between PCPs and the integrating BH providers (embedded Article 31 satellite clinic or collaborative care model) utilizing SAMSHA evidence based guidelines provided by the PPS to establish clear written protocols on warm hand-offs of patients, team meeting participation of BH and PCP providers with inclusion of support staff/practice managers, case conferences on more complex patient needs, spontaneous curbside consultation between PCP and BH providers on patient needs, exchange of clinical treatment record information (CCD's or secure MIRTH mail), coordinated care plans including agreements on prescribing practices and coordination, warm hand-offs back to the referring physician at the conclusion of BH treatment including medication needs going forward as well as resolving the often perceived power differentials between physicians and behavioral health providers in order to promote true integration of service delivery versus simply co-location. Evidence based practices above will be coordinated with Millennium where PCPs are members of both PPSs so services are delivered and integrated under one set of evidence based standards.										
Task Step 2.. Existing PMO care advisors are trained in motivational interviewing and brief interventions, which are key parts of the PMO's Care Management Program. The PMO currently utilizes social workers and nurses who have been trained and have a proven competency. As CPWNY rolls out the integrated model and as new staff are brought in, CPWNY will utilize the "train the trainer" model to train additional primary care and behavioral health staff on brief interventions and motivational interviewing.										

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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 3..Clinical transformation specialists from CPWNY (and Millennium Collaborative Care Project Manager as indicated by dual membership in both PPS's) will meet with each integrated PCP/satellite BH site staff and leadership, each collaborative PCP/BH relationship staff and leadership, and each PCP/BH collaborative relationship with a NP providing primary care services within the BH clinic at least quarterly to mutually assess and problem solve where necessary the established evidence based protocols that support integrated/collaborative treatment and practice.										
Task Step 4..Quarterly meetings between clinical transformation team and participating behavioral health/mental health/substance abuse sites will include progress on implementation, status of adoption of clinical protocols, and discussion of risks and barriers to implementation. Clinical transformation team will assess progress and help practices to address risks and identify potential for improvements. (This action is ongoing)										
Task Step 5.. The respective PPS Health Home provider (CPWNY's Health Home provider within its PPS is Health Home Partners of WNY) will meet with PPS PCPs and BH licensed providers to educate the respective practitioners about the care coordination support and engagement Health Homes can provide eligible patients and how expedited referrals can be made, as well as clarifying the role differentiation between on site PCP nurse care coordinators and community based "boots on the ground" health home care coordinators.										
Task Step 6…CPWNY Care Coordination team (and jointly with Millennium Collaborative Care Project Coordinator as appropriate) will assist PCP and BH practices in prioritizing outreach and developing a workflow for patient engagement, and examining patient expressed barriers to seeking healthcare on an outpatient basis. Barriers may be related to a lack of understanding, social, cultural, travel time, transportation needs, family dynamics, prioritization, stigma associated with mental health treatment, etc. and utilize health home care coordinators for eligible patients and Community Based Organizations for overcome these barriers.										
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.										

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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 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	10	35	60	85	110	135	160	185	210
Task Step 1…PCP's and behavioral health/mental health/substance abuse practices jointly surveyed by CPWNY & Millennium as to which preventive screenings are currently being implemented routinely for patients in both PCP's and behavioral health/mental health/substance abuse practices.										
Task Step 2...CPWNY's 3.a.i project team in collaboration with Millennium Project Manager identify best practice physical health preventive care screenings to be adopted across both PPS's PCP's in addition to PHQ9 and SBIRT screenings for both PCP's and behavioral health/mental health/substance abuse practices. The CPWNY project team in collaboration with the BH partners will assess and select appropriate SBIRT tools to be used and obtain approval from CPWNY's clinical governance committee.										
Task Step 3…A joint PPS (CPWNY & Millennium) training plan will be developed for both PCP and behavioral health/mental health/substance abuse practices to support the adoption of best practice screenings where there are current gaps within identified PCP's and behavioral health/mental health/substance abuse providers. Training plan includes educating practices on the billing codes for PHQ9 and SBIRT screens as many practices are unaware of ability to bill for these screens and absence of billing is a barrier.										
Task Step 4…CPWNY Clinical Integration teams and Millennium jointly assist in training PCPs and behavioral health/mental health/substance abuse providers participating in both PPSs and										

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CPWNY Clinical Transformation teams will provide the same training to providers uniquely in the CPWNY PPS. As CPWNY rolls out the integrated model and as new staff are brought in, CPWNY will utilize the "train the trainer" model to train additional primary care and behavioral health staff on brief interventions and motivational interviewing.										
Task Step 5...All screenings are required documentation in provider EMR's.										
Task Step 6..Clinical integration training teams (with Millennium Collaborative Care counterparts for joint PPS membership) will incorporate reviews of screening protocols and implementation with periodic technical assistance meetings with providers.										
Task Step 7..CPWNY 3.a.i project team will assess and develop reporting metrics and outcome measures including usefulness of community referrals, medication management and adherence, effectiveness of patient outreach, and quality metrics based on culture, language, and ethnicity. The project team will utilize Rapid Cycle Improvement method for continuous improvement.(assessment is implemented in increments and ongoing)										
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1…Utilizing healthcare data analytics complete an assessment of our PPS attributed Medicaid members.										
Task Step 2…Using clinical transformation team, assist practices in extracting data from EMRs on their Medicaid patients; sort by who has not been in office for 1 year or greater; and impending doctor appointment by disease conditions (Cardiovascular , HTN, Renal, Diabetes, Behavioral health)										
Task Step 3… Assess the population from claims data to ascertain hospitalizations and ER visits to obtain holistic view of patient;										

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stratify population by the aforementioned and also segment by culture, ethnicity and language.										
Task Step 4… CPWNY's PMO has an existing referral relationship with our partner Health Home for eligible patients. The 3.a.i project team will assess the current workflow and develop protocol for connecting eligible patients to PPS's health home, Health Home Partners of WNY. CPWNY will extract data for further tracking from Health Home GSI Care Coordination software for health home enrolled patients.										
Task Step 5…Utilizing data extracted, CPWNY's Clinical Transformation team and IT team will assist practices in identifying targeted patients and establishing patient registries for managing patient care and milestone reporting. The target population for patient registries and tracking will include but not be limited to conditions such as depression, substance abuse, and/or overlapping co-morbid with diabetes and cardiac disease.										
Task Step 6… Work with the information technology team to integrate behavioral health status and alerts into the medical record. This process involves obtaining a consent from the patient at the primary care site and at the behavioral health site. Once the consents are both in place, information can be shared through HEALTHeLINK direct exchange or through mirth mail. (Defined process must be in place to ensure that no downstream sharing of patient behavioral health [title 42] information takes place)										
Task Step 7… Set up documentation in EMRs to run reports on care management care plans, care transitions, preventive PCP and BH screenings etc. To be overseen by CPWNY Clinical Transformation and CPWNY IT teams.										
Milestone #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	0	10	35	60	85	110	135	160	185	210
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										

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and care manager.										
Task Policies and procedures include process for consulting with Psychiatrist.										
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.										
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.										
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Milestone #13 Measure outcomes as required in the IMPACT Model.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Milestone #14 Provide "stepped care" as required by the IMPACT Model.										
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.										
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.	235	399	399	399	399	399	399	399	399	399
Task Behavioral health services are co-located within PCMH/APC practices and are available.	45	73	73	73	73	73	73	73	73	73
Task Step 1…The project management office (PMO) staff will identify from participating providers lists primary care practices and licensed mental health, behavioral health, and substance abuse organizations across the Community Partner's of WNY geographic areas and coordinate with Millennium Collaborative Care PPS as to which primary care providers and licensed mental health, behavioral health, and substance abuse providers are in both PPS's.										
Task Step 2…PMO staff, with a cover letter detailing the kinds of support Community Partners could provide their practice, survey the identified primary care practices who are exclusively in the Community Partner's PPS as to their PCMH/NCQA Level or Advanced Primary Care status, percentage of current Medicaid patients served, their current ability to accept new Medicaid patients, EHR status and vendor, CCD capacity to receive and send records, relationship with HealtheLink RHIO, current behavioral health capacity if any, status of current use of PHQ9 and SBIRT screenings, and willingness to discuss possible integration of a satellite mental health or behavioral health (including substance abuse) clinic within their practice site (Article 28 outpatient primary care clinics are currently unable by regulation to integrate a satellite Article 31 mental and behavioral health clinic unless there is a completely separate entrance and separate waiting room making this approach to integration not feasible). The PMO has contacted the regional Department of Health Commissioner for assistance in overcoming this barrier. (Will start with high volume Medicaid practices and roll out survey in increments.)										
Task										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Step 3…CPWNY PMO and Millennium Collaborative Care designated staff will send a joint cover letter and Survey to those primary practices which are in both the Millennium and Community Partner PPS's to identify available support and ask for the same information as in Step 2										
Task Step 4...With a cover letter detailing the kinds of support available in CPWNY, with representation from Article 31 (e.g. Spectrum) partners, will survey the identified licensed mental health/CD agencies exclusively aligned with Community Partners PPS as to current experience with satellite clinic integration into primary care sites, willingness to consider satellite clinic integration into primary care sites, EHR status and vendor, HealtheLink RHIO experience/relationship, CCD and /or MIRTH mail capacity to receive and send records if any, current status/use of PHQ9 and SBIRT screenings, current capacity to provide primary care services within their existing MH clinics. (roll out in increments based on CNA)										
Task Step 5…CPWNY, with representation from Article 31 partners, and Millennium Collaborative Care designated staff will send a joint cover letter and Survey to those licensed mental health providers which are in both the Millennium and Community Partner PPS's identifying PPS support available and asking for the same information as in Step 3.										
Task Step 6…CPWNY, with representation from Article 31 partners, and Millennium Collaborative Care designated staff will jointly determine if the restrictions on integrating Article 31 clinics into Article 28 outpatient primary care facilities identified above are DOH regulations or Federal regulations. If DOH regulations jointly seek a waiver. If waiver not feasible explore the feasibility of the Article 28 clinics being able (if not already so) to hire their own mental or behavioral health (including substance abuse) professional and what supports would be needed to do so from respective PPS's if the Article 28 was in both PPS's. Survey solely or jointly by both PPS's as appropriate the Article 28's for the same information as in Steps 2 or 3.										
Task Step 7…Hold geographically accessible planning meetings for primary care and behavioral health providers who expressed via survey interest in proceeding toward integrated services.. Meetings will be led by teams consisting of physician, mental health leaders and CPWNY central office representatives										

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Include Millennium Collaborative Care representatives to address those providers who will be serving patients from both PPS's. Initiate outreach to PCP's by physician ambassadors from CPWNY and CPWNY mental health ambassadors to mental health providers to engage those providers who either did not respond to surveys or declined interest. Discuss their obstacles to participation and how CPWNY can help to resolve obstacles and engage their active participation in the project through a shadowing visit to existing sites that have integrated behavioral health with primary care. Continue quarterly planning meetings throughout the project to support a learning community approach. Maintain regional meetings for providers throughout the project										
Task Step 8… CPWNY will use a variety of integration models to achieve the goals of this project. These include 1. embedding a mental or behavioral health provider from an Article 31 partner community based organization into a primary care site; 2. building evidence based behavioral health and substance abuse screening tools into the PCMH work flow; 3. facilitating same day access and referral to a geographically accessible behavioral health or substance abuse service for patients identified as in need.										
Task Step 9...For practices that do not have a behavioral health provider physically located in the primary care practice, "warm transfers" will be facilitated in person by an available member of the PCP office to behavioral health/substance abuse providers located close by or in the same building, or via a scheduled conference call with participating behavioral health/substance abuse providers, primary care physicians, and the patient.										
Task Step 10…Finalize contracts/MOU's with participating PCP's and behavioral health and substance abuse providers that outlines their commitment to participate in developing and operationalizing integrated services within the CPWNY PPS or, as appropriate, CPWNY and Millennium PPS's if members of both PPS's. Coordinate content of the contracts/MOU's between PPS's to standardize expectations. (incremental roll out - start with high volume practices and high need areas based on Community Needs Assessment)										
Task Step 11…Analyze current status of EMR systems used for both PCP's and Behavioral health/substance abuse 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
practices, the status of Meaningful Use (AUI, Stage 1, Stage 2, or none), and status of PCMH (Level 3, 2, 1, in process, or none) by participating provider practices. Create a work plan and timeline for getting PCP practices not yet at PCMH Level 3 and MU to achieve them both by end of DY3.										
Task Step 12...Assign each PCP practice a Clinical Transformation Specialist to work with them and be their point of contact on EMR, MU, PCMH, and Population Health/Quality Outcome Measures. Need to hire additional personnel to take on additional practices and workload										
Task Step 13..Create a targeted survey or contact practices to understand practice readiness to engage in PCMH or MU activities (if not currently engaged). Create a work plan for training and educating those who are ready. Create an intervention strategy to help engage those who are not ready through the use of Regional Primary Care Leaders, Hospital leadership, and other resources yet to be determined (such as providing more care management assistance or behavioral health assistance to help the practice feel more comfortable with their ability to take on PCMH recognition)										
Task Step 14...Create educational training materials for Meaningful Use. Provide targeted education based on each practices' need, especially for those who did not meet MU on DY1, for either in person training, web based (WebEx), or user-group by EMR vendor training										
Task 14.a. *Provide education and training to greater than half of practices on Meaningful Use										
Task 14.b. *Provide education and training to greater than 75% practices on Meaningful Use										
Task 14.c *Provide education and training to 100% practices on Meaningful Use										
Task 14.d *All practices on Meaningful Use by end of DY 3= Steps listed below that correspond with 2014 standards but focusing on EMR capabilities and practice use of these capabilities:										
Task Step 15… Improving quality, safety , efficiency and reducing										

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health disparities (these measures will help to provide better access to comprehensive patient data for patient's health team; use evidence based order sets and Computer Order entry; apply clinical decision support at the point of care; generate list of patients who need care and use them to reach out to patients.)										
Task Step 16…Engage patients and families in their health care (these measures will provide patients and families with timely access to data; tools to make informed decisions and manage their health)										
Task Step 17… Improve care coordination (These measures will allow practices to exchange meaningful clinical information among a professional health care team)										
Task Step 18… Improve population and public health (these measures will allow physicians to communicate with public health agencies and better track of health information across communities)										
Task Step 19…Ensure adequate privacy and security protections for personal health information (These measures will help ensure : the privacy & security protections for confidential health information through operating policies , procedures and technology; compliance with applicable law; and transparency of data sharing to the patient.										
Task Step 20…Create education and training materials for PCMH recognition. Create a series of classes focused on teaching of standards, leadership skills, project management skills, IT/EMR support) for practices not yet achieved PCMH to teach the steps on how to achieve level 3 recognition. Find practices that have already achieved level 3 recognition that are willing to act as mentors and leaders to other practices who have not yet achieved level 3 and connect them.										
Task 20.a *Provide education and training to greater than half practices on PCMH										
Task 20.b *Provide education and training to greater than 75% practices on PCMH										
Task 20.c *Provide education and training to 100% practices on PCMH										
Task 20.d * All Primary Care practices achieve PCMH by end of										

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DY3==Steps listed below that are individualized to the assessment of each practice and has meaningful use standards embedded in the applicable standard:										
Task Step 21…Insure PCMH policies and procedures are in place with a process to review , revise and re-approve (templates are provided for office adaptation, customization)										
Task Step 22…Ability to run reports to track missed appointments, upcoming appointments, gaps in preventive care, gaps in chronic disease management, hospitalization and transitions of care documentation, and care management interventions.										
Task Step 23…Appointment Access and availability reports completed (and follow policy). Enhance recruitment of providers based on access and availability report and CAHPS surveys through hospital and IPA recruitment offices										
Task Step 24…Roles and job descriptions completed for practice team members in PCMH and training to PCMH as noted above										
Task Step 25…Evidence Based guidelines built into the EMR along with tools to manage patient care (care management including referrals to CBOs, educational tools, follow up, motivational interviewing)										
Task Step 26…Assessment of diversity in the practice and ability to run quality metrics based on culture, language, and ethnicity										
Task Step 27…Track outreach to patients in attempts to close gaps in care (along with preferred methods of contact as stipulated by the patient)										
Task Step 28…Exchange of information (care coordination)-- reports to show timeliness of incoming and outgoing patient information.(referral agreements in place and information exchanged according to agreements and policy)										
Task Step 29…Quality improvement program in the office, utilizing Rapid Cycle Evaluation										
Task Step 30…Evaluation of usefulness of community referrals.										

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Task Step 31…Medication management (monitors cost, best practice, allergies, interactions, e-scripts)										
Task Step 32... Set up a process for continued education and assistance with PCMH and Meaningful Use. PCMH renewals occur every three years, and meaningful use is yearly. So many practices will have to renew PCMH recognition during this time period, as well as continuing their MU attestations. We want to set up a process to ensure their continued success in the future. There are also standards in which you must show achievement during the interim years of recognition like the measurement and improvement of quality measures.										
Task Step 33…For primary care practices whose Medicaid patient percentages are too low to support an integrated mental or behavioral health (including substance abuse) satellite clinic, collaborative care agreements will be developed with the assistance of the PPS (or PPSs as appropriate) with geographically accessible licensed mental health clinics and behavioral health and substance abuse providers. Evidence based protocols will be codified in MOU's that define the respective responsibilities of both the PCP and BH provider. Protocols in the MOU will include same day/next day access for patients referred by the PCP, concurrent exchange of patient treatment information through CCD's or MIRTH mail as available, connectivity by both PPSs with HEALTHeLINK RHIO to support exchange of treatment information, and regular communication to coordinate treatment plans and medication management. Clinical transformation specialists will meet quarterly with providers and their leadership to support the collaborative care relationship and provide problem solving as necessary. (ongoing)										
Task Step 34… CPWNY is aware that services rendered by an Article 31 provider within an Article 28 facility are not billable to Medicaid. CPWNY is exploring mitigation options such as deploying social worker in Article 28 facility to facilitate warm handoff of patients.										
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.										
Task										

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Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
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..CPWNY Clinical transformation specialists in collaboration with Millennium Collaborative Care Project Manager will develop agreements between each PCP and the integrating BH providers (embedded Article 31 satellite clinic or collaborative care model) utilizing SAMSHA evidence based guidelines provided by the PPS to establish clear written protocols on warm hand-offs of patients, team meeting participation of BH and PCP providers with inclusion of support staff/practice managers, case conferences on more complex patient needs, spontaneous curbside consultation between PCP and BH providers on patient needs, exchange of clinical treatment record information (CCD's or secure MIRTH mail), coordinated care plans including agreements on prescribing practices and coordination, warm hand-offs back to the referring physician at the conclusion of BH treatment including medication needs going forward as well as resolving the often perceived power differentials between physicians and behavioral health providers in order to promote true integration of service delivery versus simply co-location. Evidence based practices above will be coordinated with Millennium Collaborative Care where PCPs are members of both PPSs so services are delivered and integrated under one set of evidence based standards.										
Task Step 2.. Existing PMO care advisors are trained in motivational interviewing and brief interventions, which are key parts of the PMO's Care Management Program. The PMO currently utilizes social workers and nurses who have been trained and have a proven competency. As CPWNY rolls out the integrated model and as new staff are brought in, CPWNY will utilize the "train the trainer" program to train additional primary care and behavioral health staff on brief interventions and motivational interviewing.										
Task Step 3..Clinical transformation specialists from CPWNY (and Millennium Collaborative Care Project Manager as indicated by dual membership in both PPS's) will meet with each integrated PCP/satellite BH site staff and leadership, each collaborative PCP/BH relationship staff and leadership, and each PCP/BH collaborative relationship with a NP providing primary 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
services within the BH clinic at least quarterly to mutually assess and problem solve where necessary the established evidence based protocols that support integrated/collaborative treatment and practice.										
Task Step 4... Quarterly meetings between clinical transformation team and participating behavioral health/mental health/substance abuse sites will include progress on implementation, status of adoption of clinical protocols, and discussion of risks and barriers to implementation. Clinical transformation team will assess progress and help practices to address risks and identify potential for improvements. (This action will be ongoing)										
Task Step 5... The respective PPS Health Home provider (CPWNY's Health Home provider within its PPS is Health Home Partners of WNY) will meet with PPS PCPs and BH licensed providers to educate all of the respective practitioners about the care coordination support and engagement Health Homes can provide eligible patients and how expedited referrals can be made, as well as clarifying the role differentiation between on site PCP nurse care coordinators and community based "boots on the ground" health home care coordinators.										
Task Step 6…CPWNY Care Coordination team (and jointly with Millennium Collaborative Care Project Coordinator as appropriate) will assist PCP and BH practices in prioritizing outreach and developing a workflow on patient engagement, examining patient expressed barriers to seeking healthcare on an outpatient basis. Barriers may be related to a lack of understanding, social, cultural, travel time, transportation needs, family dynamics, prioritization, stigma associated with mental health treatment, etc. and utilize health home care coordinators for eligible patients and Community Based Organizations to overcome these barriers.										
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										

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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.	235	399	399	399	399	399	399	399	399	399
Task Step 1…PCP's and BH practices jointly surveyed by CPWNY & Millennium Collaborative Care as to which preventive screenings are currently routinely being used for patients in both PCP's and BH practices.										
Task Step 2...CPWNY's 3.a.i project team in collaboration with Millennium Collaborative Care Project Manager will identify best practice physical health preventive care screenings to be adopted across both PPS's PCP's in addition to PHQ9 and SBIRT screenings for both PCP's and behavioral health (including substance abuse) practices. The CPWNY project team in collaboration with the Behavioral Health partners will assess and select appropriate SBIRT tools to be used and obtain approval from CPWNY's clinical governance committee.										
Task Step 3…A joint PPS (CPWNY & Millennium) training plan will be developed for both PCP and behavioral health practices to support the adoption of best practice screenings where there are current gaps within identified PCP's and behavioral health (including substance abuse) providers. Training plan includes educating practices on the billing codes for PHQ9 and SBIRT screens as many practices are unaware of ability to bill for these screens and absence of billing is a barrier.										
Task Step 4…CPWNY Clinical Integration teams and Millennium Collaborative Care will jointly assist in training to PCP's and behavioral health (including substance abuse) providers participating in both PPS's and CPWNY Clinical Transformation teams will assist in providing the same training to providers uniquely in the CPWNY PPS. As CPWNY rolls out the integrated model and as new staff are brought in, CPWNY will utilize the "train the trainer" program to train additional primary care and behavioral health staff on brief interventions and motivational interviewing.										
Task Step 5...All screenings are required to have documentation in										

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provider EMR's.										
Task Step 6..Clinical integration training teams (with Millennium Collaborative Care counterparts for joint PPS membership) will incorporate reviews of screening protocols and implementation with periodic technical assistance meetings with providers.										
Task Step 7..CPWNY 3.a.i project team will assess and develop reporting metrics and outcome measures including usefulness of community referrals, medication management and adherence, effectiveness of patient outreach, and quality metrics based on culture, language, and ethnicity. The project team will utilize Rapid Cycle Improvement method for continuous improvement.(assessment is implemented in increments and ongoing)										
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…Utilizing healthcare data analytics, complete an assessment of our PPS attributed Medicaid members.										
Task Step 2…The clinical transformation team will assist practices in extracting data from EMRs on their Medicaid patients; sort by who has not been in office for 1 year or greater; and impending doctor appointment by disease conditions (Cardiovascular , HTN, Renal, Diabetes, Behavioral health)										
Task Step 3… Assess the population from claims data to ascertain hospitalizations and ER visits to obtain holistic view of patient; stratify population by the aforementioned and also segment by culture, ethnicity and language.										
Task Step 4… CPWNY's PMO has existing referral relationship with our partner Health Home for eligible patients. The 3.a.i project team will assess the current workflow and develop a protocol for connecting eligible patients to the PPS's health home, Health										

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Home Partners of WNY. CPWNY will extract data for further tracking from Health Home GSI Care Coordination software for health home enrolled patients.										
Task Step 5…Utilizing data extracted, CPWNY's Clinical Transformation team and IT team with help practices to identify targeted patients and establish patient registries for managing patient care and milestone reporting. The target population for patient registries and tracking will include but not limited to conditions such as depression, substance abuse, and/or overlapping co-morbid with diabetes and cardiac disease.										
Task Step 6… Work with the information technology team to integrate behavioral health status and alerts into the medical record. This process involves obtaining a consent from the patient at the primary care site and at the behavioral health site. Once the consents are both in place, information can be shared through HEALTHeLINK direct exchange or through mirth mail. (Defined process must be in place to ensure that no downstream sharing of patient behavioral health [title 42] information takes place)										
Task Step 7… Set up documentation in EMRs to run reports on care management care plans, care transitions, preventive PCP and BH screenings etc. To be overseen by CPWNY Clinical Transformation and CPWNY IT teams.										
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.	235	399	399	399	399	399	399	399	399	399
Task Primary care services are co-located within behavioral Health practices and are available.	235	399	399	399	399	399	399	399	399	399
Task Primary care services are co-located within behavioral Health practices and are available.	45	73	73	73	73	73	73	73	73	73
Task Step 1…The project management office (PMO) staff will identify from participating provider lists primary care practices and licensed mental health, behavioral health, and substance abuse provider organizations across the Community Partner's of WNY geographic areas and coordinate with Millennium Collaborative Care PPS to identify which primary care providers and licensed mental health, behavioral health, and substance abuse providers										

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are in both PPS's.										
Task Step 2…PMO staff, with a cover letter detailing the kinds of support Community Partners could provide their practice, will survey the identified primary care practices who are exclusively in the Community Partner's PPS as to their PCMH/NCQA Level or Advanced Primary Care status, percentage of current Medicaid patients served, their current ability to accept new Medicaid patients, EHR status and vendor, CCD capacity to receive and send records, relationship with HealtheLink RHIO, current behavioral health/mental health/substance abuse capacity if any, status of current use of PHQ9 and SBIRT screenings, and willingness to discuss possible integration of a satellite mental health, behavioral health, or substance abuse clinic within their practice site (Article 28 outpatient primary care clinics are currently unable by regulation to integrate a satellite Article 31 clinic unless there is a completely separate entrance and separate waiting room making this approach to integration not feasible). The PMO has contacted the regional Department of Health Commissioner for assistance in overcoming this barrier. (Will start with high volume Medicaid practices and roll out survey in increments.)										
Task Step 3…CPWNY PMO and Millennium Collaborative Care designated staff will send a joint cover letter and Survey to those primary care practices which are in both the MCC and Community Partner PPS's identifying available support and asking for the same information as in Step 2										
Task Step 4...With a cover letter detailing the kinds of support available in the CPWNY PPS network, with representation from Article 31 (e.g. Spectrum) partners, will survey the identified licensed mental health/CD agencies exclusively aligned with Community Partners PPS as to current experience and capacity to provide primary care services within existing mental health, behavioral health, and substance abuse clinics, EHR status and vendor, HealtheLink RHIO experience/relationship, CCD and /or MIRTH mail capacity to receive and send records if any, current status/use of PHQ9 and SBIRT screenings. (roll out in increments based on CNA)										
Task Step 5…CPWNY, with representation from Article 31 partners,										

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and Millennium Collaborative Care designated staff will send a joint cover letter and Survey to those licensed mental health, behavioral health, and substance abuse providers which are in both the Millennium Collaborative Care and Community Partner PPSs identifying PPS support available and asking for the same information as in Step 3.										
Task Step 6…CPWNY, with representation from Article 31 partners, and Millennium Collaborative Care designated staff will jointly determine if the restrictions on integrating Article 31 clinics into Article 28 outpatient primary care facilities identified above are DOH regulations or Federal regulations. If DOH regulations, jointly seek a waiver. If waiver not feasible explore the feasibility of the Article 28 clinics being able (if not already so) to hire their own MH professional and what support would be needed to do so from respective PPS's if the Article 28 was in both PPS's. Survey solely or jointly by both PPS's as appropriate the Article 28's for the same information as in Steps 2 or 3.										
Task Step 7…Hold geographically accessible planning meetings for primary care and behavioral health providers who expressed via survey interest in proceeding toward integrated services.. Meetings will be led by teams consisting of physician, mental health leaders and CPWNY central office representatives. Include Millennium Collaborative Care representatives to address those providers who will be serving patients from both PPSs. Initiate outreach to PCPs by physician ambassadors from CPWNY and CPWNY mental health ambassadors to mental health providers to engage those providers who either did not respond to surveys or declined interest. Discuss their obstacles to participation and how CPWNY can help to resolve obstacles and engage their active participation in the project through a shadowing visit to existing sites that have integrated behavioral health with primary care. Continue quarterly planning meetings throughout the project to support a leaning community approach. Maintain regional meetings for providers throughout the project										
Task Step 8…CPWNY will work with Millennium PPS to integrate advanced care management services into Article 31 organizations and other mental health, behavioral health, and substance abuse sites to promote improvements and key health indicators that are targeted to be achieved for the behavioral health populations.										
Task										

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Step 9…Finalize contracts/MOU's with participating PCP's and BH providers that outlines their commitment to participate in developing and operationalizing integrated services within the CPWNY PPS or, as appropriate, CPWNY and Millennium PPSs if members of both PPS's. Coordinate content of the contracts/MOU's between PPS's to standardize expectations. (incremental roll out - start with high volume practices and high need areas based on Community Needs Assessment)										
Task Step 10…Analyze current status of EMR systems used for both PCP's and behavioral health, mental health, and substance abuse provider practices, the status of Meaningful Use (AUI, Stage 1, Stage 2, or none), and status of PCMH (Level 3, 2, 1, in process, or none) by participating provider practices. Create a work plan and timeline for getting PCP practices not yet at PCMH Level 3 and MU to achieve them both by end of DY3.										
Task Step 11...Assign each PCP practice a Clinical Transformation Specialist to work with them and be their point of contact on EMR, MU, PCMH, and Population Health/Quality Outcome Measures. Need to hire additional personnel to take on additional practices and workload										
Task Step 12..Create a targeted survey or contact practices to understand practice readiness to engage in PCMH or MU activities (if not currently engaged). Create work plan for training and educating those who are ready. Create an intervention strategy to help engage those who are not ready through the use of Regional Primary Care Leaders, Hospital leadership, and other resources yet to be determined (such as providing more care management assistance or behavioral health assistance to help the practice feel more comfortable with their ability to take on PCMH recognition)										
Task Step 13...Create educational training materials for Meaningful Use. Provide targeted education based on each practices needs, especially for those who did not meet MU on DY1, for either in person training, web based (WebEx), or user-group by EMR vendor training										
Task 13.a. *Provide education and training to greater than half of practices on Meaningful Use										
Task										

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13.b. *Provide education and training to greater than 75% practices on Meaningful Use										
Task 13.c *Provide education and training to 100% practices on Meaningful Use										
Task 13.d *All practices on Meaningful Use by end of DY 3= Steps listed below that correspond with 2014 standards but focusing on EMR capabilities and practice use of these capabilities:										
Task Step 14…Improving quality, safety , efficiency and reducing health disparities (these measures will help to provide better access to comprehensive patient data for patients health team; use evidence based order sets and Computer Order entry; apply clinical decision support at the point of care; generate list of patients who need care and use them to reach out to patients.)										
Task Step 15…Engage patients and families in their health care (these measures will provide patients and families with timely access to data; tools to make informed decisions and manage their health)										
Task Step 16…Improve care coordination (These measures will allow practices to exchange meaningful clinical information among a professional health care team)										
Task Step 17…Improve population and public health (these measures will allow physicians to communicate with public health agencies and better track of health information across communities)										
Task Step 18…Ensure adequate privacy and security protections for personal health information (These measures will help ensure: the privacy & security protections for confidential health information through operating policies , procedures and technology; compliance with applicable law; and transparency of data sharing to the patient.										
Task Step 19…Create education and training materials for PCMH recognition. Create a series of classes focused on teaching of standards, leadership skills, project management skills, IT/EMR support) for practices not yet achieved PCMH to teach the steps on how to achieve level 3 recognition. Find practices that have already achieved level 3 recognition that are willing to act as mentors and leaders to other practices who have not yet achieved level 3 and connect them.										

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Task 19.a *Provide education and training to greater than half practices on PCMH										
Task 19.b *Provide education and training to greater than 75% practices on PCMH										
Task 19.c *Provide education and training to 100% practices on PCMH										
Task 19.d * All Primary Care practices achieve PCMH by end of DY3==Steps listed below that are individualized to the assessment of each practice and has meaningful use standards embedded in the applicable standard:										
Task Step 20…Insure PCMH policies and procedures in place with a process to review, revise and re-approve (templates are provided for office adaptation, customization)										
Task Step 21…Ability to run reports to track missed appointments, upcoming appointments, gaps in preventive care, gaps in chronic disease management, hospitalization and transitions of care documentation, and care management interventions.										
Task Step 22…Appointment Access and availability reports completed (and follow policy). Enhance recruitment of providers based on access and availability report and CAHPS surveys through hospital and IPA recruitment offices										
Task Step 23…Roles and job descriptions completed for practice team members in PCMH and training to PCMH as noted above										
Task Step 24…Evidence Based guidelines built into the EMR along with tools to manage patient care (care management including referrals to CBOs, educational tools, follow up , motivational interviewing)										
Task Step 25... The PPS leadership and clinical transformation staff will ensure that participating behavioral health/mental health/substance abuse sites will meet article 31 certification requirements for medical screening and follow up and are aligned with the DSRIP outcome metrics.										
Task Step 26…Assessment of diversity in the practice and ability to run quality metrics based on culture, language, and ethnicity										

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Task Step 27…Track outreach to patients in attempts to close gaps in care (along with preferred methods of contact as stipulated by the patient)										
Task Step 28…Exchange of information (care coordination)-- reports to show timeliness of incoming and outgoing patient information.(referral agreements in place and information exchanged according to agreements and policy)										
Task Step 29…Quality improvement program in the office, utilizing Rapid Cycle Evaluation										
Task Step 30…Evaluation of usefulness of community referrals.										
Task Step 31…Medication management (monitors cost, best practice, allergies, interactions, e-scripts)										
Task Step 32... Set up a process for continued education and assistance with PCMH and Meaningful Use. PCMH renewals occur every three years, and meaningful use is yearly. So many practices will have to renew PCMH recognition during this time period, as well as continuing their MU attestations. We want to set up a process to ensure their continued success in the future. There are also standards in which you must show achievement during the interim years of recognition like the measurement and improvement of quality measures.										
Task Step 33... CPWNY will Use the results of the joint survey with MCC to identify primary care providers willing to accept patients identified with medical needs at behavioral health sites.										
Task Step 34…For behavioral health, mental health, and substance abuse providers who choose to integrate primary care services into their practice collaborative care agreements will be developed with the assistance of the PPS (or PPS's as appropriate)with geographically accessible primary care providers and mobile nurse practitioners. Evidence based protocols will be codified in MOU's that define the respective responsibilities of both the PCP and BH/MH/substance abuse provider. Protocols in the MOU will include same day/next day access for patients referred by the behavioral health/mental health/substance abuse provider including but not limited to scheduled conference calls between collaborative providers and										

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the patient to discuss conditions and treatment plans. Concurrent exchange of patient treatment information through CCD's or MIRTH mail as available, connectivity by both with HEALTHeLINK RHIO to support exchange of treatment information, and regular communication to coordinate treatment plans and medication management. Clinical transformation specialists will meet quarterly with providers and their leadership teams to support the collaborative care relationship and provide problem solving as necessary. (ongoing)										
Task Step 35…To support the provision of primary care services within licensed MH clinics the PPS (or PPS's s appropriate to clinics in both PPS's) will fund the hiring of nurse practitioners to be attached to a collaborative PCP, whose role will be to spend one day a week on average at five different high volume Medicaid BH clinics to provide basic primary care screening, preventive medicine and medication management in collaboration with the BH/MH/substance abuse therapist and psychiatric provider as indicated. The population to be served are those Medicaid patients of the behavioral health/mental health/substance abuse clinic who refuse to be linked to a PCP practice. The NP will have a collaborative agreement with the host PCP to support their practice with this population. The PPS (or PPS's) will also fund, where none is available, a LPN nurse at each licensed behavioral health/mental health/substance abuse clinic to support basic health screening, wellness education and follow-up for both the NP and psychiatric providers. This collaborative relationship between the PCP and the behavioral health/mental health/substance abuse clinic will be supported by both a detailed MOU with defined protocols and an assigned clinical transformation specialist from CPWNY who will hold, at a minimum, quarterly meetings with the PCP and behavioral health/mental health/substance abuse practitioners/leadership with the assigned NP to assess the experience for patients and providers and support problem solving as needed.										
Task Step 36... NP will be hired to provide primary care assessments to patients who are lost to contact with their primary care provider and following that will be linked to a primary care site. In addition the participating behavioral health/mental health/ substance abuse providers will have embedded nurse care coordinators to assist in supporting the patients and ensuring follow up and continuation of their care plan.										
Task										

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Step 37…. Eligible patients will be referred to health home. (This action is ongoing)										
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.										
Task Step 1.. CPWNY Clinical transformation specialists in collaboration with Millennium Collaborative Care Project Manager will develop agreements between PCPs and the integrating BH providers (embedded Article 31 satellite clinic or collaborative care model) utilizing SAMSHA evidence based guidelines provided by the PPS to establish clear written protocols on warm hand-offs of patients, team meeting participation of BH and PCP providers with inclusion of support staff/practice managers, case conferences on more complex patient needs, spontaneous curbside consultation between PCP and BH providers on patient needs, exchange of clinical treatment record information (CCD's or secure MIRTH mail), coordinated care plans including agreements on prescribing practices and coordination, warm hand-offs back to the referring physician at the conclusion of BH treatment including medication needs going forward as well as resolving the often perceived power differentials between physicians and behavioral health providers in order to promote true integration of service delivery versus simply co-location. Evidence based practices above will be coordinated with Millennium where PCPs are members of both PPSs so services are delivered and integrated under one set of evidence based standards.										
Task Step 2.. Existing PMO care advisors are trained in motivational interviewing and brief interventions, which are key parts of the PMO's Care Management Program. The PMO currently utilizes social workers and nurses who have been trained and have a proven competency. As CPWNY rolls out the integrated model and as new staff are brought in, CPWNY will utilize the "train the trainer" model to train additional primary care and behavioral health staff on brief interventions and motivational interviewing.										

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Task Step 3..Clinical transformation specialists from CPWNY (and Millennium Collaborative Care Project Manager as indicated by dual membership in both PPS's) will meet with each integrated PCP/satellite BH site staff and leadership, each collaborative PCP/BH relationship staff and leadership, and each PCP/BH collaborative relationship with a NP providing primary care services within the BH clinic at least quarterly to mutually assess and problem solve where necessary the established evidence based protocols that support integrated/collaborative treatment and practice.										
Task Step 4..Quarterly meetings between clinical transformation team and participating behavioral health/mental health/substance abuse sites will include progress on implementation, status of adoption of clinical protocols, and discussion of risks and barriers to implementation. Clinical transformation team will assess progress and help practices to address risks and identify potential for improvements. (This action is ongoing)										
Task Step 5.. The respective PPS Health Home provider (CPWNY's Health Home provider within its PPS is Health Home Partners of WNY) will meet with PPS PCPs and BH licensed providers to educate the respective practitioners about the care coordination support and engagement Health Homes can provide eligible patients and how expedited referrals can be made, as well as clarifying the role differentiation between on site PCP nurse care coordinators and community based "boots on the ground" health home care coordinators.										
Task Step 6…CPWNY Care Coordination team (and jointly with Millennium Collaborative Care Project Coordinator as appropriate) will assist PCP and BH practices in prioritizing outreach and developing a workflow for patient engagement, and examining patient expressed barriers to seeking healthcare on an outpatient basis. Barriers may be related to a lack of understanding, social, cultural, travel time, transportation needs, family dynamics, prioritization, stigma associated with mental health treatment, etc. and utilize health home care coordinators for eligible patients and Community Based Organizations for overcome these barriers.										
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.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Screenings are 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.	235	399	399	399	399	399	399	399	399	399
Task Step 1…PCP's and behavioral health/mental health/substance abuse practices jointly surveyed by CPWNY & Millennium as to which preventive screenings are currently being implemented routinely for patients in both PCP's and behavioral health/mental health/substance abuse practices.										
Task Step 2...CPWNY's 3.a.i project team in collaboration with Millennium Project Manager identify best practice physical health preventive care screenings to be adopted across both PPS's PCP's in addition to PHQ9 and SBIRT screenings for both PCP's and behavioral health/mental health/substance abuse practices. The CPWNY project team in collaboration with the BH partners will assess and select appropriate SBIRT tools to be used and obtain approval from CPWNY's clinical governance committee.										
Task Step 3…A joint PPS (CPWNY & Millennium) training plan will be developed for both PCP and behavioral health/mental health/substance abuse practices to support the adoption of best practice screenings where there are current gaps within identified PCP's and behavioral health/mental health/substance abuse providers. Training plan includes educating practices on the billing codes for PHQ9 and SBIRT screens as many practices are unaware of ability to bill for these screens and absence of billing is a barrier.										
Task Step 4…CPWNY Clinical Integration teams and Millennium jointly assist in training PCPs and behavioral health/mental health/substance abuse providers participating in both PPSs 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
CPWNY Clinical Transformation teams will provide the same training to providers uniquely in the CPWNY PPS. As CPWNY rolls out the integrated model and as new staff are brought in, CPWNY will utilize the "train the trainer" model to train additional primary care and behavioral health staff on brief interventions and motivational interviewing.										
Task Step 5...All screenings are required documentation in provider EMR's.										
Task Step 6..Clinical integration training teams (with Millennium Collaborative Care counterparts for joint PPS membership) will incorporate reviews of screening protocols and implementation with periodic technical assistance meetings with providers.										
Task Step 7..CPWNY 3.a.i project team will assess and develop reporting metrics and outcome measures including usefulness of community referrals, medication management and adherence, effectiveness of patient outreach, and quality metrics based on culture, language, and ethnicity. The project team will utilize Rapid Cycle Improvement method for continuous improvement.(assessment is implemented in increments and ongoing)										
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1…Utilizing healthcare data analytics complete an assessment of our PPS attributed Medicaid members.										
Task Step 2…Using clinical transformation team, assist practices in extracting data from EMRs on their Medicaid patients; sort by who has not been in office for 1 year or greater; and impending doctor appointment by disease conditions (Cardiovascular , HTN, Renal, Diabetes, Behavioral health)										
Task Step 3… Assess the population from claims data to ascertain hospitalizations and ER visits to obtain holistic view of patient;										

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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
stratify population by the aforementioned and also segment by culture, ethnicity and language.										
Task Step 4… CPWNY's PMO has an existing referral relationship with our partner Health Home for eligible patients. The 3.a.i project team will assess the current workflow and develop protocol for connecting eligible patients to PPS's health home, Health Home Partners of WNY. CPWNY will extract data for further tracking from Health Home GSI Care Coordination software for health home enrolled patients.										
Task Step 5…Utilizing data extracted, CPWNY's Clinical Transformation team and IT team will assist practices in identifying targeted patients and establishing patient registries for managing patient care and milestone reporting. The target population for patient registries and tracking will include but not be limited to conditions such as depression, substance abuse, and/or overlapping co-morbid with diabetes and cardiac disease.										
Task Step 6… Work with the information technology team to integrate behavioral health status and alerts into the medical record. This process involves obtaining a consent from the patient at the primary care site and at the behavioral health site. Once the consents are both in place, information can be shared through HEALTHeLINK direct exchange or through mirth mail. (Defined process must be in place to ensure that no downstream sharing of patient behavioral health [title 42] information takes place)										
Task Step 7… Set up documentation in EMRs to run reports on care management care plans, care transitions, preventive PCP and BH screenings etc. To be overseen by CPWNY Clinical Transformation and CPWNY IT teams.										
Milestone #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	235	399	399	399	399	399	399	399	399	399
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										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
and care manager.										
Task Policies and procedures include process for consulting with Psychiatrist.										
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.										
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.										
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Milestone #13 Measure outcomes as required in the IMPACT Model.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Milestone #14 Provide "stepped care" as required by the IMPACT Model.										
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.										
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
in this project.	

Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

• Risk: Difficulty engaging and sustaining patient participation. Lack of participation is a liability for performance. Mitigation: CPWNY will train primary care and cardiac providers in the social and structural determinants of health. Community health workers and social workers will provide home visits, linkage to community resources, and free blood pressure monitoring. PCMH practices will provide open appointment access and consider patient work schedules and transportation to ensure compliance. Patient reminder systems will include secure text messages for blood pressure checks, lab work, and appointment reminders. CPWNY will enlist experienced peers in the design of wellness programs. Providers will engage patient family members to create a familiar support network.

• Risk: Lack of standard treatment protocols on follow up for cardiac patients. This could create problems for consistency of care and ensuring treatment according to DSRIP goals. Mitigation: CPWNY will develop PPS-wide protocols and policies for treatment of patients, development of care plans and strategic follow up. Policies will mandate that providers offer follow up blood pressure checks without appointment or co-pay, and that primary care practices meet PCMH and patient engagement. CPWNY will develop policies for identifying high-risk patients to be referred to a health home or a care coordinator for additional management. The PPS will provide training to staff and patients on proper BP monitoring.

• Risk: Providers resist or refuse to adopt DSRIP policies. This could affect performance and patient outcomes. Mitigation: As a federal Accountable Care Organization, Catholic Medical Partners has experience engaging physicians in quality of care and performance reporting protocols. This is done through use of physician champions, performance incentives, providing resources, and remediation for providers who fail to perform at the expected level. CPWNY will employ these existing strategies to ensure participation in DSRIP protocols. The executive governance board will review performance for possible remediation.

• Risk: Lack of electronic information sharing capability between providers due to lack of EMR technology or gaps in interoperability. This would create a barrier for care coordination and information sharing. Mitigation: CPWNY will use HealtheLink and their functionality for direct exchange of patient data, including capability for Bi-directional exchange of CCD/CCDA data, to close information gaps. Capital funding will be used to provide EMRs to practices using paper charts and to upgrade existing EMRs to ensure interoperability and data capture. To start, CPWNY will instruct providers without an EMR to use Mirth mail through HEALTHeLINK for secure exchanges. The PPS will dedicate resources for improvements in CVD management through data integration, systems interoperability, patient registries, and alerts and reminders to update providers and patients.

• Risk: Practices cannot afford nutritionists, care coordinators, and patient educators. Without access to these resources, practices have limited ability to engage patients and improve outcomes. Mitigation: CPWNY will use partner Health Homes to provide integrated services. CPWNY will hire centralized care coordinators that assist multiple practices in managing patients, minimizing direct costs to providers. Patients will be referred to nutritionists at CPWNY partner organizations and community settings for education and budget meal planning promoting hypertension and cholesterol control. CPWNY will provide nutritionists and patient educators to act as resources to practices on an as-needed basis. CPWNY will also develop group programs for wellness education and medication management for patients with cardiac conditions.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	20,019

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
1,096	2,105	16.18%	10,907	10.52%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (13,012)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
dcao	Rosters	46_PMDL4215_1_3_20160129153740_CPWNY_Patient_List_for_3.b.i_Cardiovascular_Health_DY1_Q3.pdf	CPWNY Patient List for 3.b.i Cardiovascular Health DY1 Q3.	01/29/2016 03:40 PM

Narrative Text :

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

CPWNY further defines the counting criteria for actively engaged patients in project 3.b.i according to available DSRIP guidelines:
Patients with chronic condition (if any of the CAD, CKD, CHF, diabetes or HTN diagnosis is present) who have documented self-management counseling/assessment (BMI counseling, or exercise counseling, or nutritional assessment, or smoking counseling) in the 12-month rolling look-back period (look-back period for DY1 Q1 is 7/1/2014 – 6/30/2015; look-back period for DY1 Q2 is 10/1/2014 – 9/30/2015; look-back period for DY1 Q3 is 1/1/2015 – 12/31/2015).

CPWNY's patient engagement numbers for project 3.b.i in DY1 Q1 through Q3 are underestimated due to the following reasons:

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• Patient lists are only collected from a limited number of PCP practices, which are engaged in EMR data collection. CPWNY didn't have sufficient time to roll out IT integration and data collection effort to other partners.
• Data are incomplete for the most recent two months. Thus patients engaged in November or December 2015 are not reportable at this time.

Regarding patient identifier information for project 3.b.i: We provide payer name, CIN or MCO policy number when available. For those we cannot provider CIN/MCO policy number, we report patient last name, first name, and group/practice name as a combination for traceable patient identifier for DY1 Q1 through Q3.

Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its actively engaged commitments for DY1Q3. The documentation does not support the reported actively engaged numbers.

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Project	N/A	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Step 1…Assess practice adoption of evidence based guidelines with protocols for cardiovascular conditions including elevated cholesterol, Coronary Artery Disease, Congestive Heart Failure and Hypertension. Catholic Medical Partners, currently uses evidence based guidelines in consistent with nationally recognized ICSI Standard for assessment. The current ICSI standard has the following patient engagement requirements: smoking cessation, diet exercise medication adherence, and assessment of underlining risk factors such as depression. Currently 70% of the PPS's primary care practices have adopted the ICSI standard reporting guidelines and are receiving reports on successful implementation. We will use regional partner meetings to educate additional practices on the ICSI standards. These ICSI guidelines utilizied are the most recent version and are consistent in application with the ACC /AHA guidelines and JNC8 (as reviewed by a board certified cardiologist in our network).	Project		In Progress	09/02/2015	01/30/2016	09/02/2015	01/30/2016	03/31/2016	DY1 Q4
Task Step 2…Clinical transformation team and care management team will engage practices in cardiovascular risk reduction by emphasizing value based payment for success and our health	Project		In Progress	03/01/2016	09/02/2016	03/01/2016	09/02/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
plan contracts as well as for overall physician performance in the emerging value based payment world. PPS will expand the reporting/monitoring to other PPS partners.									
Task Step 3… Existing clinical transformation team will work with practices to develop/implement point of care reminders (clinical decision support) in alignment with evidence based guidelines determined by the clinical governance committee. Reminder system will be evaluated based on Hedeis and other quality measure.	Project		In Progress	03/01/2016	09/02/2016	03/01/2016	09/02/2016	09/30/2016	DY2 Q2
Task Step 4…Clinical Governance Committee to implement standard evidence based guidelines for cardiovascular disease including CAD, elevated cholesterol, CHF and hypertension	Project		In Progress	03/01/2016	09/02/2016	03/01/2016	09/02/2016	09/30/2016	DY2 Q2
Task Step 5... Communicate and promote standard evidence based guidelines for cardiovascular conditions via website with annual review. (This action will be ongoing)	Project		In Progress	11/01/2016	03/30/2018	11/01/2016	03/30/2018	03/31/2018	DY3 Q4
Task Step 6... Create and distribute patient education materials that promote healthy lifestyle practices and behaviors to reduce cardiovascular risks.	Project		In Progress	11/01/2016	03/30/2018	11/01/2016	03/30/2018	03/31/2018	DY3 Q4
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	Project	N/A	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Mental Health	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
PPS uses alerts and secure messaging functionality.									
Task Step 1. CPWNY and Millennium PPS working together to perform IT assessment of partners to include:	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task a. Use of EMR, HIE and other information systems; b. data sharing capabilities; c readiness for connection to QE (RHIOs/HIE; Performance reporting capabilities and modalities; dashboard and platforms for patient generated data; future plans for IT integration; use of data security and confidentiality plans	Project		In Progress	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task b. Share results of readiness survey with PPS partners	Project		In Progress	09/30/2015	03/30/2016	09/30/2015	03/30/2016	03/31/2016	DY1 Q4
Task c. Map future state needs from Project Implementation plan to readiness assessment to identify gaps. Road map of future needs will be a requirement in the current state assessment and gap analysis engagement.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task d. Update and approve IT Project Implementation plan	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task e. Evaluate current RHIO capabilities to fill identified gaps. HEALTHeLINK will be integrally involved in the current state assessment and gap analysis.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2…Create inventory of Safety Net and non-Safety Net providers are signed on to HEALTHeLINK, whether they send complete CCD after encounter, whether they send/receive via HISP, whether they can do virtual record lookup. Determine the EMRs they are using.	Project		Completed	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3
Task Step 3…Roll out of partner agreements that stipulate the sharing of health information and use of the RHIO	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 4…In addition to agreements, HEALTHeLINK will be purchasing 500 authentication tokens for PPS practices that will make authentication for access to the RHIO information easier and free of cost to the partner. This will enable providers to access information securely and easily. CPWNY PPS and	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Millennium Collaborative Care PPS are working collaboratively with HEALTHeLINK to ensure that all safety net provider are able to communicate with HEALTHeLINK and all HEALTHeLINK providers through the use of secure email. HEALTHeLINK is currently using MIRTH mail technology.									
Task Step 5…HEALTHeLINK will provide a community-wide patient event notification service that keys on multiple event types and is configurable at the practice/provider level. HEALTHeLINK is working with CPWNY PPS and Millennium Collaborative Care PPS to develop a notification system for all hospital admissions/ discharges and transfers, as well as results delivery.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 6…Build a directory that contains the DIRECT address of providers and practices across the community . This would facilitate the direct exchange of patient information between healthcare settings and would be readily accessible by any provider/user	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 7…Data exchange solution that enables Omni-directional communication between care providers and patients: a. Roll-out of patient portal to PPS partners without EMR= DY 1,Q 4; Roll-out to other PPS partners= DY 2, Q 4; Integrate MobileMD with RHIO (HEALTHeLINK) = DY 1, Q4; Integrate MobileMD with PPS EMR , first PPS EMR = DY2, Q4; Integrate with all other PPS EMRs such as behavioral health, Skilled Nursing Facilities, home care= DY 3, Q4 (NOTE: MobileMD is an HIE that provides comprehensive data exchange solutions and will be directly integrated with the community-wide HEALTHeLINK RHIO/SHIN-NY).	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Step...8 Catholic Medical Partners, currently has implemented a clinical integration program aligned with population health and value based purchasing. Catholic Medical Partners will continue to educate and engage PPS partners to develop clinical processes that drive clinical and financial results. This clinical model and its business model will be used to sustain the DSRIP initiatives to support the successful completion of the DSRIP	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
grant. (This action will be ongoing)									
Task Step... 9 Catholic Medical Partners, currently uses utilization and quality reports that are developed from the Milliman MedInsight program and is developing a population health clinical and business intelligence system using Crimson Management system that highlights utilization and quality against best practices and has a specific care management program that will be used by the PCMH practices to focus on interventions on patient's quality of care.	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Project	N/A	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Step 1... Analyze current status of EMR systems used, the status of Meaningful Use (AUI, Stage 1, Stage 2, or none), and status of PCMH (Level 3, 2, 1, in process, or none) by participating provider practices. Create a work plan and timelines for getting practices not yet at PCMH Level 3 and MU to achieve them both by end of DY3.	Project		In Progress	04/01/2015	12/30/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2... Assign each PCP practice a Clinical Transformation Specialist to work with them and be their point of contact on EMR, MU, PCMH, and Population Health/Quality Outcome Measures. Need to hire additional personnel to take on additional practices and workload. Roll out will be in phases starting with those practices with the largest volume of Medicaid patients.	Project		In Progress	04/01/2015	12/30/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3... Understand EMR system capabilities and if they have	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4

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DSRIP Implementation Plan Project

Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
the ability to meet MU/PCMH for those who are not currently there. If there are gaps in capabilities create a work plan and timeline for working with the vendor or possibly transitioning some practices to more "ready" vendors(those practices that need to transition to more " ready" vendors will need more time and will not be completed until DY 3, Q4)									
Task Step 4… Have 100% of practices on EMR systems that enable them to meet MU and PCMH	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 1…Currently 70% of CPWNY PPS providers have a CCHIT-certified EMR, are using EMR prompts and reminders to identify gaps in care for cardiac related diseases. They are also receiving results delivery and ADTs on diagnostic testing and will use this technology for notification on admission, discharges, and transfers. Over 50% of the current CPWNY PPS providers are submitting EMR data to CMP and this data is been integrated into CMP's population health management system's cardiac module that will produce reports on patient utilization, quality, gaps in care, and engagement. CPWNY will assess the remaining PPS providers who are not currently reporting electronically.	Project		Completed	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3
Task Step 2…For identified practices who don't have a self management module in their EMR, CPWNY will develop a web-based registry reporting system to document care management activities.	Project		Completed	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3
Task Step 3… The current CMP system does not identify cardiac patients who specifically receive insurance through Medicaid. CMP will develop stratified reports by Medicaid managed care payers using both EMR and claims data to track patients	Project		In Progress	04/01/2015	12/30/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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utilization and engagement. A key to this process will be to identify patients who have not accessed a primary care provider as well as patients who are receiving majority of their medical care from a non primary care provider. Note CPWNY PPS will use CMP's existing registry reporting system for practices whose EMR is not currently integrated in Crimson system. This system is been used for CMS ACO reporting.									
Task Step 4... Current CMP providers who have implemented an EMR but not submitting EMR data into the Crimson Population Health Management System will be engaged and their EMR vendor will be asked to interface their EMR system with the Crimson Population Health Management System.	Project		In Progress	04/01/2015	12/30/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5...Create data dictionary of registry elements	Project		In Progress	04/01/2015	12/30/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 6…Practices will Create and maintain patient registries for cardiac conditions from practice EMRs to track engaged patients.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 7…Monitor and educate to improve data getting into the EMR via queryable fields to include interventions and patient engagement.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 8…Data quality check and robust data aggregation /reporting. (This action is ongoing)	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 9…Data analytics function in place	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 10…Appropriate clinical oversight /review in place	Project		In Progress	04/01/2015	12/30/2016	04/01/2015	12/30/2016	12/31/2016	DY2 Q3
Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate tobacco control protocols.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff to incorporate the use of	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4

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EHR to prompt the use of 5 A's of tobacco control.									
Task Step 1… Assess practice EMR documentation templates for inclusion of tobacco use screening and intervention	Project		Completed	09/03/2015	12/20/2015	09/03/2015	12/20/2015	12/31/2015	DY1 Q3
Task Step 2… The EMR systems being utilized by the majority of CPWNY's partners have tobacco prompt modules. The EMR prompts the treating provider to assess whether the patient is a current smoker or has been a smoker in the past. This allows the provider to assess the patient's current smoking status and risk of recidivism. Following the assessment provider will assist the patient through referral to the "Opt to Quit" program in use in Roswell Park Cancer Institute. CPWNY will address any gaps in tobacco prompt.	Project		In Progress	09/03/2015	12/20/2016	09/03/2015	12/20/2016	12/31/2016	DY2 Q3
Task Step 3 Develop and deploy standard templates for providers identified in gap analysis to support evidence based guidelines and protocols, including 5 As for tobacco cessation.	Project		In Progress	09/01/2015	12/22/2016	09/01/2015	12/22/2016	12/31/2016	DY2 Q3
Task Step 4. Develop training for CPWNY practitioners and staff on tobacco control 5 As via web based tool with attestation	Project		In Progress	10/01/2016	03/30/2017	10/01/2016	03/30/2017	03/31/2017	DY2 Q4
Task Step 5. CPWNY will assess smoking cessation efforts on a periodic basis and compare to baseline data on smoking. Results will be communicated through reports and improvements will be made using Rapid Cycle improvement and Change Management strategy. (this action will be ongoing)	Project		In Progress	10/01/2016	03/30/2017	10/01/2016	03/30/2017	03/31/2017	DY2 Q4
Task Step 6. CPWNY, in collaboration with Roswell Park Cancer Institute, will provide periodic training and educational materials on tobacco control to both patient and PPS partners. (This action will be ongoing)	Project		In Progress	10/01/2015	03/30/2017	10/01/2015	03/30/2017	03/31/2017	DY2 Q4
Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4

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(NCEP) or US Preventive Services Task Force (USPSTF).									
Task Step 1… Catholic Medical Partners, will identify and adopt nationally recognized standards for hypertension and elevated cholesterol treatments protocols, such as ICSI guidelines. These ICSI guidelines utilizied are the most recent version and are consistent in application with the ACC /AHA guidelines and JNC8 (as reviewed by a board certified cardiologist in our network).Our current system monitors blood pressure, LDL levels, medication lists and adherence, and beta blockers.	Project		In Progress	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task Step 2…Assess practice adoption of evidence based guidelines for Hypertension and elevated cholesterol.	Project		In Progress	09/01/2016	12/30/2016	09/01/2016	12/30/2016	12/31/2016	DY2 Q3
Task Step 3 .. Implement the treatment protocol in all PCMH practices and cardiology practices.	Project		In Progress	10/01/2016	03/28/2017	10/01/2016	03/28/2017	03/31/2017	DY2 Q4
Task Step 4 .. CPWNY will assess practice adoption of these standard protocols and monitor performance on quarterly basis. (This action will be ongoing)	Project		In Progress	10/01/2016	03/28/2017	10/01/2016	03/28/2017	03/31/2017	DY2 Q4
Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Care coordination processes are in place.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 1… Assess CPWNY member practices for current "care coordination teams", policies and documented workflows	Project		Completed	09/10/2015	12/04/2015	09/10/2015	12/04/2015	12/31/2015	DY1 Q3

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Task Step 2… Compile findings for "Gap Analysis". Develop staffing and work plan for practices to have access to nurse care coordinators, clinical pharmacists, social workers, community health workers and registered dieticians	Project		In Progress	12/15/2015	06/20/2016	12/15/2015	06/20/2016	06/30/2016	DY2 Q1
Task Step 3... Leverage and adopt CPWNY's existing care management models, NCQA PCMH standards for care coordination, job descriptions, training, practice processes/workflows in practices without Care Coordination at the time of the assessment	Project		In Progress	03/30/2016	06/30/2016	03/30/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 4... Assess EMR documentation templates for patient care coordination assessments that include project elements	Project		In Progress	06/01/2016	12/15/2016	06/01/2016	12/15/2016	12/31/2016	DY2 Q3
Task Step 5 Develop and deliver via web based resources training for CPWNY care coordinators with attestation for completion (this action will be ongoing)	Project		In Progress	01/02/2017	03/28/2017	01/02/2017	03/28/2017	03/31/2017	DY2 Q4
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	Project	N/A	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Step 1… Assess current policy for MCOs with office visit co-pays for BP checks	Project		In Progress	10/01/2015	12/01/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2 Assess gaps in CPWNY practice capability and policy for "open access" for BP checks	Project		In Progress	01/03/2016	09/25/2016	01/03/2016	09/25/2016	09/30/2016	DY2 Q2
Task Step 3... Implement "open access" scheduling using IHI's open access scheduling model. CPWNY will use physician champions to engage the providers in understanding the importance of BP control in achieving DSRIP milestones for the cardiac project and how this relates to value based purchasing.	Project		In Progress	01/03/2016	09/25/2016	01/03/2016	09/25/2016	09/30/2016	DY2 Q2
Task Step 4... It is our understanding that Medicaid patients do not	Project		In Progress	01/02/2016	03/30/2018	01/02/2016	03/30/2018	03/31/2018	DY3 Q4

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have any co-payment for blood pressure checks. In case there is copayment, CPWNY will work with MCOs in eliminating any financial barriers for Medicaid patients to monitor blood pressure.									
Task Step 5... Clinical Transformation staff to support practices with EMR system changes to support waiving copay for BP check office visit and schedule modifications to standardize "open access" for BP check. Ability to generate reports on BP checks.	Project		In Progress	08/01/2016	12/28/2017	08/01/2016	12/28/2017	12/31/2017	DY3 Q3
Task Step 6... Develop and deliver via web based resources training for CPWNY staff and practitioners with attestation for completion	Project		In Progress	01/02/2016	03/30/2018	01/02/2016	03/30/2018	03/31/2018	DY3 Q4
Task Step 7 CPWNY will assess the effectiveness of training, the implementation of the policy and monitor performance periodically. (This action will be ongoing)	Project		In Progress	01/02/2018	03/30/2018	01/02/2018	03/30/2018	03/31/2018	DY3 Q4
Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 1…The Cardiac project team will research the existing best practices on BP monitoring and equipment.	Project		In Progress	06/30/2015	03/30/2016	06/30/2015	03/30/2016	03/31/2016	DY1 Q4
Task Step 2…The Cardiac project team will identify gaps in current protocols on BP monitoring.	Project		In Progress	10/02/2015	03/30/2016	10/02/2015	03/30/2016	03/31/2016	DY1 Q4
Task Step 3…Develop and provide broad web based training on proper BP measurement technique with attestation at practice level for participation	Project		In Progress	01/02/2016	06/30/2016	01/02/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 4…Assess practice staff proficiency with proper BP measurement technique through practice based clinical skills competency assessment.	Project		In Progress	02/28/2016	09/30/2016	02/28/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5…CPWNY will delegate to each practice to ensure that all	Project		In Progress	01/02/2016	12/30/2016	01/02/2016	12/30/2016	12/31/2016	DY2 Q3

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staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment. Practices will attest to proficiency of their staff in monitoring BP.									
Task Step 6... Staff proficiency of BP monitoring will be assessed periodically to ensure correct measurement and techniques. (This action will be ongoing.)	Project		In Progress	01/02/2016	03/30/2017	01/02/2016	03/30/2017	03/31/2017	DY2 Q4
Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	Project	N/A	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Step 1…Assess practice EMR capability to track BP readings over time	Project		Completed	09/03/2015	12/20/2015	09/03/2015	12/20/2015	12/31/2015	DY1 Q3
Task Step 2…Clinical transformation team along with healthcare analysts will assist the practices to identify the patients who are potentially un-diagnosed for hypertension.	Project		In Progress	09/03/2015	06/30/2016	09/03/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3…Communicate and promote standard evidence based guideline protocol including additional work up for repeated elevated BP via website	Project		In Progress	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 4.... CPWNY will assist the practices in setting up EMR reminders to prompt proper coding and timely follow-up on patients with repeated elevated BP.	Project		In Progress	09/01/2015	09/30/2017	09/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 5... CPWNY will work with our population health	Project		In Progress	01/02/2016	03/30/2018	01/02/2016	03/30/2018	03/31/2018	DY3 Q4

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management system to send messages to providers who have patients with elevated blood pressure without a proper ICD code. CPWNY will also monitor coding to ensure all patients with chronic cardiac conditions continue to be coded properly.									
Task Step 6... Develop and deliver ongoing training via web based resources for CPWNY staff and practitioners with attestation for completion.	Project		In Progress	01/02/2016	03/30/2018	01/02/2016	03/30/2018	03/31/2018	DY3 Q4
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 1…CPWNY will work with health plans to develop a preferred formulary of medications that have once-daily regimens or fixed dose combinations pills.	Project		In Progress	11/30/2015	02/28/2016	11/30/2015	02/28/2016	03/31/2016	DY1 Q4
Task Step 2…Develop and communicate current list of once daily hypertension medications to practices, prioritizing practices with Medicaid cardiac patients.	Project		In Progress	11/15/2015	03/30/2016	11/15/2015	03/30/2016	03/31/2016	DY1 Q4
Task Step 3... Assess CPWNY member practices for standard policy and workflow for medication review, amend or implement medication review policy and a process to include once daily medications to improve adherence	Project		In Progress	10/10/2015	12/30/2016	10/10/2015	12/30/2016	12/31/2016	DY2 Q3
Task Step 4…Work with MCOs to provide practice specific reports of patients not on once-daily regimens or fixed dose combination pills, review annually.	Project		In Progress	11/30/2015	03/30/2017	11/30/2015	03/30/2017	03/31/2017	DY2 Q4
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	Project	N/A	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Self-management goals are documented in the clinical record.	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4

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PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.									
Task Step 1…Assess CPWNY member practices for current policy and process for documenting patient engagement in self management of diet exercise, smoking, and medication adherence.	Project		Completed	09/03/2015	12/20/2015	09/03/2015	12/20/2015	12/31/2015	DY1 Q3
Task Step 2…Compile findings for "Gap Analysis" and develop work plan to implement a standard workflow and documentation standards for patient centric self management goals related to their cardiovascular condition	Project		In Progress	01/04/2016	07/30/2016	01/04/2016	07/30/2016	09/30/2016	DY2 Q2
Task Step 3... CPWNY's PPS network has experience with meeting NCQA PCMH standards. Currently 70% of our practices are NCQA recognized. In order to meet these standards providers must work with patients to develop patient-driven self management goals and document review at relevant visits. We will use our continued recognition as evidence of appropriate documentation and use of patient self management goals. These reviews are done according to NCQA standards and policies. We will work with our non-PCMH partners to achieve level 3 recognition.	Project		In Progress	09/03/2015	12/30/2016	09/03/2015	12/30/2016	12/31/2016	DY2 Q3
Task Step 4…CPWNY's mobile care transformation team will meet with practices to review their adherence to the guidelines and to the documentation requirements to patient driven self-management goals. Care transformation team will provide training, practice processes/workflows in practices as needed.	Project		In Progress	09/03/2015	03/30/2017	09/03/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 5... The care transformation team will develop and deliver via web based resources training for CPWNY staff and practitioners with attestation for training completion. (this action will be ongoing)	Project		In Progress	11/15/2016	03/30/2018	11/15/2016	03/30/2018	03/31/2018	DY3 Q4
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	Project	N/A	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4

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Task PPS has developed referral and follow-up process and adheres to process.	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff on warm referral and follow-up process.	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Step 1…CPWNY project management office has developed referral agreements between primary care physicians and behavioral health agencies, the health home. Existing agreement and policy will be expanded to other PPS partners and other community agencies including but not limited to Catholic Charities, the Urban League, and hospice/palliative care. CPWNY will monitor referrals from CPWNY providers to these organizations.	Project		Completed	09/03/2015	12/30/2015	09/03/2015	12/30/2015	12/31/2015	DY1 Q3
Task Step 2…Assess CPWNY member practice policies and processes for tracking and follow up on BH, Wellness/Health Promotion referrals	Project		Completed	09/03/2015	12/20/2015	09/03/2015	12/20/2015	12/31/2015	DY1 Q3
Task Step 3.. Compile findings for "Gap Analysis" and develop work plan to ensure practices have implemented a standard workflow for tracking and follow up on BH, Wellness/Health Promotion referrals	Project		In Progress	01/04/2016	06/30/2016	01/04/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 4… CPWNY will identify and educate the practices on available community based programs. Resources will also be posted on CPWNY's website. CPWNY will use regional meeting with providers to provide training and education about available community programs and strategies for follow up and documentation.	Project		In Progress	09/03/2015	09/30/2016	09/03/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 5…CPWNY will engage PCMH and cardiology practices in encouraging their patients to use community resources available	Project		In Progress	09/03/2015	09/30/2016	09/03/2015	09/30/2016	09/30/2016	DY2 Q2

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to improve patient self management behaviors including Wegman's for diet, health plans' exercise an yoga programs, "feeling fit" programs, and The New York State Smokers Quitline's "Opt to Quit" program for smoking cessation.									
Task Step 6… On annual basis CPWNY will conduct PPS-wide survey to all practices and a sample of patients to assess satisfaction with community based programs. The survey will assess access to care, ease of referral and reporting.	Project		In Progress	09/03/2015	03/30/2017	09/03/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 7… Patient tracking and follow-up will be accomplished through the RHIO secure email system, Mirth Mail, which allows for secure exchange of patient information between the CBOs and providers.	Project		In Progress	09/03/2015	09/30/2017	09/03/2015	09/30/2017	09/30/2017	DY3 Q2
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task PPS has developed and implemented protocols for home blood pressure monitoring.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff on warm referral and follow-up process.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 1… CPWNY will develop policy for home BP monitoring for patients with chronic cardiac diseases and other chronic conditions with cardiac complications to actively engage them in self management skills. The policy will include patient educational materials on the importance of regular BP monitoring and information about available community resources.	Project		In Progress	09/03/2015	03/30/2016	09/03/2015	03/30/2016	03/31/2016	DY1 Q4
Task Step 2… CPWNY will assess health plan policies for the provision of home BP monitoring equipment. CPWNY will follow-	Project		In Progress	09/03/2015	03/30/2016	09/03/2015	03/30/2016	03/31/2016	DY1 Q4

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up with support and processes for adopting protocols which include home blood pressure monitoring as a component of self management.									
Task Step 3… Compile findings, develop "Gap Analysis" and work plan for member practices to adopt protocols including promoting home blood pressure monitoring	Project		In Progress	03/30/2016	06/30/2016	03/30/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 4... Communicate and promote evidence based guideline protocol including home monitoring of BP	Project		In Progress	09/01/2016	12/30/2016	09/01/2016	12/30/2016	12/31/2016	DY2 Q3
Task Step 5... Develop and deliver training resources via printed material and web based resources for training CPWNY staff and practitioners with attestation for completion. The training will focus on helping the practices to teach patients to perform home BP monitoring. CPWNY will work with local pharmacies to promote patient engagement with home BP monitoring.	Project		In Progress	01/02/2016	12/30/2016	01/02/2016	12/30/2016	12/31/2016	DY2 Q3
Task Step 6… CPWNY will encourage patients to self-report BP to their providers. CPWNY will periodically monitor performance. (this action is ongoing)	Project		In Progress	07/05/2016	11/30/2016	07/05/2016	11/30/2016	12/31/2016	DY2 Q3
Task Step 7... Work with health plan to improve the approval process for getting home BP monitoring equipment.	Project		In Progress	09/01/2016	12/30/2016	09/01/2016	12/30/2016	12/31/2016	DY2 Q3
Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 1…Currently the project management office, Catholic Medical Partners, maintains a information technology warehouse that analyzes claims data and EMR data to measure access to care and gaps in care. CMP has a disease specific methodology for identifying high risk patients including patients with cardiac conditions who are not receiving recommended follow-up visits. CPWNY will leverage existing capabilities to assist practices to	Project		In Progress	08/30/2015	12/30/2015	08/30/2015	03/31/2016	03/31/2016	DY1 Q4

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identify patients with hypertension who have not had a recent visit and schedule a follow up.									
Task Step 2…Practices will Create and maintain patient registries to identify patients with hypertension who have not had a recent visit from practice EMR to o support population health management and individual patient outreach to reduce "Gaps in Care" with an annual office visit.	Project		In Progress	08/30/2015	06/30/2016	08/30/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3… CPWNY will utilize the mobile clinical transformation and care management teams to communicate to practices the disease specific methodology for identifying registries of patients with hypertension who have not had recent visits and schedule follow-up visits. The project management office will roll out this methodology to the remaining PPS partners not currently addressed by existing teams.	Project		In Progress	08/30/2015	08/30/2016	08/30/2015	08/30/2016	09/30/2016	DY2 Q2
Task Step 4… CPWNY will use Health Home and community health workers to do outreach to patients who cannot be contacted by the practice.	Project		In Progress	08/30/2015	08/30/2016	08/30/2015	08/30/2016	09/30/2016	DY2 Q2
Task Step 5… Leverage CPWNY's existing clinical transformation and care management staff to coach and mentor CPWNY member practices on patient outreach/campaigns to close "Gaps in Care"	Project		In Progress	08/01/2016	03/01/2017	08/01/2016	03/01/2017	03/31/2017	DY2 Q4
Task Step 6… CPWNY will produce periodic reports, and track and trend practice improvements in scheduling visits for patients with hypertension. (This action is ongoing)	Project		In Progress	08/01/2015	03/30/2017	08/01/2015	03/30/2017	03/31/2017	DY2 Q4
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task PPS has developed referral and follow-up process and adheres to process.	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 1… CPWNY PPS is implementing a smoking cessation program with Roswell Park Cancer Institute. This includes provider education on access to smoking cessation programs as well as educational material for patients. The NYS Smoker's	Project		In Progress	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4

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Quitline, housed at Roswell Park Cancer Institute, has an established electronic referral system that enables PPS physicians to make referrals to the Quitline's "Opt to Quit" smoking cessation program. For practices currently without any EMRs, referrals can be made to the Quitline's "Fax to Quit" program.									
Task Step 2… Assess CPWNY member practices for standard policy and workflow, including "warm transfer" at the time of screening for patients for use of tobacco and referral to the NYS smoker's Quitline	Project		In Progress	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task Step 3…Promote standard evidence based guidelines for the diagnosis and treatment of cardiovascular disease with tobacco screening and cessation support via CPWNY website	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 4… The community needs assessment estimated about 26% of the WNY Medicaid population are tobacco users. The PPS will conduct periodic reviews of population health data to determine if the prevalence of tobacco users is declining. (this action is ongoing)	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 5… CPWNY will produce periodic reports, measure patient improvement, and conduct follow-ups based on tracking data from Roswell Park's "Opt to Quit" and "Fax to Quit" programs. (This action is ongoing)	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	Project	N/A	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task If applicable, PPS has established linkages to health homes for	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4

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targeted patient populations.									
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Step 1…Catholic Medical Partners is currently using the Massachusetts General Chronic Care Management evidence-based approach to intervene with patients with the greatest burden of illness and highest risk for institutional care. Our identification system use HCC (Hierarchical Clinical Conditions) methodology to identify "hot spot" patients who need extra clinical care and services.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…The Catholic Medical Partners analytic team produces list of patients who's HCC score is higher than 1.1 on a semi annual basis. The PMO assists the practices to create registries for each primary care practice to monitor the care and treatment of this high risk population on a periodic basis. This includes referral to the Health Home. The PMO also has implemented group visits in specific practices that are provided by physician, pharmacist, and nutritionist. CPWNY will expand this model to the other PPS partners.	Project		In Progress	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task Step 3… Assess CPWNY member practices current policy and standard process for identifying "high risk" patients, those who would benefit from a group visit or peer lead chronic condition management group visits to improve adherence to treatment plans, improve self management confidence and conviction	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 4… Compile findings and develop a "Gap Analysis" and work plan with time frames and accountable party identified to increase identification of "high risk patients" and refer to Health Home, group visits and peer lead chronic condition management group visits among CPWNY partners	Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 5... Develop and deliver results of the "hot-spotting" analysis via web based resources training for CPWNY staff and practitioners with attestation for completion	Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2

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Task Step 6…CPWNY will conduct periodic review to monitor the effectiveness of implementing the HCC-based care management model. (this action is ongoing)	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Milestone #18 Adopt strategies from the Million Hearts Campaign.	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Mental Health	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 1…The Million Hearts Campaign focus on reducing acute Myocardial Infarction by 1 million. The PMO's current care management program for patients at risk for cardiac disease follows the ICSI guidelines and are consistent with the Million Hearts guidelines. The PMO will further align the guidelines and policies for current programs to the Million Hearts Campaign.	Project		Completed	08/30/2015	12/30/2015	08/30/2015	12/30/2015	12/31/2015	DY1 Q3
Task Step 2… Assess current clinical processes within CPWNY primary care practices and cardiology practices for promotion of heart healthy lifestyle including diet and exercise, BP and cholesterol level screenings and management, prescribing of aspirin per evidence based guideline, tobacco use screening and support/referral for cessation.	Project		In Progress	08/30/2015	03/30/2016	08/30/2015	03/30/2016	03/31/2016	DY1 Q4
Task Step 3…Compile findings and develop a "Gap Analysis" using evidence based guidelines for diagnosis and management of cardiovascular diseases. Develop a work plan to close the gaps.	Project		In Progress	02/28/2016	08/30/2016	02/28/2016	08/30/2016	09/30/2016	DY2 Q2
Task Step 4…The PMO will integrate performance reporting on	Project		In Progress	08/30/2015	12/30/2016	08/30/2015	12/30/2016	12/31/2016	DY2 Q3

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strategies from the Million Hearts Campaign into the Crimson Population Health Care Management module (in development by the PMO) that will be used by practice-based clinical staff to promote value based care and treatment.									
Task Step 5... Develop and make available training materials via web based resources with attestation of completion.	Project		In Progress	08/30/2015	03/30/2017	08/30/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 6… CPWNY will conduct periodic review and monitor the effectiveness of implementing the ICSI guidelines and Million Hearts Campaign for primary care and cardiology practices. (This action will be ongoing)	Project		In Progress	01/01/2016	03/30/2017	01/01/2016	03/30/2017	03/31/2017	DY2 Q4
Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	Project	N/A	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.	Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Step 1…Compile list of contacts per MCO to understand current programs and initiatives to improve early cardiovascular disease identification and management; including BP and cholesterol screening, tobacco use screening and referral for cessation support. The PPS project management office, Catholic Medical Partners, currently has Medicaid risk contracts (with Value Based Payment metrics) with 3 payers and is working to develop risk contracts with 2 additional health plans. This would include the majority of Medicaid population attributed to CPWNY. Please note that Catholic Medical Partners project management team has had Value Based contracts based on successful collaborative relationships with local health plans for over the past 10 years.	Project		In Progress	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task Step 2…Meet with MCO decision makers to develop a standard community collaborative approach. Review MCO agreements to	Project		In Progress	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2

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confirm they support coordination of services.									
Task Step 3…The PMO will continue to work with the health plans in order to receive timely information from paid claims and to use the data elements included in the claims payment abstracts to identify patients at risk for cardiovascular disease and to assess patient and practice compliance with clinical protocols of care. (This action will be ongoing)	Project		In Progress	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 4…Currently claims data is been entered into Milliman MedInsight system. In the future this data will be integrated with EMR data in Crimson population health system. The PMO's currently Medicaid managed health plans are in full agreement with this approach and are the foundation of our sustainability model.	Project		In Progress	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 5…The PMO will work with Medicaid managed care organizations to utilize the centralized care and case management services provided the health plans. The Medicaid managed care organizations will increasingly hold the PPS accountable for de-centralized care management for the populations of patients at risk for cardiovascular diseases.	Project		In Progress	09/30/2015	03/30/2017	09/30/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 6... Document defined process and agreements and communicate broadly among CPWNY practices and MCO staff.	Project		In Progress	03/30/2017	09/30/2017	03/30/2017	09/30/2017	09/30/2017	DY3 Q2
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task PPS has engaged at least 80% of their PCPs in this activity.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 1… Assess current status of CPWNY practices for diagnosis and management of cardiovascular disease per DSRIP project requirements.	Project		In Progress	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task Step 2…Currently Catholic Medical Partners is accredited by the national NCQA as an Accountable Care Organization, and has previously accredited by NCQA for disease management. The	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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PMO strategy for provider engagement is based upon supporting the clinical practices and providing the infrastructure, clinical staff, and quality and utilization data to assist the clinical practices. In addition, the PMO provides financial incentives and uses a team of physician champions as role models for practice transformation. The PMO will expand the current effort to the other PPS partners.									
Task Step 3… Currently, more than half of CPWNY's primary care providers are actively engaged in the PMO's care management program. CPWNY will develop a plan to expand the care management program for cardiac patients to the other PPS partners.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4… Develop a practice specific work plan to target practices with gaps in people, process or technology. Leverage Clinical Transformation, Care Management staff and the CPWNY Medical Director to drive change/improvement at the practice level.	Project		In Progress	05/01/2016	12/30/2016	05/01/2016	12/30/2016	12/31/2016	DY2 Q3
Task Step 5… Measure and report practice level progress semi annually to the Clinical Governance Committee and Executive Governing Board of CPWNY. (This action is ongoing)	Project		In Progress	03/30/2016	03/30/2017	03/30/2016	03/30/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task Step 1…Assess practice adoption of evidence based guidelines with protocols for cardiovascular conditions including elevated cholesterol, Coronary Artery Disease, Congestive Heart Failure and Hypertension. Catholic Medical Partners, currently uses										

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evidence based guidelines in consistent with nationally recognized ICSI Standard for assessment. The current ICSI standard has the following patient engagement requirements: smoking cessation, diet exercise medication adherence, and assessment of underlining risk factors such as depression. Currently 70% of the PPS's primary care practices have adopted the ICSI standard reporting guidelines and are receiving reports on successful implementation. We will use regional partner meetings to educate additional practices on the ICSI standards. These ICSI guidelines utilizied are the most recent version and are consistent in application with the ACC /AHA guidelines and JNC8 (as reviewed by a board certified cardiologist in our network).										
Task Step 2…Clinical transformation team and care management team will engage practices in cardiovascular risk reduction by emphasizing value based payment for success and our health plan contracts as well as for overall physician performance in the emerging value based payment world. PPS will expand the reporting/monitoring to other PPS partners.										
Task Step 3… Existing clinical transformation team will work with practices to develop/implement point of care reminders (clinical decision support) in alignment with evidence based guidelines determined by the clinical governance committee. Reminder system will be evaluated based on Hedeis and other quality measure.										
Task Step 4…Clinical Governance Committee to implement standard evidence based guidelines for cardiovascular disease including CAD, elevated cholesterol, CHF and hypertension										
Task Step 5... Communicate and promote standard evidence based guidelines for cardiovascular conditions via website with annual review. (This action will be ongoing)										
Task Step 6... Create and distribute patient education materials that promote healthy lifestyle practices and behaviors to reduce cardiovascular risks.										
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging),										

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alerts and patient record look up, by the end of DY 3.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	3	6	9	12	15	20	25
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	4	8	12	16	20	25	30
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	2	4	6	8	10	15	20
Task PPS uses alerts and secure messaging functionality.										
Task Step 1. CPWNY and Millennium PPS working together to perform IT assessment of partners to include:										
Task a. Use of EMR, HIE and other information systems; b. data sharing capabilities; c readiness for connection to QE (RHIOs/HIE; Performance reporting capabilities and modalities; dashboard and platforms for patient generated data; future plans for IT integration; use of data security and confidentiality plans										
Task b. Share results of readiness survey with PPS partners										
Task c. Map future state needs from Project Implementation plan to readiness assessment to identify gaps. Road map of future needs will be a requirement in the current state assessment and gap analysis engagement.										
Task d. Update and approve IT Project Implementation plan										
Task e. Evaluate current RHIO capabilities to fill identified gaps. HEALTHeLINK will be integrally involved in the current state assessment and gap analysis.										
Task Step 2…Create inventory of Safety Net and non-Safety Net providers are signed on to HEALTHeLINK, whether they send complete CCD after encounter, whether they send/receive via HISP, whether they can do virtual record lookup. Determine the EMRs they are using.										
Task Step 3…Roll out of partner agreements that stipulate the sharing of health information and use of the RHIO										

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Task Step 4…In addition to agreements, HEALTHeLINK will be purchasing 500 authentication tokens for PPS practices that will make authentication for access to the RHIO information easier and free of cost to the partner. This will enable providers to access information securely and easily. CPWNY PPS and Millennium Collaborative Care PPS are working collaboratively with HEALTHeLINK to ensure that all safety net provider are able to communicate with HEALTHeLINK and all HEALTHeLINK providers through the use of secure email. HEALTHeLINK is currently using MIRTH mail technology.										
Task Step 5…HEALTHeLINK will provide a community-wide patient event notification service that keys on multiple event types and is configurable at the practice/provider level. HEALTHeLINK is working with CPWNY PPS and Millennium Collaborative Care PPS to develop a notification system for all hospital admissions/ discharges and transfers, as well as results delivery.										
Task Step 6…Build a directory that contains the DIRECT address of providers and practices across the community . This would facilitate the direct exchange of patient information between healthcare settings and would be readily accessible by any provider/user										
Task Step 7…Data exchange solution that enables Omni-directional communication between care providers and patients: a. Roll-out of patient portal to PPS partners without EMR= DY 1,Q 4; Roll-out to other PPS partners= DY 2, Q 4; Integrate MobileMD with RHIO (HEALTHeLINK) = DY 1, Q4; Integrate MobileMD with PPS EMR , first PPS EMR = DY2, Q4; Integrate with all other PPS EMRs such as behavioral health, Skilled Nursing Facilities, home care= DY 3, Q4 (NOTE: MobileMD is an HIE that provides comprehensive data exchange solutions and will be directly integrated with the community-wide HEALTHeLINK RHIO/SHIN-NY).										
Task Step...8 Catholic Medical Partners, currently has implemented a clinical integration program aligned with population health and value based purchasing. Catholic Medical Partners will continue to educate and engage PPS partners to develop clinical processes that drive clinical and financial results. This clinical model and its business model will be used to sustain the DSRIP initiatives to support the successful completion of the DSRIP										

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grant. (This action will be ongoing)										
Task Step... 9 Catholic Medical Partners, currently uses utilization and quality reports that are developed from the Milliman MedInsight program and is developing a population health clinical and business intelligence system using Crimson Management system that highlights utilization and quality against best practices and has a specific care management program that will be used by the PCMH practices to focus on interventions on patient's quality of care.										
Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	10	35	60	85	110	135	160	185	210
Task Step 1... Analyze current status of EMR systems used, the status of Meaningful Use (AUI, Stage 1, Stage 2, or none), and status of PCMH (Level 3, 2, 1, in process, or none) by participating provider practices. Create a work plan and timelines for getting practices not yet at PCMH Level 3 and MU to achieve them both by end of DY3.										
Task Step 2... Assign each PCP practice a Clinical Transformation Specialist to work with them and be their point of contact on EMR, MU, PCMH, and Population Health/Quality Outcome Measures. Need to hire additional personnel to take on additional practices and workload. Roll out will be in phases starting with those practices with the largest volume of Medicaid patients.										
Task Step 3... Understand EMR system capabilities and if they have the ability to meet MU/PCMH for those who are not currently there. If there are gaps in capabilities create a work plan and timeline for working with the vendor or possibly transitioning some practices to more "ready" vendors(those practices that need to transition to more " ready" vendors will need more time and will not be completed until DY 3, Q4)										

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Task Step 4… Have 100% of practices on EMR systems that enable them to meet MU and PCMH										
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1…Currently 70% of CPWNY PPS providers have a CCHIT-certified EMR, are using EMR prompts and reminders to identify gaps in care for cardiac related diseases. They are also receiving results delivery and ADTs on diagnostic testing and will use this technology for notification on admission, discharges, and transfers. Over 50% of the current CPWNY PPS providers are submitting EMR data to CMP and this data is been integrated into CMP's population health management system's cardiac module that will produce reports on patient utilization, quality, gaps in care, and engagement. CPWNY will assess the remaining PPS providers who are not currently reporting electronically.										
Task Step 2…For identified practices who don't have a self management module in their EMR, CPWNY will develop a web-based registry reporting system to document care management activities.										
Task Step 3… The current CMP system does not identify cardiac patients who specifically receive insurance through Medicaid. CMP will develop stratified reports by Medicaid managed care payers using both EMR and claims data to track patients utilization and engagement. A key to this process will be to identify patients who have not accessed a primary care provider as well as patients who are receiving majority of their medical care from a non primary care provider. Note CPWNY PPS will use CMP's existing registry reporting system for practices whose EMR is not currently integrated in Crimson system. This system is been used for CMS ACO reporting.										
Task Step 4... Current CMP providers who have implemented an EMR but not submitting EMR data into the Crimson Population Health Management System will be engaged and their EMR vendor will be asked to interface their EMR system with the Crimson										

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Population Health Management System.										
Task Step 5...Create data dictionary of registry elements										
Task Step 6…Practices will Create and maintain patient registries for cardiac conditions from practice EMRs to track engaged patients.										
Task Step 7…Monitor and educate to improve data getting into the EMR via queryable fields to include interventions and patient engagement.										
Task Step 8…Data quality check and robust data aggregation /reporting. (This action is ongoing)										
Task Step 9…Data analytics function in place										
Task Step 10…Appropriate clinical oversight /review in place										
Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).										
Task PPS has implemented an automated scheduling system to facilitate tobacco control protocols.										
Task PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.										
Task Step 1… Assess practice EMR documentation templates for inclusion of tobacco use screening and intervention										
Task Step 2… The EMR systems being utilized by the majority of CPWNY's partners have tobacco prompt modules. The EMR prompts the treating provider to assess whether the patient is a current smoker or has been a smoker in the past. This allows the provider to assess the patient's current smoking status and risk of recidivism. Following the assessment provider will assist the patient through referral to the "Opt to Quit" program in use in Roswell Park Cancer Institute. CPWNY will address any gaps in tobacco prompt.										
Task Step 3 Develop and deploy standard templates for providers identified in gap analysis to support evidence based guidelines and protocols, including 5 As for tobacco cessation.										

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Task Step 4. Develop training for CPWNY practitioners and staff on tobacco control 5 As via web based tool with attestation										
Task Step 5. CPWNY will assess smoking cessation efforts on a periodic basis and compare to baseline data on smoking. Results will be communicated through reports and improvements will be made using Rapid Cycle improvement and Change Management strategy. (this action will be ongoing)										
Task Step 6. CPWNY, in collaboration with Roswell Park Cancer Institute, will provide periodic training and educational materials on tobacco control to both patient and PPS partners. (This action will be ongoing)										
Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.										
Task Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).										
Task Step 1… Catholic Medical Partners, will identify and adopt nationally recognized standards for hypertension and elevated cholesterol treatments protocols, such as ICSI guidelines. These ICSI guidelines utilizied are the most recent version and are consistent in application with the ACC /AHA guidelines and JNC8 (as reviewed by a board certified cardiologist in our network).Our current system monitors blood pressure, LDL levels, medication lists and adherence, and beta blockers.										
Task Step 2…Assess practice adoption of evidence based guidelines for Hypertension and elevated cholesterol.										
Task Step 3 .. Implement the treatment protocol in all PCMH practices and cardiology practices.										
Task Step 4 .. CPWNY will assess practice adoption of these standard protocols and monitor performance on quarterly basis. (This action will be ongoing)										
Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues,										

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and patient self-efficacy and confidence in self-management.										
Task Clinically Interoperable System is in place for all participating providers.										
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.										
Task Care coordination processes are in place.										
Task Step 1… Assess CPWNY member practices for current "care coordination teams", policies and documented workflows										
Task Step 2… Compile findings for "Gap Analysis". Develop staffing and work plan for practices to have access to nurse care coordinators, clinical pharmacists, social workers, community health workers and registered dieticians										
Task Step 3... Leverage and adopt CPWNY's existing care management models, NCQA PCMH standards for care coordination, job descriptions, training, practice processes/workflows in practices without Care Coordination at the time of the assessment										
Task Step 4... Assess EMR documentation templates for patient care coordination assessments that include project elements										
Task Step 5 Develop and deliver via web based resources training for CPWNY care coordinators with attestation for completion (this action will be ongoing)										
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.										
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	0	10	35	60	85	110	135	160	185	210
Task Step 1… Assess current policy for MCOs with office visit co-pays for BP checks										
Task Step 2 Assess gaps in CPWNY practice capability and policy for "open access" for BP checks										

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Task Step 3... Implement "open access" scheduling using IHI's open access scheduling model. CPWNY will use physician champions to engage the providers in understanding the importance of BP control in achieving DSRIP milestones for the cardiac project and how this relates to value based purchasing.										
Task Step 4... It is our understanding that Medicaid patients do not have any co-payment for blood pressure checks. In case there is copayment, CPWNY will work with MCOs in eliminating any financial barriers for Medicaid patients to monitor blood pressure.										
Task Step 5... Clinical Transformation staff to support practices with EMR system changes to support waiving copay for BP check office visit and schedule modifications to standardize "open access" for BP check. Ability to generate reports on BP checks.										
Task Step 6... Develop and deliver via web based resources training for CPWNY staff and practitioners with attestation for completion										
Task Step 7 CPWNY will assess the effectiveness of training, the implementation of the policy and monitor performance periodically. (This action will be ongoing)										
Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.										
Task PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.										
Task Step 1…The Cardiac project team will research the existing best practices on BP monitoring and equipment.										
Task Step 2…The Cardiac project team will identify gaps in current protocols on BP monitoring.										
Task Step 3…Develop and provide broad web based training on proper BP measurement technique with attestation at practice level for participation										
Task Step 4…Assess practice staff proficiency with proper BP measurement technique through practice based clinical skills competency assessment.										

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Task Step 5…CPWNY will delegate to each practice to ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment. Practices will attest to proficiency of their staff in monitoring BP.										
Task Step 6... Staff proficiency of BP monitoring will be assessed periodically to ensure correct measurement and techniques. (This action will be ongoing.)										
Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.										
Task PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.										
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.										
Task PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.										
Task Step 1…Assess practice EMR capability to track BP readings over time										
Task Step 2…Clinical transformation team along with healthcare analysts will assist the practices to identify the patients who are potentially un-diagnosed for hypertension.										
Task Step 3…Communicate and promote standard evidence based guideline protocol including additional work up for repeated elevated BP via website										
Task Step 4.... CPWNY will assist the practices in setting up EMR reminders to prompt proper coding and timely follow-up on patients with repeated elevated BP.										
Task Step 5... CPWNY will work with our population health management system to send messages to providers who have patients with elevated blood pressure without a proper ICD code. CPWNY will also monitor coding to ensure all patients with chronic cardiac conditions continue to be coded properly.										

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Task Step 6... Develop and deliver ongoing training via web based resources for CPWNY staff and practitioners with attestation for completion.										
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.										
Task PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.										
Task Step 1…CPWNY will work with health plans to develop a preferred formulary of medications that have once-daily regimens or fixed dose combinations pills.										
Task Step 2…Develop and communicate current list of once daily hypertension medications to practices, prioritizing practices with Medicaid cardiac patients.										
Task Step 3... Assess CPWNY member practices for standard policy and workflow for medication review, amend or implement medication review policy and a process to include once daily medications to improve adherence										
Task Step 4…Work with MCOs to provide practice specific reports of patients not on once-daily regimens or fixed dose combination pills, review annually.										
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.										
Task Self-management goals are documented in the clinical record.										
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.										
Task Step 1…Assess CPWNY member practices for current policy and process for documenting patient engagement in self management of diet exercise, smoking, and medication adherence.										
Task Step 2…Compile findings for "Gap Analysis" and develop work plan to implement a standard workflow and documentation										

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standards for patient centric self management goals related to their cardiovascular condition										
Task Step 3... CPWNY's PPS network has experience with meeting NCQA PCMH standards. Currently 70% of our practices are NCQA recognized. In order to meet these standards providers must work with patients to develop patient-driven self management goals and document review at relevant visits. We will use our continued recognition as evidence of appropriate documentation and use of patient self management goals. These reviews are done according to NCQA standards and policies. We will work with our non-PCMH partners to achieve level 3 recognition.										
Task Step 4…CPWNY's mobile care transformation team will meet with practices to review their adherence to the guidelines and to the documentation requirements to patient driven self-management goals. Care transformation team will provide training, practice processes/workflows in practices as needed.										
Task Step 5... The care transformation team will develop and deliver via web based resources training for CPWNY staff and practitioners with attestation for training completion. (this action will be ongoing)										
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task PPS provides periodic training to staff on warm referral and follow-up process.										
Task Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.										
Task Step 1…CPWNY project management office has developed referral agreements between primary care physicians and behavioral health agencies, the health home. Existing agreement and policy will be expanded to other PPS partners and other community agencies including but not limited to Catholic										

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Charities, the Urban League, and hospice/palliative care. CPWNY will monitor referrals from CPWNY providers to these organizations.										
Task Step 2…Assess CPWNY member practice policies and processes for tracking and follow up on BH, Wellness/Health Promotion referrals										
Task Step 3.. Compile findings for "Gap Analysis" and develop work plan to ensure practices have implemented a standard workflow for tracking and follow up on BH, Wellness/Health Promotion referrals										
Task Step 4… CPWNY will identify and educate the practices on available community based programs. Resources will also be posted on CPWNY's website. CPWNY will use regional meeting with providers to provide training and education about available community programs and strategies for follow up and documentation.										
Task Step 5…CPWNY will engage PCMH and cardiology practices in encouraging their patients to use community resources available to improve patient self management behaviors including Wegman's for diet, health plans' exercise an yoga programs, "feeling fit" programs, and The New York State Smokers Quitline's "Opt to Quit" program for smoking cessation.										
Task Step 6… On annual basis CPWNY will conduct PPS-wide survey to all practices and a sample of patients to assess satisfaction with community based programs. The survey will assess access to care, ease of referral and reporting.										
Task Step 7… Patient tracking and follow-up will be accomplished through the RHIO secure email system, Mirth Mail, which allows for secure exchange of patient information between the CBOs and providers.										
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.										
Task PPS has developed and implemented protocols for home blood pressure monitoring.										
Task PPS provides follow up to support to patients with ongoing blood										

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pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.										
Task PPS provides periodic training to staff on warm referral and follow-up process.										
Task Step 1… CPWNY will develop policy for home BP monitoring for patients with chronic cardiac diseases and other chronic conditions with cardiac complications to actively engage them in self management skills. The policy will include patient educational materials on the importance of regular BP monitoring and information about available community resources.										
Task Step 2… CPWNY will assess health plan policies for the provision of home BP monitoring equipment. CPWNY will follow-up with support and processes for adopting protocols which include home blood pressure monitoring as a component of self management.										
Task Step 3… Compile findings, develop "Gap Analysis" and work plan for member practices to adopt protocols including promoting home blood pressure monitoring										
Task Step 4... Communicate and promote evidence based guideline protocol including home monitoring of BP										
Task Step 5... Develop and deliver training resources via printed material and web based resources for training CPWNY staff and practitioners with attestation for completion. The training will focus on helping the practices to teach patients to perform home BP monitoring. CPWNY will work with local pharmacies to promote patient engagement with home BP monitoring.										
Task Step 6… CPWNY will encourage patients to self-report BP to their providers. CPWNY will periodically monitor performance. (this action is ongoing)										
Task Step 7... Work with health plan to improve the approval process for getting home BP monitoring equipment.										
Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.										
Task PPS has implemented an automated scheduling system to										

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facilitate scheduling of targeted hypertension patients.										
Task Step 1…Currently the project management office, Catholic Medical Partners, maintains a information technology warehouse that analyzes claims data and EMR data to measure access to care and gaps in care. CMP has a disease specific methodology for identifying high risk patients including patients with cardiac conditions who are not receiving recommended follow-up visits. CPWNY will leverage existing capabilities to assist practices to identify patients with hypertension who have not had a recent visit and schedule a follow up.										
Task Step 2…Practices will Create and maintain patient registries to identify patients with hypertension who have not had a recent visit from practice EMR to o support population health management and individual patient outreach to reduce "Gaps in Care" with an annual office visit.										
Task Step 3… CPWNY will utilize the mobile clinical transformation and care management teams to communicate to practices the disease specific methodology for identifying registries of patients with hypertension who have not had recent visits and schedule follow-up visits. The project management office will roll out this methodology to the remaining PPS partners not currently addressed by existing teams.										
Task Step 4… CPWNY will use Health Home and community health workers to do outreach to patients who cannot be contacted by the practice.										
Task Step 5… Leverage CPWNY's existing clinical transformation and care management staff to coach and mentor CPWNY member practices on patient outreach/campaigns to close "Gaps in Care"										
Task Step 6… CPWNY will produce periodic reports, and track and trend practice improvements in scheduling visits for patients with hypertension. (This action is ongoing)										
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.										
Task PPS has developed referral and follow-up process and adheres to process.										

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Task Step 1… CPWNY PPS is implementing a smoking cessation program with Roswell Park Cancer Institute. This includes provider education on access to smoking cessation programs as well as educational material for patients. The NYS Smoker's Quitline, housed at Roswell Park Cancer Institute, has an established electronic referral system that enables PPS physicians to make referrals to the Quitline's "Opt to Quit" smoking cessation program. For practices currently without any EMRs, referrals can be made to the Quitline's "Fax to Quit" program.										
Task Step 2… Assess CPWNY member practices for standard policy and workflow, including "warm transfer" at the time of screening for patients for use of tobacco and referral to the NYS smoker's Quitline										
Task Step 3…Promote standard evidence based guidelines for the diagnosis and treatment of cardiovascular disease with tobacco screening and cessation support via CPWNY website										
Task Step 4… The community needs assessment estimated about 26% of the WNY Medicaid population are tobacco users. The PPS will conduct periodic reviews of population health data to determine if the prevalence of tobacco users is declining. (this action is ongoing)										
Task Step 5… CPWNY will produce periodic reports, measure patient improvement, and conduct follow-ups based on tracking data from Roswell Park's "Opt to Quit" and "Fax to Quit" programs. (This action is ongoing)										
Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.										
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.										
Task If applicable, PPS has established linkages to health homes for targeted patient populations.										

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Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.										
Task Step 1…Catholic Medical Partners is currently using the Massachusetts General Chronic Care Management evidence-based approach to intervene with patients with the greatest burden of illness and highest risk for institutional care. Our identification system use HCC (Hierarchical Clinical Conditions) methodology to identify "hot spot" patients who need extra clinical care and services.										
Task Step 2…The Catholic Medical Partners analytic team produces list of patients who's HCC score is higher than 1.1 on a semi annual basis. The PMO assists the practices to create registries for each primary care practice to monitor the care and treatment of this high risk population on a periodic basis. This includes referral to the Health Home. The PMO also has implemented group visits in specific practices that are provided by physician, pharmacist, and nutritionist. CPWNY will expand this model to the other PPS partners.										
Task Step 3… Assess CPWNY member practices current policy and standard process for identifying "high risk" patients, those who would benefit from a group visit or peer lead chronic condition management group visits to improve adherence to treatment plans, improve self management confidence and conviction										
Task Step 4… Compile findings and develop a "Gap Analysis" and work plan with time frames and accountable party identified to increase identification of "high risk patients" and refer to Health Home, group visits and peer lead chronic condition management group visits among CPWNY partners										
Task Step 5... Develop and deliver results of the "hot-spotting" analysis via web based resources training for CPWNY staff and practitioners with attestation for completion										
Task Step 6…CPWNY will conduct periodic review to monitor the effectiveness of implementing the HCC-based care management model. (this action is ongoing)										
Milestone #18 Adopt strategies from the Million Hearts Campaign.										

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Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	10	35	60	85	110	135	160	185	210
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	5	25	45	65	85	105	125	145	165
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	0	5	10	15	20	25	30	35	40
Task Step 1…The Million Hearts Campaign focus on reducing acute Myocardial Infarction by 1 million. The PMO's current care management program for patients at risk for cardiac disease follows the ICSI guidelines and are consistent with the Million Hearts guidelines. The PMO will further align the guidelines and policies for current programs to the Million Hearts Campaign.										
Task Step 2… Assess current clinical processes within CPWNY primary care practices and cardiology practices for promotion of heart healthy lifestyle including diet and exercise, BP and cholesterol level screenings and management, prescribing of aspirin per evidence based guideline, tobacco use screening and support/referral for cessation.										
Task Step 3…Compile findings and develop a "Gap Analysis" using evidence based guidelines for diagnosis and management of cardiovascular diseases. Develop a work plan to close the gaps.										
Task Step 4…The PMO will integrate performance reporting on strategies from the Million Hearts Campaign into the Crimson Population Health Care Management module (in development by the PMO) that will be used by practice-based clinical staff to promote value based care and treatment.										
Task Step 5... Develop and make available training materials via web based resources with attestation of completion.										
Task Step 6… CPWNY will conduct periodic review and monitor the effectiveness of implementing the ICSI guidelines and Million Hearts Campaign for primary care and cardiology practices. (This action will be ongoing)										

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Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.										
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.										
Task Step 1…Compile list of contacts per MCO to understand current programs and initiatives to improve early cardiovascular disease identification and management; including BP and cholesterol screening, tobacco use screening and referral for cessation support. The PPS project management office, Catholic Medical Partners, currently has Medicaid risk contracts (with Value Based Payment metrics) with 3 payers and is working to develop risk contracts with 2 additional health plans. This would include the majority of Medicaid population attributed to CPWNY. Please note that Catholic Medical Partners project management team has had Value Based contracts based on successful collaborative relationships with local health plans for over the past 10 years.										
Task Step 2…Meet with MCO decision makers to develop a standard community collaborative approach. Review MCO agreements to confirm they support coordination of services.										
Task Step 3…The PMO will continue to work with the health plans in order to receive timely information from paid claims and to use the data elements included in the claims payment abstracts to identify patients at risk for cardiovascular disease and to assess patient and practice compliance with clinical protocols of care. (This action will be ongoing)										
Task Step 4…Currently claims data is been entered into Milliman MedInsight system. In the future this data will be integrated with EMR data in Crimson population health system. The PMO's currently Medicaid managed health plans are in full agreement with this approach and are the foundation of our sustainability model.										
Task Step 5…The PMO will work with Medicaid managed care organizations to utilize the centralized care and case										

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management services provided the health plans. The Medicaid managed care organizations will increasingly hold the PPS accountable for de-centralized care management for the populations of patients at risk for cardiovascular diseases.										
Task Step 6... Document defined process and agreements and communicate broadly among CPWNY practices and MCO staff.										
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.										
Task PPS has engaged at least 80% of their PCPs in this activity.	0	10	35	60	85	110	135	160	185	210
Task Step 1… Assess current status of CPWNY practices for diagnosis and management of cardiovascular disease per DSRIP project requirements.										
Task Step 2…Currently Catholic Medical Partners is accredited by the national NCQA as an Accountable Care Organization, and has previously accredited by NCQA for disease management. The PMO strategy for provider engagement is based upon supporting the clinical practices and providing the infrastructure, clinical staff, and quality and utilization data to assist the clinical practices. In addition, the PMO provides financial incentives and uses a team of physician champions as role models for practice transformation. The PMO will expand the current effort to the other PPS partners.										
Task Step 3… Currently, more than half of CPWNY's primary care providers are actively engaged in the PMO's care management program. CPWNY will develop a plan to expand the care management program for cardiac patients to the other PPS partners.										
Task Step 4… Develop a practice specific work plan to target practices with gaps in people, process or technology. Leverage Clinical Transformation, Care Management staff and the CPWNY Medical Director to drive change/improvement at the practice level.										
Task Step 5… Measure and report practice level progress semi annually to the Clinical Governance Committee and Executive Governing Board of CPWNY. (This action is ongoing)										

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Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task Step 1…Assess practice adoption of evidence based guidelines with protocols for cardiovascular conditions including elevated cholesterol, Coronary Artery Disease, Congestive Heart Failure and Hypertension. Catholic Medical Partners, currently uses evidence based guidelines in consistent with nationally recognized ICSI Standard for assessment. The current ICSI standard has the following patient engagement requirements: smoking cessation, diet exercise medication adherence, and assessment of underlining risk factors such as depression. Currently 70% of the PPS's primary care practices have adopted the ICSI standard reporting guidelines and are receiving reports on successful implementation. We will use regional partner meetings to educate additional practices on the ICSI standards. These ICSI guidelines utilizied are the most recent version and are consistent in application with the ACC /AHA guidelines and JNC8 (as reviewed by a board certified cardiologist in our network).										
Task Step 2…Clinical transformation team and care management team will engage practices in cardiovascular risk reduction by emphasizing value based payment for success and our health plan contracts as well as for overall physician performance in the emerging value based payment world. PPS will expand the reporting/monitoring to other PPS partners.										
Task Step 3… Existing clinical transformation team will work with practices to develop/implement point of care reminders (clinical decision support) in alignment with evidence based guidelines determined by the clinical governance committee. Reminder system will be evaluated based on Hedeis and other quality measure.										
Task Step 4…Clinical Governance Committee to implement standard evidence based guidelines for cardiovascular disease including CAD, elevated cholesterol, CHF and hypertension										

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Task Step 5... Communicate and promote standard evidence based guidelines for cardiovascular conditions via website with annual review. (This action will be ongoing)										
Task Step 6... Create and distribute patient education materials that promote healthy lifestyle practices and behaviors to reduce cardiovascular risks.										
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	30	53	53	53	53	53	53	53	53	53
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	35	69	69	69	69	69	69	69	69	69
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	25	34	34	34	34	34	34	34	34	34
Task PPS uses alerts and secure messaging functionality.										
Task Step 1. CPWNY and Millennium PPS working together to perform IT assessment of partners to include:										
Task a. Use of EMR, HIE and other information systems; b. data sharing capabilities; c readiness for connection to QE (RHIOs/HIE; Performance reporting capabilities and modalities; dashboard and platforms for patient generated data; future plans for IT integration; use of data security and confidentiality plans										
Task b. Share results of readiness survey with PPS partners										
Task c. Map future state needs from Project Implementation plan to readiness assessment to identify gaps. Road map of future needs will be a requirement in the current state assessment and gap analysis engagement.										
Task d. Update and approve IT Project Implementation plan										
Task e. Evaluate current RHIO capabilities to fill identified gaps.										

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HEALTHeLINK will be integrally involved in the current state assessment and gap analysis.										
Task Step 2…Create inventory of Safety Net and non-Safety Net providers are signed on to HEALTHeLINK, whether they send complete CCD after encounter, whether they send/receive via HISP, whether they can do virtual record lookup. Determine the EMRs they are using.										
Task Step 3…Roll out of partner agreements that stipulate the sharing of health information and use of the RHIO										
Task Step 4…In addition to agreements, HEALTHeLINK will be purchasing 500 authentication tokens for PPS practices that will make authentication for access to the RHIO information easier and free of cost to the partner. This will enable providers to access information securely and easily. CPWNY PPS and Millennium Collaborative Care PPS are working collaboratively with HEALTHeLINK to ensure that all safety net provider are able to communicate with HEALTHeLINK and all HEALTHeLINK providers through the use of secure email. HEALTHeLINK is currently using MIRTH mail technology.										
Task Step 5…HEALTHeLINK will provide a community-wide patient event notification service that keys on multiple event types and is configurable at the practice/provider level. HEALTHeLINK is working with CPWNY PPS and Millennium Collaborative Care PPS to develop a notification system for all hospital admissions/ discharges and transfers, as well as results delivery.										
Task Step 6…Build a directory that contains the DIRECT address of providers and practices across the community . This would facilitate the direct exchange of patient information between healthcare settings and would be readily accessible by any provider/user										
Task Step 7…Data exchange solution that enables Omni-directional communication between care providers and patients: a. Roll-out of patient portal to PPS partners without EMR= DY 1,Q 4; Roll-out to other PPS partners= DY 2, Q 4; Integrate MobileMD with RHIO (HEALTHeLINK) = DY 1, Q4; Integrate MobileMD with PPS EMR , first PPS EMR = DY2, Q4; Integrate with all other PPS EMRs such as behavioral health, Skilled Nursing Facilities, home care= DY 3, Q4 (NOTE: MobileMD is an HIE that provides										

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comprehensive data exchange solutions and will be directly integrated with the community-wide HEALTHeLINK RHIO/SHIN-NY).										
Task Step...8 Catholic Medical Partners, currently has implemented a clinical integration program aligned with population health and value based purchasing. Catholic Medical Partners will continue to educate and engage PPS partners to develop clinical processes that drive clinical and financial results. This clinical model and its business model will be used to sustain the DSRIP initiatives to support the successful completion of the DSRIP grant. (This action will be ongoing)										
Task Step... 9 Catholic Medical Partners, currently uses utilization and quality reports that are developed from the Milliman MedInsight program and is developing a population health clinical and business intelligence system using Crimson Management system that highlights utilization and quality against best practices and has a specific care management program that will be used by the PCMH practices to focus on interventions on patient's quality of care.										
Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	235	399	399	399	399	399	399	399	399	399
Task Step 1... Analyze current status of EMR systems used, the status of Meaningful Use (AUI, Stage 1, Stage 2, or none), and status of PCMH (Level 3, 2, 1, in process, or none) by participating provider practices. Create a work plan and timelines for getting practices not yet at PCMH Level 3 and MU to achieve them both by end of DY3.										
Task Step 2... Assign each PCP practice a Clinical Transformation Specialist to work with them and be their point of contact on EMR, MU, PCMH, and Population Health/Quality Outcome Measures. Need to hire additional personnel to take on additional practices and workload. Roll out will be in phases										

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starting with those practices with the largest volume of Medicaid patients.										
Task Step 3... Understand EMR system capabilities and if they have the ability to meet MU/PCMH for those who are not currently there. If there are gaps in capabilities create a work plan and timeline for working with the vendor or possibly transitioning some practices to more "ready" vendors(those practices that need to transition to more " ready" vendors will need more time and will not be completed until DY 3, Q4)										
Task Step 4… Have 100% of practices on EMR systems that enable them to meet MU and PCMH										
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1…Currently 70% of CPWNY PPS providers have a CCHIT-certified EMR, are using EMR prompts and reminders to identify gaps in care for cardiac related diseases. They are also receiving results delivery and ADTs on diagnostic testing and will use this technology for notification on admission, discharges, and transfers. Over 50% of the current CPWNY PPS providers are submitting EMR data to CMP and this data is been integrated into CMP's population health management system's cardiac module that will produce reports on patient utilization, quality, gaps in care, and engagement. CPWNY will assess the remaining PPS providers who are not currently reporting electronically.										
Task Step 2…For identified practices who don't have a self management module in their EMR, CPWNY will develop a web-based registry reporting system to document care management activities.										
Task Step 3… The current CMP system does not identify cardiac patients who specifically receive insurance through Medicaid. CMP will develop stratified reports by Medicaid managed care payers using both EMR and claims data to track patients utilization and engagement. A key to this process will be to identify patients who have not accessed a primary care provider										

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as well as patients who are receiving majority of their medical care from a non primary care provider. Note CPWNY PPS will use CMP's existing registry reporting system for practices whose EMR is not currently integrated in Crimson system. This system is been used for CMS ACO reporting.										
Task Step 4... Current CMP providers who have implemented an EMR but not submitting EMR data into the Crimson Population Health Management System will be engaged and their EMR vendor will be asked to interface their EMR system with the Crimson Population Health Management System.										
Task Step 5...Create data dictionary of registry elements										
Task Step 6…Practices will Create and maintain patient registries for cardiac conditions from practice EMRs to track engaged patients.										
Task Step 7…Monitor and educate to improve data getting into the EMR via queryable fields to include interventions and patient engagement.										
Task Step 8…Data quality check and robust data aggregation /reporting. (This action is ongoing)										
Task Step 9…Data analytics function in place										
Task Step 10…Appropriate clinical oversight /review in place										
Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).										
Task PPS has implemented an automated scheduling system to facilitate tobacco control protocols.										
Task PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.										
Task Step 1… Assess practice EMR documentation templates for inclusion of tobacco use screening and intervention										
Task Step 2… The EMR systems being utilized by the majority of CPWNY's partners have tobacco prompt modules. The EMR prompts the treating provider to assess whether the patient is a										

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current smoker or has been a smoker in the past. This allows the provider to assess the patient's current smoking status and risk of recidivism. Following the assessment provider will assist the patient through referral to the "Opt to Quit" program in use in Roswell Park Cancer Institute. CPWNY will address any gaps in tobacco prompt.										
Task Step 3 Develop and deploy standard templates for providers identified in gap analysis to support evidence based guidelines and protocols, including 5 As for tobacco cessation.										
Task Step 4. Develop training for CPWNY practitioners and staff on tobacco control 5 As via web based tool with attestation										
Task Step 5. CPWNY will assess smoking cessation efforts on a periodic basis and compare to baseline data on smoking. Results will be communicated through reports and improvements will be made using Rapid Cycle improvement and Change Management strategy. (this action will be ongoing)										
Task Step 6. CPWNY, in collaboration with Roswell Park Cancer Institute, will provide periodic training and educational materials on tobacco control to both patient and PPS partners. (This action will be ongoing)										
Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.										
Task Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).										
Task Step 1… Catholic Medical Partners, will identify and adopt nationally recognized standards for hypertension and elevated cholesterol treatments protocols, such as ICSI guidelines. These ICSI guidelines utilizied are the most recent version and are consistent in application with the ACC /AHA guidelines and JNC8 (as reviewed by a board certified cardiologist in our network).Our current system monitors blood pressure, LDL levels, medication lists and adherence, and beta blockers.										
Task Step 2…Assess practice adoption of evidence based guidelines for Hypertension and elevated cholesterol.										
Task										

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Step 3 .. Implement the treatment protocol in all PCMH practices and cardiology practices.										
Task Step 4 .. CPWNY will assess practice adoption of these standard protocols and monitor performance on quarterly basis. (This action will be ongoing)										
Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.										
Task Clinically Interoperable System is in place for all participating providers.										
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.										
Task Care coordination processes are in place.										
Task Step 1… Assess CPWNY member practices for current "care coordination teams", policies and documented workflows										
Task Step 2… Compile findings for "Gap Analysis". Develop staffing and work plan for practices to have access to nurse care coordinators, clinical pharmacists, social workers, community health workers and registered dieticians										
Task Step 3... Leverage and adopt CPWNY's existing care management models, NCQA PCMH standards for care coordination, job descriptions, training, practice processes/workflows in practices without Care Coordination at the time of the assessment										
Task Step 4... Assess EMR documentation templates for patient care coordination assessments that include project elements										
Task Step 5 Develop and deliver via web based resources training for CPWNY care coordinators with attestation for completion (this action will be ongoing)										
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.										

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Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	235	399	399	399	399	399	399	399	399	399
Task Step 1… Assess current policy for MCOs with office visit co-pays for BP checks										
Task Step 2 Assess gaps in CPWNY practice capability and policy for "open access" for BP checks										
Task Step 3... Implement "open access" scheduling using IHI's open access scheduling model. CPWNY will use physician champions to engage the providers in understanding the importance of BP control in achieving DSRIP milestones for the cardiac project and how this relates to value based purchasing.										
Task Step 4... It is our understanding that Medicaid patients do not have any co-payment for blood pressure checks. In case there is copayment, CPWNY will work with MCOs in eliminating any financial barriers for Medicaid patients to monitor blood pressure.										
Task Step 5... Clinical Transformation staff to support practices with EMR system changes to support waiving copay for BP check office visit and schedule modifications to standardize "open access" for BP check. Ability to generate reports on BP checks.										
Task Step 6... Develop and deliver via web based resources training for CPWNY staff and practitioners with attestation for completion										
Task Step 7 CPWNY will assess the effectiveness of training, the implementation of the policy and monitor performance periodically. (This action will be ongoing)										
Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.										
Task PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.										
Task Step 1…The Cardiac project team will research the existing best practices on BP monitoring and equipment.										
Task Step 2…The Cardiac project team will identify gaps in current										

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protocols on BP monitoring.										
Task Step 3…Develop and provide broad web based training on proper BP measurement technique with attestation at practice level for participation										
Task Step 4…Assess practice staff proficiency with proper BP measurement technique through practice based clinical skills competency assessment.										
Task Step 5…CPWNY will delegate to each practice to ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment. Practices will attest to proficiency of their staff in monitoring BP.										
Task Step 6... Staff proficiency of BP monitoring will be assessed periodically to ensure correct measurement and techniques. (This action will be ongoing.)										
Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.										
Task PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.										
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.										
Task PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.										
Task Step 1…Assess practice EMR capability to track BP readings over time										
Task Step 2…Clinical transformation team along with healthcare analysts will assist the practices to identify the patients who are potentially un-diagnosed for hypertension.										
Task Step 3…Communicate and promote standard evidence based guideline protocol including additional work up for repeated elevated BP via website										

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Task Step 4.... CPWNY will assist the practices in setting up EMR reminders to prompt proper coding and timely follow-up on patients with repeated elevated BP.										
Task Step 5... CPWNY will work with our population health management system to send messages to providers who have patients with elevated blood pressure without a proper ICD code. CPWNY will also monitor coding to ensure all patients with chronic cardiac conditions continue to be coded properly.										
Task Step 6... Develop and deliver ongoing training via web based resources for CPWNY staff and practitioners with attestation for completion.										
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.										
Task PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.										
Task Step 1…CPWNY will work with health plans to develop a preferred formulary of medications that have once-daily regimens or fixed dose combinations pills.										
Task Step 2…Develop and communicate current list of once daily hypertension medications to practices, prioritizing practices with Medicaid cardiac patients.										
Task Step 3... Assess CPWNY member practices for standard policy and workflow for medication review, amend or implement medication review policy and a process to include once daily medications to improve adherence										
Task Step 4…Work with MCOs to provide practice specific reports of patients not on once-daily regimens or fixed dose combination pills, review annually.										
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.										
Task Self-management goals are documented in the clinical record.										

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Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.										
Task Step 1…Assess CPWNY member practices for current policy and process for documenting patient engagement in self management of diet exercise, smoking, and medication adherence.										
Task Step 2…Compile findings for "Gap Analysis" and develop work plan to implement a standard workflow and documentation standards for patient centric self management goals related to their cardiovascular condition										
Task Step 3... CPWNY's PPS network has experience with meeting NCQA PCMH standards. Currently 70% of our practices are NCQA recognized. In order to meet these standards providers must work with patients to develop patient-driven self management goals and document review at relevant visits. We will use our continued recognition as evidence of appropriate documentation and use of patient self management goals. These reviews are done according to NCQA standards and policies. We will work with our non-PCMH partners to achieve level 3 recognition.										
Task Step 4…CPWNY's mobile care transformation team will meet with practices to review their adherence to the guidelines and to the documentation requirements to patient driven self-management goals. Care transformation team will provide training, practice processes/workflows in practices as needed.										
Task Step 5... The care transformation team will develop and deliver via web based resources training for CPWNY staff and practitioners with attestation for training completion. (this action will be ongoing)										
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task PPS provides periodic training to staff on warm referral and										

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follow-up process.										
Task Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.										
Task Step 1…CPWNY project management office has developed referral agreements between primary care physicians and behavioral health agencies, the health home. Existing agreement and policy will be expanded to other PPS partners and other community agencies including but not limited to Catholic Charities, the Urban League, and hospice/palliative care. CPWNY will monitor referrals from CPWNY providers to these organizations.										
Task Step 2…Assess CPWNY member practice policies and processes for tracking and follow up on BH, Wellness/Health Promotion referrals										
Task Step 3.. Compile findings for "Gap Analysis" and develop work plan to ensure practices have implemented a standard workflow for tracking and follow up on BH, Wellness/Health Promotion referrals										
Task Step 4… CPWNY will identify and educate the practices on available community based programs. Resources will also be posted on CPWNY's website. CPWNY will use regional meeting with providers to provide training and education about available community programs and strategies for follow up and documentation.										
Task Step 5…CPWNY will engage PCMH and cardiology practices in encouraging their patients to use community resources available to improve patient self management behaviors including Wegman's for diet, health plans' exercise an yoga programs, "feeling fit" programs, and The New York State Smokers Quitline's "Opt to Quit" program for smoking cessation.										
Task Step 6… On annual basis CPWNY will conduct PPS-wide survey to all practices and a sample of patients to assess satisfaction with community based programs. The survey will assess access to care, ease of referral and reporting.										

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Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Step 7… Patient tracking and follow-up will be accomplished through the RHIO secure email system, Mirth Mail, which allows for secure exchange of patient information between the CBOs and providers.										
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.										
Task PPS has developed and implemented protocols for home blood pressure monitoring.										
Task PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.										
Task PPS provides periodic training to staff on warm referral and follow-up process.										
Task Step 1… CPWNY will develop policy for home BP monitoring for patients with chronic cardiac diseases and other chronic conditions with cardiac complications to actively engage them in self management skills. The policy will include patient educational materials on the importance of regular BP monitoring and information about available community resources.										
Task Step 2… CPWNY will assess health plan policies for the provision of home BP monitoring equipment. CPWNY will follow-up with support and processes for adopting protocols which include home blood pressure monitoring as a component of self management.										
Task Step 3… Compile findings, develop "Gap Analysis" and work plan for member practices to adopt protocols including promoting home blood pressure monitoring										
Task Step 4... Communicate and promote evidence based guideline protocol including home monitoring of BP										
Task Step 5... Develop and deliver training resources via printed material and web based resources for training CPWNY staff and practitioners with attestation for completion. The training will focus on helping the practices to teach patients to perform home BP monitoring. CPWNY will work with local pharmacies to										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
promote patient engagement with home BP monitoring.										
Task Step 6… CPWNY will encourage patients to self-report BP to their providers. CPWNY will periodically monitor performance. (this action is ongoing)										
Task Step 7... Work with health plan to improve the approval process for getting home BP monitoring equipment.										
Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.										
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.										
Task Step 1…Currently the project management office, Catholic Medical Partners, maintains a information technology warehouse that analyzes claims data and EMR data to measure access to care and gaps in care. CMP has a disease specific methodology for identifying high risk patients including patients with cardiac conditions who are not receiving recommended follow-up visits. CPWNY will leverage existing capabilities to assist practices to identify patients with hypertension who have not had a recent visit and schedule a follow up.										
Task Step 2…Practices will Create and maintain patient registries to identify patients with hypertension who have not had a recent visit from practice EMR to o support population health management and individual patient outreach to reduce "Gaps in Care" with an annual office visit.										
Task Step 3… CPWNY will utilize the mobile clinical transformation and care management teams to communicate to practices the disease specific methodology for identifying registries of patients with hypertension who have not had recent visits and schedule follow-up visits. The project management office will roll out this methodology to the remaining PPS partners not currently addressed by existing teams.										
Task Step 4… CPWNY will use Health Home and community health workers to do outreach to patients who cannot be contacted by the practice.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Step 5… Leverage CPWNY's existing clinical transformation and care management staff to coach and mentor CPWNY member practices on patient outreach/campaigns to close "Gaps in Care"										
Task Step 6… CPWNY will produce periodic reports, and track and trend practice improvements in scheduling visits for patients with hypertension. (This action is ongoing)										
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task Step 1… CPWNY PPS is implementing a smoking cessation program with Roswell Park Cancer Institute. This includes provider education on access to smoking cessation programs as well as educational material for patients. The NYS Smoker's Quitline, housed at Roswell Park Cancer Institute, has an established electronic referral system that enables PPS physicians to make referrals to the Quitline's "Opt to Quit" smoking cessation program. For practices currently without any EMRs, referrals can be made to the Quitline's "Fax to Quit" program.										
Task Step 2… Assess CPWNY member practices for standard policy and workflow, including "warm transfer" at the time of screening for patients for use of tobacco and referral to the NYS smoker's Quitline										
Task Step 3…Promote standard evidence based guidelines for the diagnosis and treatment of cardiovascular disease with tobacco screening and cessation support via CPWNY website										
Task Step 4… The community needs assessment estimated about 26% of the WNY Medicaid population are tobacco users. The PPS will conduct periodic reviews of population health data to determine if the prevalence of tobacco users is declining. (this action is ongoing)										
Task Step 5… CPWNY will produce periodic reports, measure patient improvement, and conduct follow-ups based on tracking data from Roswell Park's "Opt to Quit" and "Fax to Quit" programs. (This action is ongoing)										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.										
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.										
Task If applicable, PPS has established linkages to health homes for targeted patient populations.										
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.										
Task Step 1…Catholic Medical Partners is currently using the Massachusetts General Chronic Care Management evidence-based approach to intervene with patients with the greatest burden of illness and highest risk for institutional care. Our identification system use HCC (Hierarchical Clinical Conditions) methodology to identify "hot spot" patients who need extra clinical care and services.										
Task Step 2…The Catholic Medical Partners analytic team produces list of patients who's HCC score is higher than 1.1 on a semi annual basis. The PMO assists the practices to create registries for each primary care practice to monitor the care and treatment of this high risk population on a periodic basis. This includes referral to the Health Home. The PMO also has implemented group visits in specific practices that are provided by physician, pharmacist, and nutritionist. CPWNY will expand this model to the other PPS partners.										
Task Step 3… Assess CPWNY member practices current policy and standard process for identifying "high risk" patients, those who would benefit from a group visit or peer lead chronic condition management group visits to improve adherence to treatment plans, improve self management confidence and conviction										
Task Step 4… Compile findings and develop a "Gap Analysis" and work plan with time frames and accountable party identified to increase identification of "high risk patients" and refer to Health										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Home, group visits and peer lead chronic condition management group visits among CPWNY partners										
Task Step 5... Develop and deliver results of the "hot-spotting" analysis via web based resources training for CPWNY staff and practitioners with attestation for completion										
Task Step 6…CPWNY will conduct periodic review to monitor the effectiveness of implementing the HCC-based care management model. (this action is ongoing)										
Milestone #18 Adopt strategies from the Million Hearts Campaign.										
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	235	399	399	399	399	399	399	399	399	399
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	185	293	293	293	293	293	293	293	293	293
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	45	73	73	73	73	73	73	73	73	73
Task Step 1…The Million Hearts Campaign focus on reducing acute Myocardial Infarction by 1 million. The PMO's current care management program for patients at risk for cardiac disease follows the ICSI guidelines and are consistent with the Million Hearts guidelines. The PMO will further align the guidelines and policies for current programs to the Million Hearts Campaign.										
Task Step 2… Assess current clinical processes within CPWNY primary care practices and cardiology practices for promotion of heart healthy lifestyle including diet and exercise, BP and cholesterol level screenings and management, prescribing of aspirin per evidence based guideline, tobacco use screening and support/referral for cessation.										
Task Step 3…Compile findings and develop a "Gap Analysis" using evidence based guidelines for diagnosis and management of cardiovascular diseases. Develop a work plan to close the gaps.										
Task Step 4…The PMO will integrate performance reporting on										

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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
strategies from the Million Hearts Campaign into the Crimson Population Health Care Management module (in development by the PMO) that will be used by practice-based clinical staff to promote value based care and treatment.										
Task Step 5... Develop and make available training materials via web based resources with attestation of completion.										
Task Step 6… CPWNY will conduct periodic review and monitor the effectiveness of implementing the ICSI guidelines and Million Hearts Campaign for primary care and cardiology practices. (This action will be ongoing)										
Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.										
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.										
Task Step 1…Compile list of contacts per MCO to understand current programs and initiatives to improve early cardiovascular disease identification and management; including BP and cholesterol screening, tobacco use screening and referral for cessation support. The PPS project management office, Catholic Medical Partners, currently has Medicaid risk contracts (with Value Based Payment metrics) with 3 payers and is working to develop risk contracts with 2 additional health plans. This would include the majority of Medicaid population attributed to CPWNY. Please note that Catholic Medical Partners project management team has had Value Based contracts based on successful collaborative relationships with local health plans for over the past 10 years.										
Task Step 2…Meet with MCO decision makers to develop a standard community collaborative approach. Review MCO agreements to confirm they support coordination of services.										
Task Step 3…The PMO will continue to work with the health plans in order to receive timely information from paid claims and to use the data elements included in the claims payment abstracts to identify patients at risk for cardiovascular disease and to assess										

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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
patient and practice compliance with clinical protocols of care. (This action will be ongoing)										
Task Step 4…Currently claims data is been entered into Milliman MedInsight system. In the future this data will be integrated with EMR data in Crimson population health system. The PMO's currently Medicaid managed health plans are in full agreement with this approach and are the foundation of our sustainability model.										
Task Step 5…The PMO will work with Medicaid managed care organizations to utilize the centralized care and case management services provided the health plans. The Medicaid managed care organizations will increasingly hold the PPS accountable for de-centralized care management for the populations of patients at risk for cardiovascular diseases.										
Task Step 6... Document defined process and agreements and communicate broadly among CPWNY practices and MCO staff.										
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.										
Task PPS has engaged at least 80% of their PCPs in this activity.	235	399	399	399	399	399	399	399	399	399
Task Step 1… Assess current status of CPWNY practices for diagnosis and management of cardiovascular disease per DSRIP project requirements.										
Task Step 2…Currently Catholic Medical Partners is accredited by the national NCQA as an Accountable Care Organization, and has previously accredited by NCQA for disease management. The PMO strategy for provider engagement is based upon supporting the clinical practices and providing the infrastructure, clinical staff, and quality and utilization data to assist the clinical practices. In addition, the PMO provides financial incentives and uses a team of physician champions as role models for practice transformation. The PMO will expand the current effort to the other PPS partners.										
Task Step 3… Currently, more than half of CPWNY's primary care providers are actively engaged in the PMO's care management program. CPWNY will develop a plan to expand the care management program for cardiac patients to the other PPS										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
partners.										
Task Step 4… Develop a practice specific work plan to target practices with gaps in people, process or technology. Leverage Clinical Transformation, Care Management staff and the CPWNY Medical Director to drive change/improvement at the practice level.										
Task Step 5… Measure and report practice level progress semi annually to the Clinical Governance Committee and Executive Governing Board of CPWNY. (This action is ongoing)										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	
Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	
Use EHRs or other technical platforms to track all patients engaged in this project.	
Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	
Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	
Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	
Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	
Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	
Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	
Document patient driven self-management goals in the medical record and review with patients at each visit.	
Follow up with referrals to community based programs to document participation and behavioral and health status changes.	
Develop and implement protocols for home blood pressure monitoring with follow up support.	
Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	
Facilitate referrals to NYS Smoker's Quitline.	
Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	
Adopt strategies from the Million Hearts Campaign.	
Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	
Engage a majority (at least 80%) of primary care providers in this project.	

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Ongoing	
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Ongoing	
Milestone #9	Pass & Ongoing	
Milestone #10	Pass & Ongoing	
Milestone #11	Pass & Ongoing	
Milestone #12	Pass & Ongoing	
Milestone #13	Pass & Ongoing	
Milestone #14	Pass & Ongoing	
Milestone #15	Pass & Ongoing	
Milestone #16	Pass & Ongoing	
Milestone #17	Pass & Ongoing	
Milestone #18	Pass & Ongoing	
Milestone #19	Pass & Ongoing	
Milestone #20	Pass & Ongoing	

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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Project 3.f.i – Increase support programs for maternal & child health (including high risk pregnancies) (Example: Nurse-Family Partnership)

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

Instructions :

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

• Risk: Hiring staff and completing specific Nurse Family Partnership (NFP) training prior to project implementation. Without timely hiring and training, the program risks being understaffed and CPWNY will not meet patient engagement. Mitigation: CPWNY started the HR process of posting job descriptions and filling positions prior to the April 1st start date, hiring an administrative lead and project supervisor. CPWNY will contract with Nurse Family Partnership to use their resources while the program is developed internally. CPWNY will also look internally for nurses interested in participating in this program and obtaining NFP certification, which will eliminate hiring time as an obstacle. Once initial resources are in place, additional staff can be hired and trained as needed.

• Risk: Obtaining sufficient volume of referrals to the program. Referrals are necessary for the effectiveness and sustainability of the program. Mitigation: Referrals to the program requires communication with agencies that impact first time Medicaid moms. CPWNY has begun conversations with partner providers and community based organizations to drive referrals, including our own primary care centers, clinics, and faith-based organizations. Protocols will be developed and distributed to all CPWNY partners that define the specific target population targeted and how and where to refer them.

• Risk: Some providers may refuse to adopt new policies or engage with DSRIP goals. This could affect project performance and limit quality of care. Mitigation: CPWNY will educate physicians on the benefits of this program in connecting patients with resources outside of the healthcare system that impact compliance and patient health status that physicians may not otherwise have access to. As a federal Accountable Care Organization, Catholic Medical Partners has experience engaging physicians in PPS wide protocols through use of physician champions, performance incentives, providing resources, and remediation for providers who fail to perform. CPWNY will use these proven strategies to ensure participation and engagement. The executive governance board will review performance for potential remediation.

• Risk: Adequately identifying the target population. Without clear guidelines about the target population, providers may be unsure and unlikely to refer to the program. Mitigation: CPWNY will work with Nurse Family Partnership to develop guidelines for defining eligible high-risk mothers. CPWNY will develop protocols that define how to facilitate a formal referral and where to send patients for additional information. CPWNY will offer DSRIP resources to NFP to supplement existing referral and information services. CPWNY will prioritize providers and partner organizations that see high volumes of high-risk mothers, such as safety net clinics with OBGYN services, social service providers, or faith-based organizations.

• Risk: Some providers or organizations seeing CPWNY patients may not be formal partners of the PPS. This could create a problem for ensuring providers perform according to DSRIP goals and refer to CPWNY programs. Mitigation: In our region, there are two PPS provider networks: CPWNY and Millennium Collaborative Care (MCC). CPWNY will establish a mutual agreement with MCC to treat each other's patients according to DSRIP standards and host monthly meetings to discuss opportunities for collaboration and resource sharing. For providers and community organizations outside of either network, CPWNY will establish referral agreements to create a mutual benefit and encourage volume for respective programs. Patients who see providers outside of either network will be referred to internal care management resources to follow up on appropriate care, appointment attendance, and progress towards care plan milestones.

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

Instructions :

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

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

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
11	25	35.71%	45	8.33%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (70)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
dcao	Rosters	46_PMDL5015_1_3_20160126153103_CPWNY_Patient_List_for_3.f.i_NFP_DY1_Q3.xlsx.pdf	CPWNY patient list for project 3.f.i in DY1 Q3.	01/26/2016 03:31 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement an evidence-based home visitation model, such as the Nurse Family Partnership, for pregnant high- risk mothers including high-risk first time mothers.	Model 1	Project	N/A	In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task PPS has developed a project plan that includes a timeline for implementation of an evidence-based home visiting model, such as Nurse-Family Partnership visitation model, for this population.		Project		In Progress	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Step 1…Meet with representative from National Office of Nurse Family Partnership to determine needs and application requirements. NFP is a evidence-based prescribed step-by-step process, which anyone who implements must follow with high fidelity. Complete site visits, multiple communication and reviews of application before submitted. Obtain current application to complete.		Project		Completed	04/01/2015	04/01/2015	04/01/2015	04/01/2015	06/30/2015	DY1 Q1
Task Step 2… Engage providers such as OB/GYN and primary care through newsletter, face-to-face meetings, the community advisory board, and other maternal child coalitions that are already established in Erie and Chautauqua County. We presented the plan in OB/GYN meetings that reached more than 60 OB/GYN and primary care physicians.		Project		Completed	04/01/2015	04/01/2015	04/01/2015	04/01/2015	06/30/2015	DY1 Q1
Task Step 3….Establish relationships (through face-to-face meetings, national conferences, working with assigned mentor agency, etc.) with Chautauqua providers and CBOs		Project		Completed	04/01/2015	09/30/2015	04/01/2015	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	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
(such as United Way of Buffalo and Erie County, WIC, Jericho Road, Buffalo Prenatal Perinatal Network, etc.), as well as deepen relationships with providers and CBOs in Erie County, ensure support prior to implementation of model. CPWNY's partners such as Catholic Health Women Services has existing relationship with CBOs and community based programs for high risk mothers. CPWNY will leverage and expand existing relationships to notify about the NFP program and gain referrals. Note: this activity will be ongoing through DY5.										
Task Step 4….In partnership with Chautauqua County, who already has funding for education and travel expenses for their planned program, apply for NFP medallion.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 5….Develop HR Plan for recruitment of staff for program, particularly for Supervisor and Nurse Home Visitors to reflect population served		Project		Completed	04/01/2015	05/15/2015	04/01/2015	05/15/2015	06/30/2015	DY1 Q1
Task Step 6….Search for Program Coordinator/Administrator for program to lead implementation. SUBSTEPS in relation for step 6:		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task a. Hire Program Coordinator/Administrator		Project		Completed	04/01/2015	05/15/2015	04/01/2015	05/15/2015	06/30/2015	DY1 Q1
Task b. Train Program Coordinator/Administrator on NFP		Project		Completed	06/08/2015	06/30/2015	06/08/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 7….Search for Nurse Supervisor to lead nursing team in Chautauqua County. SUBSTEPS in relation to step 7:		Project		Completed	04/01/2015	07/17/2015	04/01/2015	07/17/2015	09/30/2015	DY1 Q2
Task a. Hire 1 Nurse Supervisor for Chautauqua team		Project		Completed	04/01/2015	06/22/2015	04/01/2015	06/22/2015	06/30/2015	DY1 Q1
Task b. Train 1 Nurse Supervisor on NFP		Project		Completed	04/01/2015	07/17/2015	04/01/2015	07/17/2015	09/30/2015	DY1 Q2
Task Step 8….Search for Nurse Home Visitors to join nursing team in Chautauqua County. SUBSTEPS in relation to step 8:		Project		Completed	04/01/2015	08/15/2015	04/01/2015	08/15/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task a. Hire 2 Nurse Home Visitors for Chautauqua team		Project		Completed	04/01/2015	07/27/2015	04/01/2015	07/27/2015	09/30/2015	DY1 Q2
Task b. Train 2 Nurse Home Visitors on NFP		Project		Completed	07/27/2015	08/14/2015	07/27/2015	08/14/2015	09/30/2015	DY1 Q2
Task Step 9….Search for 0.5 time data/administrative assistant to join team in Chautauqua County. SUBSTEPS in relation to step 9:		Project		Completed	06/01/2015	09/01/2015	06/01/2015	09/01/2015	09/30/2015	DY1 Q2
Task a. Hire 0.5 data/administrative assistant for Chautauqua team		Project		Completed	06/01/2015	09/01/2015	06/01/2015	09/01/2015	09/30/2015	DY1 Q2
Task b. Train 0.5 data/administrative assistant on NFP		Project		Completed	06/01/2015	09/01/2015	06/01/2015	09/01/2015	09/30/2015	DY1 Q2
Task Step 10….Begin Implementation of program in Chautauqua County in DY1 Q3 to achieve required enrollment objectives		Project		Completed	06/01/2015	09/01/2015	06/01/2015	09/01/2015	09/30/2015	DY1 Q2
Task Step 11….Search for Nurse Supervisor to lead nursing team in Erie County. SUBSTEPS in relation to step 11:		Project		In Progress	12/01/2015	02/01/2016	12/01/2015	07/30/2016	09/30/2016	DY2 Q2
Task a. Hire 1 Nurse Supervisor for Erie County team		Project		In Progress	12/01/2015	02/01/2016	12/01/2015	07/01/2016	09/30/2016	DY2 Q2
Task b. Train 1 Nurse Supervisor on NFP		Project		In Progress	02/01/2016	03/01/2016	02/01/2016	07/30/2016	09/30/2016	DY2 Q2
Task Step 12….Search for Nurse Home Visitors to join nursing team in Erie County. SUBSTEPS in relation to step 12:		Project		In Progress	12/01/2015	03/30/2018	12/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task a. Hire 5 Nurse Home Visitors for Erie County team (DY1, Q4 (1); DY2, Q4 (2); DY3 Q4 (2))		Project		In Progress	12/01/2015	01/07/2018	12/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task b. Train 5 Nurse Home Visitors on NFP (DY1, Q4 (1); DY2, Q4 (2); DY3 Q4 (2))		Project		In Progress	12/01/2015	01/07/2018	12/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Step 13….Search for 1 data/administrative assistant to join team in Erie County. SUBSTEPS in relation to step 13:		Project		In Progress	01/01/2016	03/01/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task		Project		In Progress	01/01/2016	03/01/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2

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a. Hire 1 data/administrative assistant for Erie team										
Task b. Train 1 data/administrative assistant on NFP		Project		In Progress	01/01/2016	03/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 14….Begin Implementation of program in Erie County in DY1 Q4 to achieve required enrollment objectives		Project		In Progress	01/01/2016	03/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 15….Establish referral mechanism (see below) with local agencies to grow Erie County enrollment in DY2 Q3. The CPWNY 3.f.i project team will work with providers such OB/GYN and primary care providers in establishing referral system. (This action is ongoing)		Project		In Progress	07/01/2015	03/30/2018	07/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Step 16….Conduct regular team meetings and staff supervision as outlined below. SUBSTEPS in relation to step 16:		Project		In Progress	09/01/2015	03/30/2018	09/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task a. One-to-one clinical supervision - nurse and supervisor meet once a week to reflect on a nurse's caseload and quality assurance. (this action is ongoing)		Project		In Progress	09/01/2015	03/30/2018	09/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task b. Case conferences - twice monthly meetings with the team dedicated to joint review of cases, data reports and charts, with the purpose to find solutions, problem solve and professional growth. The 3.f.i project team will utilize the case conferences as a PDSA continuous improvement cycle. (this action is ongoing)		Project		In Progress	09/01/2015	03/30/2018	09/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task c. Team meetings- twice monthly meetings held for administrative purposes, to discuss program implementation issues, and team building. (this action is ongoing)		Project		In Progress	09/01/2015	03/30/2018	09/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task d. Field supervision - every 4 months the supervisor makes a joint home visit with each nurse to at least one client. (this action is ongoing)		Project		In Progress	09/01/2015	03/30/2018	09/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task		Project		Completed	04/01/2015	04/15/2015	04/01/2015	04/15/2015	06/30/2015	DY1 Q1

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Step 17….NFP requires the creation of an active Community Advisory Board (CAB) to advise, support, and sustain NFP over time. The CAB consists of members from partner CBOs, other agencies, and clients. Substeps in relation to step 17:										
Task a. Meet and share NFP progress, challenges, and updates with CAB on a quarterly basis. (this action is ongoing)		Project		In Progress	04/15/2015	03/30/2018	04/15/2015	03/30/2018	03/31/2018	DY3 Q4
Task Step 18…. CPWNY 3.f.i project team will develop and adopt reporting metrics and outcome measures based on the DSRIP requirement to evaluate the effectiveness of evidence-based home visitation model for pregnant high-risk mothers including high-risk first time mothers. NFP has a prescribed guidelines to report and track participating patient outcomes. CPWNY will utilize such guidelines along with DSRIP requirements in reporting and assessment.		Project		In Progress	09/01/2015	12/30/2015	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 19…. CPWNY 3.f.i project team will conduct periodic assessment on implementation of NFP in Erie and Chautauqua County, apply Rapid Cycle Improvement methods to evaluate and address identified gaps as needed.		Project		In Progress	04/15/2015	12/30/2016	04/15/2015	05/28/2017	06/30/2017	DY3 Q1
Milestone #2 Develop a referral system for early identification of women who are or may be at high-risk.	Model 1	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task PPS has developed a referral system for early identification of women who are or may be at high-risk.		Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 1….Develop a working definition of high risk mothers to be engaged in this project. CPWNY will use the nationally recognized Nurse Family Partnership definition for enrollment, which is first time mothers, prior to 28 weeks pregnant, who are Medicaid/WIC eligible and considered high risk due to economic issues.		Project		Completed	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3

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Task Step 2…..Obtain policies from National office of NFP to follow their referral process and modify to ensure meets needs of our community.		Project		Completed	06/29/2015	06/30/2015	06/29/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 3….Coordinate with Chautauqua County Home visiting program to identify patients in their service area. SUBSTEPS in relation to step 3: (Note: ongoing activity.)		Project		In Progress	08/01/2015	03/30/2017	08/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task a. Meet with Chautauqua County clinics, primary care centers, OB/GYN practices and hospitals to educate on NFP and ask for appropriate referrals. Note: ongoing activity.		Project		In Progress	08/04/2015	03/30/2017	08/04/2015	03/30/2017	03/31/2017	DY2 Q4
Task b. Attend Chautauqua County CAB meeting to discuss NFP program and ask for appropriate referrals. Note: ongoing activity.		Project		In Progress	09/30/2015	03/30/2017	09/30/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 4….Work with all Erie County FQHCs, primary care centers, physician offices, agencies, hospitals to identify women who meet qualifications identified above and make referrals to NFP program. SUBSTEPS in relation to step 4: (Note: ongoing activity.)		Project		In Progress	06/22/2015	03/30/2017	06/22/2015	03/30/2017	03/31/2017	DY2 Q4
Task a. Meet with one-on-one with heads of Erie County clinics, primary care centers, OB/GYN practices and hospitals to discuss NFP and ask for appropriate referrals. Note: ongoing activity.		Project		In Progress	06/22/2015	03/30/2017	06/22/2015	03/30/2017	03/31/2017	DY2 Q4
Task b. Conduct educational sessions on NFP for medical and social service staff at Erie County clinics, primary care centers, OB/GYN practices and hospitals, and ask for appropriate referrals. Note: ongoing activity.		Project		In Progress	02/01/2016	03/30/2017	02/01/2016	03/30/2017	03/31/2017	DY2 Q4
Task c. Identify office/agency "NFP champion" at Erie County clinics, primary care centers, OB/GYN practices and hospital, to facilitate referrals. Note: ongoing activity.		Project		In Progress	12/01/2015	03/30/2017	12/01/2015	03/30/2017	03/31/2017	DY2 Q4

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Task d. Embed Nurse Home Visitors in agencies/locations with potential high volume referrals. Note: ongoing activity.		Project		In Progress	03/01/2016	03/30/2017	03/01/2016	03/30/2017	03/31/2017	DY2 Q4
Task Step 5.... In the existing referral system, 100% of Chautauqua County's all pregnant women are referred to the County Health Department. Chautauqua County Health Department then directs patients to appropriate CBOs including NFP. In turn NFP will refer patients to other appropriate services. NFP will follow-up the success of referral through face-to-face in-home visits. The 3.f.i will utilize PDSA method to periodically evaluate the effectiveness of CBOs and other services regarding NFP and address gaps thereby mitigating risks. Note: ongoing activity.		Project		In Progress	07/15/2015	03/30/2017	07/15/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 6.... In Erie County, which also include Niagara County patients, CPWNY's partner hospitals see greater than 50% of all Medicaid high risk mothers from the community and have close relationships with leadership of the NFP program for substantial amount of referrals. The 3.f.i will also work with Erie County Buffalo Prenatal Perinatal Network to identify patients that fit in home visiting programs and direct patients to appropriate programs based on needs. The 3.f.i will utilize PDSA method to periodically evaluate the effectiveness of CBOs and other services regarding NFP and address gaps thereby mitigating risks. Note: ongoing activity.		Project		In Progress	07/15/2015	03/30/2017	07/15/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 7….Establish a mentor/mentee relationship with neighboring NFP agencies (Monroe County) to learn best practices and options for referral system. Note: ongoing activity.		Project		In Progress	07/14/2015	03/30/2017	07/14/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 8….Develop visual diagram to use as education to various agencies to identify referral process		Project		Completed	04/01/2015	10/01/2015	04/01/2015	10/01/2015	12/31/2015	DY1 Q3
Task		Project		Completed	04/01/2015	10/01/2015	04/01/2015	10/01/2015	12/31/2015	DY1 Q3

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Step 9….Create local website for reference and referral.										
Task Step 10… CPWNY's 3.f.i project team will periodically assess the effectiveness of our referral system in identifying high risk mothers and connecting them to necessary resources. The success of the referral system will be measured by qualified referral volume and by ongoing active referral relationship with CBOs and other partners as verified via bi-directional communications. Information technology reports will be collected from CPWNY's partner hospitals and prenatal services. Workflow and referral procedure will be documented and implemented. (this action is ongoing)		Project		In Progress	08/01/2015	03/30/2017	08/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 11…. CPWNY 3.f.i project team will apply Rapid Cycle Improvement methods to evaluate and address identified gaps in the implementation of our referral system. (this action is ongoing)		Project		In Progress	04/15/2015	03/30/2017	04/15/2015	03/30/2017	03/31/2017	DY2 Q4
Milestone #3 Establish a quality oversight committee of OB/GYN and primary care providers to monitor quality outcomes and implement new or change activities as appropriate.	Model 1	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.		Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.		Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics listed in Attachment J Domain 3 Perinatal Care Metrics.		Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Service and quality outcome measures are reported to all		Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4

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stakeholders.										
Task Step 1…..CPWNY PMO, in concert with the 3.f.i project team, will develop a committee structure for a quality oversight committee of OB/GYN, primary care providers, and nurse home visitors. This committee will report to CPWNY's clinical governance committee and work closely with CPWNY's data/IT governance committee to oversee quality outcomes and to implement new or change activities as needed.		Project		Completed	04/01/2015	10/01/2015	04/01/2015	10/01/2015	12/31/2015	DY1 Q3
Task Step 2…..Recruit committee members from CPWNY partners including but not limited to representatives from Catholic Health Women Services, OB/GYN providers, primary care providers, nurse home visitors and/or supervisors, and CBOs.		Project		Completed	04/01/2015	10/01/2015	04/01/2015	10/01/2015	12/31/2015	DY1 Q3
Task Step 3…..Oversight committee will take place quarterly with CHS Chairs of OB/GYN and community stakeholders. Note: ongoing activity.		Project		In Progress	10/01/2015	03/30/2017	10/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 4….The oversight committee will develop a quality improvement plan for the NFP project utilizing quality improvement methods such as root cause analysis, clinical quality improvement action plan, and rapid cycle improvement. Meeting minutes and follow-up plans will be documented. Newsletters and periodic reports will be distributed.		Project		In Progress	12/30/2015	03/30/2017	12/30/2015	03/30/2017	03/31/2017	DY2 Q4
Milestone #4 Use EHRs or other IT platforms to track all patients engaged in this project.	Model 1	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Step 1….Through participation of the national Nurse Family		Project		In Progress	09/01/2015	03/30/2017	09/01/2015	03/30/2017	03/31/2017	DY2 Q4

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Partnership program, CPWNY has access to their IT platform, the Efforts to Outcomes (ETO) computer software - a system that has been designed to provide implementing agencies with the information that is needed to monitor the quality of program implementation and the progress of enrolled families in attaining program goals. Note: ongoing activity.										
Task Step 2…. 3.f.i project staff will be trained on using ETO to track patients and quality outcome. Continuous training will be available to existing and additional staff.		Project		In Progress	09/01/2015	03/30/2016	09/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task Step 3… CPWNY will leverage the capability of ETO and integrate with the Crimson population health management system to monitor the effectiveness of the NFP project.		Project		In Progress	01/01/2016	03/30/2017	01/01/2016	03/30/2017	03/31/2017	DY2 Q4
Task Step 4… The NFP program dictates the tracking of information and what information to be tracked. All information is inputted in the ETO software. 3.f.i project team will produce reports from ETO data and share with the quality oversight committee and give client-specific feedback to CBOs who referred the patients. High level reports will be shared via website URLs and periodic newsletters.		Project		In Progress	01/01/2016	03/30/2017	01/01/2016	03/30/2017	03/31/2017	DY2 Q4
Milestone #5 Identify and engage a regional medical center with expertise in management of high-risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center).	Model 2	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has identified and engaged with a regional medical center to address the care of high-risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center). Assessment of the volume of high-risk pregnancies to be obtained through the CNA.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #6 Develop a multidisciplinary team of experts with clinical and	Model 2	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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social support expertise who will co-manage care of the high-risk mother and infant with local community obstetricians and pediatric providers.										
Task PPS has assembled a team of experts, including the number and type of experts and specialists and roles in the multidisciplinary team, to address the management of care of high-risk mothers and infants.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has established MOUs or joint operating agreements with substantive multidisciplinary team responsible for co-managing care of high-risk mothers and infants.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #7 Develop service MOUs between multidisciplinary team and OB/GYN providers.	Model 2	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has identified and established MOUs or joint operating agreements between multidisciplinary team and OB/GYN providers.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #8 Utilize best evidence care guidelines for management of high risk pregnancies and newborns and implement uniform clinical protocols based upon evidence-based guidelines.	Model 2	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has developed/adopted uniform clinical protocols guidelines based upon evidence-based standards agreed to by all partners.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has established best practice guidelines, policies and procedures, and plans for dissemination and training for interdisciplinary team on best practices.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Training has been completed.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #9 Ensure that all PPS safety net providers are actively sharing EHR systems or other IT platforms with local health	Model 2	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.										
Task EHR or other IT platforms, meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task EHR or other IT platforms, meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task EHR or other IT platforms, meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Clinic	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS uses alerts and secure messaging functionality.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #10 Ensure that EHR systems or other IT platforms used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Model 2	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task EHR or other IT platforms meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #11 Use EHRs or other IT platforms to track all patients engaged in this project.	Model 2	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #12 Develop a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Collaboratives (MICHC) program; access NYSDOH-funded CHW training program.										
Task PPS developed a work plan to use NYSDOH CHW training program and ensure CHW-trained members are integrated into the multidisciplinary team. PPS has obtained DOH funding for CHW training.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #13 Employ a Community Health Worker Coordinator responsible for supervision of 4 - 6 community health workers. Duties and qualifications are per NYS DOH criteria.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has named assigned CHW Coordinator(s) or timeline for hiring CHW Coordinator(s).		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #14 Employ qualified candidates for Community Health Workers who meet criteria such as cultural competence, communication, and appropriate experience and training.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has developed a CHW workforce strategy and attendant qualifications of CHW(s) who meet the following criteria: 1) Indigenous community resident of the targeted area; 2) Writing ability sufficient to provide adequate documentation in the family record, referral forms and other service coordination forms, and reading ability to the level necessary to comprehend training materials and assist others to fill out forms; 3) Bilingual skills, depending on the community and families being served; 4) Knowledge of the community, community organizations, and community leaders; 5)Ability to work flexible hours, including evening and weekend hours.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #15 Establish protocols for deployment of CHW.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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DSRIP Implementation Plan Project

Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
PPS has established timelines to complete protocols (policies and procedures) for CHW program, including methods for new and ongoing training for CHWs.										
Task PPS has developed plans to develop operational program components of CHW.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #16 Coordinate with the Medicaid Managed Care organizations serving the target population.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has established agreements with MCOs demonstrating coordination regarding CHW program, or attestation of intent to establish coverage agreements, as well as progress to date.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #17 Use EHRs or other IT platforms to track all patients engaged in this project.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Implement an evidence-based home visitation model, such as the Nurse Family Partnership, for pregnant high- risk mothers including high-risk first time mothers.										
Task PPS has developed a project plan that includes a timeline for implementation of an evidence-based home visiting model, such as Nurse-Family Partnership visitation model, for this population.										
Task Step 1…Meet with representative from National Office of Nurse Family Partnership to determine needs and application requirements. NFP is a evidence-based prescribed step-by-step process, which anyone who implements must follow with high fidelity. Complete site visits, multiple communication and reviews of application before submitted. Obtain current application to complete.										

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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 2… Engage providers such as OB/GYN and primary care through newsletter, face-to-face meetings, the community advisory board, and other maternal child coalitions that are already established in Erie and Chautauqua County. We presented the plan in OB/GYN meetings that reached more than 60 OB/GYN and primary care physicians.										
Task Step 3….Establish relationships (through face-to-face meetings, national conferences, working with assigned mentor agency, etc.) with Chautauqua providers and CBOs (such as United Way of Buffalo and Erie County, WIC, Jericho Road, Buffalo Prenatal Perinatal Network, etc.), as well as deepen relationships with providers and CBOs in Erie County, ensure support prior to implementation of model. CPWNY's partners such as Catholic Health Women Services has existing relationship with CBOs and community based programs for high risk mothers. CPWNY will leverage and expand existing relationships to notify about the NFP program and gain referrals. Note: this activity will be ongoing through DY5.										
Task Step 4….In partnership with Chautauqua County, who already has funding for education and travel expenses for their planned program, apply for NFP medallion.										
Task Step 5….Develop HR Plan for recruitment of staff for program, particularly for Supervisor and Nurse Home Visitors to reflect population served										
Task Step 6….Search for Program Coordinator/Administrator for program to lead implementation. SUBSTEPS in relation for step 6:										
Task a. Hire Program Coordinator/Administrator										
Task b. Train Program Coordinator/Administrator on NFP										
Task Step 7….Search for Nurse Supervisor to lead nursing team in Chautauqua County. SUBSTEPS in relation to step 7:										
Task a. Hire 1 Nurse Supervisor for Chautauqua team										
Task b. Train 1 Nurse Supervisor on NFP										

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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 8….Search for Nurse Home Visitors to join nursing team in Chautauqua County. SUBSTEPS in relation to step 8:										
Task a. Hire 2 Nurse Home Visitors for Chautauqua team										
Task b. Train 2 Nurse Home Visitors on NFP										
Task Step 9….Search for 0.5 time data/administrative assistant to join team in Chautauqua County. SUBSTEPS in relation to step 9:										
Task a. Hire 0.5 data/administrative assistant for Chautauqua team										
Task b. Train 0.5 data/administrative assistant on NFP										
Task Step 10….Begin Implementation of program in Chautauqua County in DY1 Q3 to achieve required enrollment objectives										
Task Step 11….Search for Nurse Supervisor to lead nursing team in Erie County. SUBSTEPS in relation to step 11:										
Task a. Hire 1 Nurse Supervisor for Erie County team										
Task b. Train 1 Nurse Supervisor on NFP										
Task Step 12….Search for Nurse Home Visitors to join nursing team in Erie County. SUBSTEPS in relation to step 12:										
Task a. Hire 5 Nurse Home Visitors for Erie County team (DY1, Q4 (1); DY2, Q4 (2); DY3 Q4 (2))										
Task b. Train 5 Nurse Home Visitors on NFP (DY1, Q4 (1); DY2, Q4 (2); DY3 Q4 (2))										
Task Step 13….Search for 1 data/administrative assistant to join team in Erie County. SUBSTEPS in relation to step 13:										
Task a. Hire 1 data/administrative assistant for Erie team										
Task b. Train 1 data/administrative assistant on NFP										
Task Step 14….Begin Implementation of program in Erie County in DY1 Q4 to achieve required enrollment objectives										

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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 15….Establish referral mechanism (see below) with local agencies to grow Erie County enrollment in DY2 Q3. The CPWNY 3.f.i project team will work with providers such OB/GYN and primary care providers in establishing referral system. (This action is ongoing)										
Task Step 16….Conduct regular team meetings and staff supervision as outlined below. SUBSTEPS in relation to step 16:										
Task a. One-to-one clinical supervision - nurse and supervisor meet once a week to reflect on a nurse's caseload and quality assurance. (this action is ongoing)										
Task b. Case conferences - twice monthly meetings with the team dedicated to joint review of cases, data reports and charts, with the purpose to find solutions, problem solve and professional growth. The 3.f.i project team will utilize the case conferences as a PDSA continuous improvement cycle. (this action is ongoing)										
Task c. Team meetings- twice monthly meetings held for administrative purposes, to discuss program implementation issues, and team building. (this action is ongoing)										
Task d. Field supervision - every 4 months the supervisor makes a joint home visit with each nurse to at least one client. (this action is ongoing)										
Task Step 17….NFP requires the creation of an active Community Advisory Board (CAB) to advise, support, and sustain NFP over time. The CAB consists of members from partner CBOs, other agencies, and clients. Substeps in relation to step 17:										
Task a. Meet and share NFP progress, challenges, and updates with CAB on a quarterly basis. (this action is ongoing)										
Task Step 18…. CPWNY 3.f.i project team will develop and adopt reporting metrics and outcome measures based on the DSRIP requirement to evaluate the effectiveness of evidence-based home visitation model for pregnant high- risk mothers including high-risk first time mothers. NFP has a prescribed guidelines to report and track participating patient outcomes. CPWNY will utilize such guidelines along with DSRIP requirements in reporting and assessment.										

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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 19…. CPWNY 3.f.i project team will conduct periodic assessment on implementation of NFP in Erie and Chautauqua County, apply Rapid Cycle Improvement methods to evaluate and address identified gaps as needed.										
Milestone #2 Develop a referral system for early identification of women who are or may be at high-risk.										
Task PPS has developed a referral system for early identification of women who are or may be at high-risk.										
Task Step 1….Develop a working definition of high risk mothers to be engaged in this project. CPWNY will use the nationally recognized Nurse Family Partnership definition for enrollment, which is first time mothers, prior to 28 weeks pregnant, who are Medicaid/WIC eligible and considered high risk due to economic issues.										
Task Step 2…..Obtain policies from National office of NFP to follow their referral process and modify to ensure meets needs of our community.										
Task Step 3….Coordinate with Chautauqua County Home visiting program to identify patients in their service area. SUBSTEPS in relation to step 3: (Note: ongoing activity.)										
Task a. Meet with Chautauqua County clinics, primary care centers, OB/GYN practices and hospitals to educate on NFP and ask for appropriate referrals. Note: ongoing activity.										
Task b. Attend Chautauqua County CAB meeting to discuss NFP program and ask for appropriate referrals. Note: ongoing activity.										
Task Step 4….Work with all Erie County FQHCs, primary care centers, physician offices, agencies, hospitals to identify women who meet qualifications identified above and make referrals to NFP program. SUBSTEPS in relation to step 4: (Note: ongoing activity.)										
Task a. Meet with one-on-one with heads of Erie County clinics, primary care centers, OB/GYN practices and hospitals to discuss NFP and ask for appropriate referrals. Note: ongoing activity.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task b. Conduct educational sessions on NFP for medical and social service staff at Erie County clinics, primary care centers, OB/GYN practices and hospitals, and ask for appropriate referrals. Note: ongoing activity.										
Task c. Identify office/agency "NFP champion" at Erie County clinics, primary care centers, OB/GYN practices and hospital, to facilitate referrals. Note: ongoing activity.										
Task d. Embed Nurse Home Visitors in agencies/locations with potential high volume referrals. Note: ongoing activity.										
Task Step 5.... In the existing referral system, 100% of Chautauqua County's all pregnant women are referred to the County Health Department. Chautauqua County Health Department then directs patients to appropriate CBOs including NFP. In turn NFP will refer patients to other appropriate services. NFP will follow-up the success of referral through face-to-face in-home visits. The 3.f.i will utilize PDSA method to periodically evaluate the effectiveness of CBOs and other services regarding NFP and address gaps thereby mitigating risks. Note: ongoing activity.										
Task Step 6.... In Erie County, which also include Niagara County patients, CPWNY's partner hospitals see greater than 50% of all Medicaid high risk mothers from the community and have close relationships with leadership of the NFP program for substantial amount of referrals. The 3.f.i will also work with Erie County Buffalo Prenatal Perinatal Network to identify patients that fit in home visiting programs and direct patients to appropriate programs based on needs. The 3.f.i will utilize PDSA method to periodically evaluate the effectiveness of CBOs and other services regarding NFP and address gaps thereby mitigating risks. Note: ongoing activity.										
Task Step 7….Establish a mentor/mentee relationship with neighboring NFP agencies (Monroe County) to learn best practices and options for referral system. Note: ongoing activity.										
Task Step 8….Develop visual diagram to use as education to various agencies to identify referral process										
Task Step 9….Create local website for reference and referral.										

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Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project 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 10… CPWNY's 3.f.i project team will periodically assess the effectiveness of our referral system in identifying high risk mothers and connecting them to necessary resources. The success of the referral system will be measured by qualified referral volume and by ongoing active referral relationship with CBOs and other partners as verified via bi-directional communications. Information technology reports will be collected from CPWNY's partner hospitals and prenatal services. Workflow and referral procedure will be documented and implemented. (this action is ongoing)										
Task Step 11…. CPWNY 3.f.i project team will apply Rapid Cycle Improvement methods to evaluate and address identified gaps in the implementation of our referral system. (this action is ongoing)										
Milestone #3 Establish a quality oversight committee of OB/GYN and primary care providers to monitor quality outcomes and implement new or change activities as appropriate.										
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.										
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics listed in Attachment J Domain 3 Perinatal Care Metrics.										
Task Service and quality outcome measures are reported to all stakeholders.										
Task Step 1…..CPWNY PMO, in concert with the 3.f.i project team, will develop a committee structure for a quality oversight committee of OB/GYN, primary care providers, and nurse home visitors. This committee will report to CPWNY's clinical governance committee and work closely with CPWNY's data/IT governance committee to oversee quality outcomes and to implement new or change activities as needed.										

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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 2…..Recruit committee members from CPWNY partners including but not limited to representatives from Catholic Health Women Services, OB/GYN providers, primary care providers, nurse home visitors and/or supervisors, and CBOs.										
Task Step 3…..Oversight committee will take place quarterly with CHS Chairs of OB/GYN and community stakeholders. Note: ongoing activity.										
Task Step 4….The oversight committee will develop a quality improvement plan for the NFP project utilizing quality improvement methods such as root cause analysis, clinical quality improvement action plan, and rapid cycle improvement. Meeting minutes and follow-up plans will be documented. Newsletters and periodic reports will be distributed.										
Milestone #4 Use EHRs or other IT platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1….Through participation of the national Nurse Family Partnership program, CPWNY has access to their IT platform, the Efforts to Outcomes (ETO) computer software - a system that has been designed to provide implementing agencies with the information that is needed to monitor the quality of program implementation and the progress of enrolled families in attaining program goals. Note: ongoing activity.										
Task Step 2…. 3.f.i project staff will be trained on using ETO to track patients and quality outcome. Continuous training will be available to existing and additional staff.										
Task Step 3… CPWNY will leverage the capability of ETO and integrate with the Crimson population health management system to monitor the effectiveness of the NFP project.										
Task Step 4… The NFP program dictates the tracking of information and what information to be tracked. All information is inputted in the ETO software. 3.f.i project team will produce reports from ETO data and share with the quality oversight committee and give client-specific feedback to CBOs who referred the patients.										

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Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
High level reports will be shared via website URLs and periodic newsletters.										
Milestone #5 Identify and engage a regional medical center with expertise in management of high-risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center).										
Task PPS has identified and engaged with a regional medical center to address the care of high-risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center). Assessment of the volume of high-risk pregnancies to be obtained through the CNA.										
Milestone #6 Develop a multidisciplinary team of experts with clinical and social support expertise who will co-manage care of the high-risk mother and infant with local community obstetricians and pediatric providers.										
Task PPS has assembled a team of experts, including the number and type of experts and specialists and roles in the multidisciplinary team, to address the management of care of high-risk mothers and infants.										
Task PPS has established MOUs or joint operating agreements with substantive multidisciplinary team responsible for co-managing care of high-risk mothers and infants.										
Milestone #7 Develop service MOUs between multidisciplinary team and OB/GYN providers.										
Task PPS has identified and established MOUs or joint operating agreements between multidisciplinary team and OB/GYN providers.										
Milestone #8 Utilize best evidence care guidelines for management of high risk pregnancies and newborns and implement uniform clinical protocols based upon evidence-based guidelines.										
Task PPS has developed/adopted uniform clinical protocols guidelines based upon evidence-based standards agreed to by all partners.										
Task PPS has established best practice guidelines, policies and procedures, and plans for dissemination and training for interdisciplinary team on best practices.										

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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 Training has been completed.										
Milestone #9 Ensure that all PPS safety net providers are actively sharing EHR systems or other IT platforms with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.										
Task EHR or other IT platforms, meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR or other IT platforms, meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR or other IT platforms, meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task PPS uses alerts and secure messaging functionality.										
Milestone #10 Ensure that EHR systems or other IT platforms used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.										
Task EHR or other IT platforms meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	0	0	0	0	0	0	0	0	0
Milestone #11 Use EHRs or other IT platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Milestone #12 Develop a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaboratives (MICHC) program; access NYSDOH-funded CHW training program.										
Task PPS developed a work plan to use NYSDOH CHW training program and ensure CHW-trained members are integrated into										

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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
the multidisciplinary team. PPS has obtained DOH funding for CHW training.										
Milestone #13 Employ a Community Health Worker Coordinator responsible for supervision of 4 - 6 community health workers. Duties and qualifications are per NYS DOH criteria.										
Task PPS has named assigned CHW Coordinator(s) or timeline for hiring CHW Coordinator(s).										
Milestone #14 Employ qualified candidates for Community Health Workers who meet criteria such as cultural competence, communication, and appropriate experience and training.										
Task PPS has developed a CHW workforce strategy and attendant qualifications of CHW(s) who meet the following criteria: 1) Indigenous community resident of the targeted area; 2) Writing ability sufficient to provide adequate documentation in the family record, referral forms and other service coordination forms, and reading ability to the level necessary to comprehend training materials and assist others to fill out forms; 3) Bilingual skills, depending on the community and families being served; 4) Knowledge of the community, community organizations, and community leaders; 5)Ability to work flexible hours, including evening and weekend hours.										
Milestone #15 Establish protocols for deployment of CHW.										
Task PPS has established timelines to complete protocols (policies and procedures) for CHW program, including methods for new and ongoing training for CHWs.										
Task PPS has developed plans to develop operational program components of CHW.										
Milestone #16 Coordinate with the Medicaid Managed Care organizations serving the target population.										
Task PPS has established agreements with MCOs demonstrating coordination regarding CHW program, or attestation of intent to establish coverage agreements, as well as progress to date.										
Milestone #17 Use EHRs or other IT platforms to track all patients engaged in this project.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Implement an evidence-based home visitation model, such as the Nurse Family Partnership, for pregnant high- risk mothers including high-risk first time mothers.										
Task PPS has developed a project plan that includes a timeline for implementation of an evidence-based home visiting model, such as Nurse-Family Partnership visitation model, for this population.										
Task Step 1…Meet with representative from National Office of Nurse Family Partnership to determine needs and application requirements. NFP is a evidence-based prescribed step-by-step process, which anyone who implements must follow with high fidelity. Complete site visits, multiple communication and reviews of application before submitted. Obtain current application to complete.										
Task Step 2… Engage providers such as OB/GYN and primary care through newsletter, face-to-face meetings, the community advisory board, and other maternal child coalitions that are already established in Erie and Chautauqua County. We presented the plan in OB/GYN meetings that reached more than 60 OB/GYN and primary care physicians.										
Task Step 3….Establish relationships (through face-to-face meetings, national conferences, working with assigned mentor agency, etc.) with Chautauqua providers and CBOs (such as United Way of Buffalo and Erie County, WIC, Jericho Road, Buffalo Prenatal Perinatal Network, etc.), as well as deepen relationships with providers and CBOs in Erie County, ensure support prior to implementation of model. CPWNY's partners such as Catholic Health Women Services has existing relationship with CBOs and community based programs for high risk mothers. CPWNY will leverage and expand existing relationships to notify about the NFP program and gain referrals. Note: this activity will be ongoing through DY5.										
Task										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Step 4….In partnership with Chautauqua County, who already has funding for education and travel expenses for their planned program, apply for NFP medallion.										
Task Step 5….Develop HR Plan for recruitment of staff for program, particularly for Supervisor and Nurse Home Visitors to reflect population served										
Task Step 6….Search for Program Coordinator/Administrator for program to lead implementation. SUBSTEPS in relation for step 6:										
Task a. Hire Program Coordinator/Administrator										
Task b. Train Program Coordinator/Administrator on NFP										
Task Step 7….Search for Nurse Supervisor to lead nursing team in Chautauqua County. SUBSTEPS in relation to step 7:										
Task a. Hire 1 Nurse Supervisor for Chautauqua team										
Task b. Train 1 Nurse Supervisor on NFP										
Task Step 8….Search for Nurse Home Visitors to join nursing team in Chautauqua County. SUBSTEPS in relation to step 8:										
Task a. Hire 2 Nurse Home Visitors for Chautauqua team										
Task b. Train 2 Nurse Home Visitors on NFP										
Task Step 9….Search for 0.5 time data/administrative assistant to join team in Chautauqua County. SUBSTEPS in relation to step 9:										
Task a. Hire 0.5 data/administrative assistant for Chautauqua team										
Task b. Train 0.5 data/administrative assistant on NFP										
Task Step 10….Begin Implementation of program in Chautauqua County in DY1 Q3 to achieve required enrollment objectives										
Task Step 11….Search for Nurse Supervisor to lead nursing team in Erie County. SUBSTEPS in relation to step 11:										

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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 a. Hire 1 Nurse Supervisor for Erie County team										
Task b. Train 1 Nurse Supervisor on NFP										
Task Step 12….Search for Nurse Home Visitors to join nursing team in Erie County. SUBSTEPS in relation to step 12:										
Task a. Hire 5 Nurse Home Visitors for Erie County team (DY1, Q4 (1); DY2, Q4 (2); DY3 Q4 (2))										
Task b. Train 5 Nurse Home Visitors on NFP (DY1, Q4 (1); DY2, Q4 (2); DY3 Q4 (2))										
Task Step 13….Search for 1 data/administrative assistant to join team in Erie County. SUBSTEPS in relation to step 13:										
Task a. Hire 1 data/administrative assistant for Erie team										
Task b. Train 1 data/administrative assistant on NFP										
Task Step 14….Begin Implementation of program in Erie County in DY1 Q4 to achieve required enrollment objectives										
Task Step 15….Establish referral mechanism (see below) with local agencies to grow Erie County enrollment in DY2 Q3. The CPWNY 3.f.i project team will work with providers such OB/GYN and primary care providers in establishing referral system. (This action is ongoing)										
Task Step 16….Conduct regular team meetings and staff supervision as outlined below. SUBSTEPS in relation to step 16:										
Task a. One-to-one clinical supervision - nurse and supervisor meet once a week to reflect on a nurse's caseload and quality assurance. (this action is ongoing)										
Task b. Case conferences - twice monthly meetings with the team dedicated to joint review of cases, data reports and charts, with the purpose to find solutions, problem solve and professional growth. The 3.f.i project team will utilize the case conferences as a PDSA continuous improvement cycle. (this action is ongoing)										
Task c. Team meetings- twice monthly meetings held for										

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Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
administrative purposes, to discuss program implementation issues, and team building. (this action is ongoing)										
Task d. Field supervision - every 4 months the supervisor makes a joint home visit with each nurse to at least one client. (this action is ongoing)										
Task Step 17….NFP requires the creation of an active Community Advisory Board (CAB) to advise, support, and sustain NFP over time. The CAB consists of members from partner CBOs, other agencies, and clients. Substeps in relation to step 17:										
Task a. Meet and share NFP progress, challenges, and updates with CAB on a quarterly basis. (this action is ongoing)										
Task Step 18…. CPWNY 3.f.i project team will develop and adopt reporting metrics and outcome measures based on the DSRIP requirement to evaluate the effectiveness of evidence-based home visitation model for pregnant high- risk mothers including high-risk first time mothers. NFP has a prescribed guidelines to report and track participating patient outcomes. CPWNY will utilize such guidelines along with DSRIP requirements in reporting and assessment.										
Task Step 19…. CPWNY 3.f.i project team will conduct periodic assessment on implementation of NFP in Erie and Chautauqua County, apply Rapid Cycle Improvement methods to evaluate and address identified gaps as needed.										
Milestone #2 Develop a referral system for early identification of women who are or may be at high-risk.										
Task PPS has developed a referral system for early identification of women who are or may be at high-risk.										
Task Step 1….Develop a working definition of high risk mothers to be engaged in this project. CPWNY will use the nationally recognized Nurse Family Partnership definition for enrollment, which is first time mothers, prior to 28 weeks pregnant, who are Medicaid/WIC eligible and considered high risk due to economic issues.										
Task Step 2…..Obtain policies from National office of NFP to follow their referral process and modify to ensure meets needs of our										

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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
community.										
Task Step 3….Coordinate with Chautauqua County Home visiting program to identify patients in their service area. SUBSTEPS in relation to step 3: (Note: ongoing activity.)										
Task a. Meet with Chautauqua County clinics, primary care centers, OB/GYN practices and hospitals to educate on NFP and ask for appropriate referrals. Note: ongoing activity.										
Task b. Attend Chautauqua County CAB meeting to discuss NFP program and ask for appropriate referrals. Note: ongoing activity.										
Task Step 4….Work with all Erie County FQHCs, primary care centers, physician offices, agencies, hospitals to identify women who meet qualifications identified above and make referrals to NFP program. SUBSTEPS in relation to step 4: (Note: ongoing activity.)										
Task a. Meet with one-on-one with heads of Erie County clinics, primary care centers, OB/GYN practices and hospitals to discuss NFP and ask for appropriate referrals. Note: ongoing activity.										
Task b. Conduct educational sessions on NFP for medical and social service staff at Erie County clinics, primary care centers, OB/GYN practices and hospitals, and ask for appropriate referrals. Note: ongoing activity.										
Task c. Identify office/agency "NFP champion" at Erie County clinics, primary care centers, OB/GYN practices and hospital, to facilitate referrals. Note: ongoing activity.										
Task d. Embed Nurse Home Visitors in agencies/locations with potential high volume referrals. Note: ongoing activity.										
Task Step 5.... In the existing referral system, 100% of Chautauqua County's all pregnant women are referred to the County Health Department. Chautauqua County Health Department then directs patients to appropriate CBOs including NFP. In turn NFP will refer patients to other appropriate services. NFP will follow-up the success of referral through face-to-face in-home visits. The 3.f.i will utilize PDSA method to periodically evaluate the effectiveness of CBOs and other services regarding NFP 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
address gaps thereby mitigating risks. Note: ongoing activity.										
Task Step 6.... In Erie County, which also include Niagara County patients, CPWNY's partner hospitals see greater than 50% of all Medicaid high risk mothers from the community and have close relationships with leadership of the NFP program for substantial amount of referrals. The 3.f.i will also work with Erie County Buffalo Prenatal Perinatal Network to identify patients that fit in home visiting programs and direct patients to appropriate programs based on needs. The 3.f.i will utilize PDSA method to periodically evaluate the effectiveness of CBOs and other services regarding NFP and address gaps thereby mitigating risks. Note: ongoing activity.										
Task Step 7….Establish a mentor/mentee relationship with neighboring NFP agencies (Monroe County) to learn best practices and options for referral system. Note: ongoing activity.										
Task Step 8….Develop visual diagram to use as education to various agencies to identify referral process										
Task Step 9….Create local website for reference and referral.										
Task Step 10… CPWNY's 3.f.i project team will periodically assess the effectiveness of our referral system in identifying high risk mothers and connecting them to necessary resources. The success of the referral system will be measured by qualified referral volume and by ongoing active referral relationship with CBOs and other partners as verified via bi-directional communications. Information technology reports will be collected from CPWNY's partner hospitals and prenatal services. Workflow and referral procedure will be documented and implemented. (this action is ongoing)										
Task Step 11…. CPWNY 3.f.i project team will apply Rapid Cycle Improvement methods to evaluate and address identified gaps in the implementation of our referral system. (this action is ongoing)										
Milestone #3 Establish a quality oversight committee of OB/GYN and primary care providers to monitor quality outcomes and implement new or change activities as appropriate.										
Task Membership of quality committee is representative of PPS staff										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
involved in quality improvement processes and other stakeholders.										
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics listed in Attachment J Domain 3 Perinatal Care Metrics.										
Task Service and quality outcome measures are reported to all stakeholders.										
Task Step 1…..CPWNY PMO, in concert with the 3.f.i project team, will develop a committee structure for a quality oversight committee of OB/GYN, primary care providers, and nurse home visitors. This committee will report to CPWNY's clinical governance committee and work closely with CPWNY's data/IT governance committee to oversee quality outcomes and to implement new or change activities as needed.										
Task Step 2…..Recruit committee members from CPWNY partners including but not limited to representatives from Catholic Health Women Services, OB/GYN providers, primary care providers, nurse home visitors and/or supervisors, and CBOs.										
Task Step 3…..Oversight committee will take place quarterly with CHS Chairs of OB/GYN and community stakeholders. Note: ongoing activity.										
Task Step 4….The oversight committee will develop a quality improvement plan for the NFP project utilizing quality improvement methods such as root cause analysis, clinical quality improvement action plan, and rapid cycle improvement. Meeting minutes and follow-up plans will be documented. Newsletters and periodic reports will be distributed.										
Milestone #4 Use EHRs or other IT platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										

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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….Through participation of the national Nurse Family Partnership program, CPWNY has access to their IT platform, the Efforts to Outcomes (ETO) computer software - a system that has been designed to provide implementing agencies with the information that is needed to monitor the quality of program implementation and the progress of enrolled families in attaining program goals. Note: ongoing activity.										
Task Step 2…. 3.f.i project staff will be trained on using ETO to track patients and quality outcome. Continuous training will be available to existing and additional staff.										
Task Step 3… CPWNY will leverage the capability of ETO and integrate with the Crimson population health management system to monitor the effectiveness of the NFP project.										
Task Step 4… The NFP program dictates the tracking of information and what information to be tracked. All information is inputted in the ETO software. 3.f.i project team will produce reports from ETO data and share with the quality oversight committee and give client-specific feedback to CBOs who referred the patients. High level reports will be shared via website URLs and periodic newsletters.										
Milestone #5 Identify and engage a regional medical center with expertise in management of high-risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center).										
Task PPS has identified and engaged with a regional medical center to address the care of high-risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center). Assessment of the volume of high-risk pregnancies to be obtained through the CNA.										
Milestone #6 Develop a multidisciplinary team of experts with clinical and social support expertise who will co-manage care of the high-risk mother and infant with local community obstetricians and pediatric providers.										
Task PPS has assembled a team of experts, including the number and type of experts and specialists and roles in the multidisciplinary team, to address the management of care of high-risk mothers and infants.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task PPS has established MOUs or joint operating agreements with substantive multidisciplinary team responsible for co-managing care of high-risk mothers and infants.										
Milestone #7 Develop service MOUs between multidisciplinary team and OB/GYN providers.										
Task PPS has identified and established MOUs or joint operating agreements between multidisciplinary team and OB/GYN providers.										
Milestone #8 Utilize best evidence care guidelines for management of high risk pregnancies and newborns and implement uniform clinical protocols based upon evidence-based guidelines.										
Task PPS has developed/adopted uniform clinical protocols guidelines based upon evidence-based standards agreed to by all partners.										
Task PPS has established best practice guidelines, policies and procedures, and plans for dissemination and training for interdisciplinary team on best practices.										
Task Training has been completed.										
Milestone #9 Ensure that all PPS safety net providers are actively sharing EHR systems or other IT platforms with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.										
Task EHR or other IT platforms, meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR or other IT platforms, meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR or other IT platforms, meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task PPS uses alerts and secure messaging functionality.										
Milestone #10 Ensure that EHR systems or other IT platforms used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of										

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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
Demonstration Year 3.										
Task EHR or other IT platforms meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	0	0	0	0	0	0	0	0	0
Milestone #11 Use EHRs or other IT platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Milestone #12 Develop a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaboratives (MICHC) program; access NYSDOH-funded CHW training program.										
Task PPS developed a work plan to use NYSDOH CHW training program and ensure CHW-trained members are integrated into the multidisciplinary team. PPS has obtained DOH funding for CHW training.										
Milestone #13 Employ a Community Health Worker Coordinator responsible for supervision of 4 - 6 community health workers. Duties and qualifications are per NYS DOH criteria.										
Task PPS has named assigned CHW Coordinator(s) or timeline for hiring CHW Coordinator(s).										
Milestone #14 Employ qualified candidates for Community Health Workers who meet criteria such as cultural competence, communication, and appropriate experience and training.										
Task PPS has developed a CHW workforce strategy and attendant qualifications of CHW(s) who meet the following criteria: 1) Indigenous community resident of the targeted area; 2) Writing ability sufficient to provide adequate documentation in the family record, referral forms and other service coordination forms, and reading ability to the level necessary to comprehend training materials and assist others to fill out forms; 3) Bilingual skills, depending on the community and families										

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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
being served; 4) Knowledge of the community, community organizations, and community leaders; 5)Ability to work flexible hours, including evening and weekend hours.										
Milestone #15 Establish protocols for deployment of CHW.										
Task PPS has established timelines to complete protocols (policies and procedures) for CHW program, including methods for new and ongoing training for CHWs.										
Task PPS has developed plans to develop operational program components of CHW.										
Milestone #16 Coordinate with the Medicaid Managed Care organizations serving the target population.										
Task PPS has established agreements with MCOs demonstrating coordination regarding CHW program, or attestation of intent to establish coverage agreements, as well as progress to date.										
Milestone #17 Use EHRs or other IT platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement an evidence-based home visitation model, such as the Nurse Family Partnership, for pregnant high- risk mothers including high-risk first time mothers.	
Develop a referral system for early identification of women who are or may be at high-risk.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish a quality oversight committee of OB/GYN and primary care providers to monitor quality outcomes and implement new or change activities as appropriate.	
Use EHRs or other IT platforms to track all patients engaged in this project.	
Identify and engage a regional medical center with expertise in management of high-risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center).	
Develop a multidisciplinary team of experts with clinical and social support expertise who will co-manage care of the high-risk mother and infant with local community obstetricians and pediatric providers.	
Develop service MOUs between multidisciplinary team and OB/GYN providers.	
Utilize best evidence care guidelines for management of high risk pregnancies and newborns and implement uniform clinical protocols based upon evidence-based guidelines.	
Ensure that all PPS safety net providers are actively sharing EHR systems or other IT platforms with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	
Ensure that EHR systems or other IT platforms used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	
Use EHRs or other IT platforms to track all patients engaged in this project.	
Develop a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaboratives (MICHC) program; access NYSDOH-funded CHW training program.	
Employ a Community Health Worker Coordinator responsible for supervision of 4 - 6 community health workers. Duties and qualifications are per NYS DOH criteria.	
Employ qualified candidates for Community Health Workers who meet criteria such as cultural competence, communication, and	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
appropriate experience and training.	
Establish protocols for deployment of CHW.	
Coordinate with the Medicaid Managed Care organizations serving the target population.	
Use EHRs or other IT platforms to track all patients engaged in this project.	

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Ongoing	
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Ongoing	
Milestone #9	Pass & Ongoing	
Milestone #10	Pass & Ongoing	
Milestone #11	Pass & Ongoing	
Milestone #12	Pass & Ongoing	
Milestone #13	Pass & Ongoing	
Milestone #14	Pass & Ongoing	
Milestone #15	Pass & Ongoing	
Milestone #16	Pass & Ongoing	
Milestone #17	Pass & Ongoing	

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

Risk 1: The public connotation of hospice is "end-of-life care" vs. palliative care, which is chronic disease management. Without a clear understanding and distinction between hospice and palliative care, patients may not accept palliative care as a resource for chronic disease management. Mitigation: Provider and community-wide education and outreach across all care settings and patients and families.
Risk 2: Challenges inherent to difficult conversations including procrastination and issues in and around life limiting illness. Patients may be less likely to utilize hospice and palliative care when necessary. Mitigation: Provider and community-wide education and outreach across all care settings and patients and families. Increase availability of palliative care trained nurse specialists, social workers and physicians. Palliative care providers currently imbedded in hospitals and hospice will be deployed to multiple care settings including patients homes, hospitals, offices, clinics, etc.
Risk 3: Challenges of identifying appropriate palliative care referrals. Providers may not be able to identify appropriate patients at an optimum time for palliative care. Mitigation: Education and outreach across all providers. Integrate EMR based guidelines for identification and referral of palliative care/hospice appropriate patients.
Risk 4: Challenges in completing advanced directives. Inability to complete advanced directives has a potential negative impact in the patient's choice of care and may influence care provided that may be contrary to the patient's wishes. Mitigation: Utilization of Electronic Medical Orders Life Sustaining Treatment (E-MOLST) interventional protocols with consumers, their surrogates, practice managers, patient navigators and others as needed.
Risk 5: Limited payment mechanisms currently exist for palliative care service within Medicaid Managed Care. Providers may not be incentivized to engage patients in discussion around palliative care. And patients may be burdened with expensive cost. Mitigation: Expand upon existing third party payer agreements established for non-Medicaid palliative care patients and engage Medicaid Managed Care to cover the cost of these services.
Risk 6: Challenges in accommodating and understanding the cultural and ethnic beliefs and values with respect to end-of life conversations. Without sensitivity towards various cultural and ethnic values and believes, the success of palliative care interventions will be jeopardized. Mitigation: Recruit staff that are representative of diverse patient population and trained to address variable cultural beliefs regarding end of life.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	1,070

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
50	100	23.36%	328	9.35%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (428)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
dcao	Rosters	46_PMDL5115_1_3_20160127153352_CPWNY_Patient_List_for_3.g.i_Palliative_Care_DY1_Q3.pdf	CPWNY patient list for project 3.g.i in DY1 Q3.	01/27/2016 03:34 PM

Narrative Text :

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

The patient lists uploaded underreport the number of actively engaged patients for project 3.g.i. The reason is that CPWNY has not yet finalized IT infrastructure and data collection process which all PCMH practices and palliative care providers. For DY1 Q3, CPWNY is only reporting actively engaged patients from palliative care providers and PCMH practices, where accurate information can be collected and reported.

Regarding patient identifier information for project 3.g.i: CPWNY reports CIN when available. There are a few patients we don't have CIN, CPWNY reports MCO insurance ID and patient name for traceability.

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Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its actively engaged commitments for DY1Q3. The documentation does not support the reported actively engaged numbers.

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH and/or APCM have been included. The PPS has received agreement from those PCPs not PCMH and/or APCM certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: The board of the project management office (PMO) conducted a strategic assessment of the areas of clinical care that are high priorities for the next three years. The assessment identified palliative care, care of patients with dementia, and patients with multiple chronic conditions as the population in greatest need and the area where the greatest gaps exist in the prevision of timely and ongoing clinical care and services.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 2: The palliative care project team has met with Community Partners of Western New York (PPS) representatives to request recommendations of PCPs (in PCMH practices) with high Medicaid patient populations to serve as a pilot in rolling out the integration methodology. CPWNY has identified 4 MD practices targeted for initial phase of PC integration who are PCMH certified with high Medicaid patient populations. (I.e., Our Lady of Victory, Mercy Comprehensive Care Clinic, WNY Primary Care, Southgate Medical). Additional PCPs will be added to the project once the process has been solidified.	Project		Completed	04/01/2015	09/30/2015	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	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 3: The project management office (PMO) will assess PCMH primary care and internal medicine practices who are caring for patients with multiple comorbid conditions including COPD, heart failure, end stage renal disease, etc. to assist in strategizing roll out. This will be accomplished through registries and communication with the clinicians at the offices. Note: ongoing activity.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 4: The project management office (PMO) will provide education and referral linkage to palliative care services, and establish agreements with PCMH primary care practices to integrate palliative care consultation into their clinical practices. As PCMH providers are enrolled into the project, they will receive an agreement spelling out responsibilities and deliverables specific to the project.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 5: Create introductory letter to send to identified PCP offices/clinics to integrate Palliative Care into their practice who are both PCMH Certified, as well as those who are not PCMH certified.	Project		Completed	07/01/2015	10/31/2015	07/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Step 6: Develop presentation of program services, criteria and goals to be presented by DSRIP staff members to designated office and staff and implement for pilot practices , evaluating success of the education and subsequent enrollment of patients into palliative care program	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 7: Identify visit frequencies in collaboration with Primary care office and develop a time allotment for a Palliative care representative to be present in designated offices	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 8: Continue to roll out palliative care integration in an organized manner: identification of PCMH practices with high volume of Medicaid patients, education, then to offices with PCMH intent, provide intro letter, education, registry review, referral , set up time allotment for patient for palliative care.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #2	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.									
Task The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Currently the PMO has participating agreements with hospice in Erie and Chautauqua counties. The PMO is working to recruit Niagara county hospice. The Hospice Buffalo organization will be the lead in the integration of palliative care into primary care.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: CPWNY will assemble a committee of representatives from Erie, Niagara and Chautauqua Counties with expertise in palliative care and health homes to assist with execution of DSRIP 3.g.i project strategy. The committee includes representatives from hospice, health homes, primary care providers, and CPWNY's clinical transformation and care management teams.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: The PPS will conduct county-wide meetings to facilitate the development of agreements between CPWNY primary care physicians and the respective county hospice/palliative care providers.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Ongoing collaboration with representatives from Niagara and Chautauqua County Hospice to implement 3.g.i project	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Meet with and create formal relationships with CBOs (e.g. MAS Transportation Co., Meals on Wheels, Lifeline (Personal Emergency Response Service), Health Homes, etc.) to serve and support DSRIP Medicaid patients. (As each county has different CBOs , relationship building and engagement will be specific to population needs to be served.)	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Develop and adopt clinical guidelines agreed to by all partners	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
including services and eligibility.									
Task PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form. PPS has trained staff addressing role-appropriate competence in palliative care skills.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Hospice Buffalo as a member has recommended that CPWNY adopt the Center to Advance Palliative Care evidence-based clinical care guidelines. CPWNY PPS has agreed to adopt CAPC's palliative care clinical guideline.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: CPWNY will develop a PPS-wide protocol based on CAPC's palliative care guidelines for Erie, Niagara, and Chautauqua Counties. The development of the guideline will be based upon collaboration and agreement between the 3 hospice programs and CPWNY's medical leadership, in concert with CPWNY's PCMH practices.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: CPWNY's Clinical Governance Committee will review and approve the CAPC-based clinical guideline based upon the recommendations of CPWNY's medical director in concert with hospice partners.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Present PC guidelines to designated PCMH offices (roll out effort) and staff identified above as ongoing education in-services. The ongoing training will include MOLST (Medical Orders for Life Sustaining Treatment) forms. CPWNY will use physician champion to advocate for guideline adoption. (ongoing effort)	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Palliative care project team will initiate discussion with providers to complete MOLST (Medical Orders for Life Sustaining Treatment) forms with designated patients of PCP practices with a focus on designating an accountable person in the office to oversee this endeavor with appropriate	Project		In Progress	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2

Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
documentation.									
Task Step 6: CPWNY will conduct periodic assessment (use of advanced directives, MOLST forms, volume of referrals from registry) of implementation of CPWNY's palliative care guidelines and referrals. Utilize RCE method for process improvement.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: CPWNY will sustain the effort by continuously highlighting and reinforcing the value of palliative care services using physician and care team champions from both the practice community and from hospice partners. (ongoing effort)	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Staff has received appropriate palliative care skills training, including training on PPS care protocols.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1:The delivery of appropriate palliative care requires a palliative care team to train clinical staff to ensure the professional staff are confident in their ability to provide palliative care. CPWNY has specialized palliative care professionals as members of the PPS, who will assist in the design and development of staff training for PCMH practices and staff.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: The delivery of appropriate palliative care requires a palliative care team to train clinical staff to ensure the professional staff are confident in their ability to provide palliative care. CPWNY will use specialized palliative care professionals who are appropriately trained in this area of expertise to deliver care.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: CPWNY will identify PCMH practices to implement palliative care. Each PCMH practice will select staff members to receive specific palliative care trainings (on-site or webinar) consistent with the CAPC-based guidelines. For practices that	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
do not wish to train their staff members in palliative care consultations, the hospice and palliative care partners will arrange for either in-office or home-based palliative care consultations.									
Task Step 4: CPWNY will conduct periodic assessment of patient experience with palliative care consultations as well as surveys for the palliative care professionals to determine additional training needs and/or the need to training additional staff.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: CPWNY will monitor on periodic basis the frequency of palliative care consultations consistent with scale and speed.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.	Project	N/A	In Progress	07/01/2015	12/31/2018	07/01/2015	12/31/2018	12/31/2018	DY4 Q3
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.	Project		In Progress	07/01/2015	12/31/2018	07/01/2015	12/31/2018	12/31/2018	DY4 Q3
Task Step 1: CPWNY will assess current level of financial coverage for palliative care consultations for the Medicaid population and accompanied policies for the 5 managed care plans and Fee-For-Service.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 2: CPWNY's PMO has existing value based Medicaid managed care contracts. The PMO will leverage these relationships to develop protocols for treatment and accompanied reimbursement. CPWNY in concert with palliative care and PCMH partners will meet with health plans to review, prioritize, and address MMC coverage of palliative care services.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 3: The PMO will leverage its medical leadership to set forth the value and appropriateness of palliative care for the population in need.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: The PMO will conduct population health assessment of patients with chronic health conditions for each health plan. The PMO will identify the patients who could potentially benefit from	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
palliative care. The PMO in collaboration with local health plans will train PCMH staff in early identification of patients and proper approach to initiating a palliative care discussion.									
Task Step 5: CPWNY will conduct periodic assessment of palliative care effectiveness and coverage. The PMO will share the assessment with the managed care plans and the other PPS in WNY.	Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: CPWNY will identify ICD and V codes that describe any palliative care sensitive conditions.	Project		In Progress	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: CPWNY will train PCMH staff to use the codes to improve identification and tracking of patients who could potentially benefit from palliative care services. Note: As a requirement of PCMH, the practices have existing tracking capability. More than half of CPWNY's primary care partners are currently PCMH.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: CPWNY will develop and pilot a screening tool to assist PCP's to identify patients (as part of the protocol that is in concert with the guidelines adopted) who are appropriate for palliative care consultation/intervention. (start with pilot practices first)	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: CPWNY will develop a palliative care identification and tracking system within the Crimson population health management system that can be used by the practices (in addition to registries in the office) to identify the target population and to track the overall integration of palliative care within the target population. (system check)	Project		In Progress	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 5: CPWNY in collaboration with the palliative care project team will establish metrics and create dashboards to track/manage scale and speed and DSRIP goals specific to palliative care.									
Task Step 6: CPWNY will conduct periodic assessment of palliative care patient tracking via EMR and IT platforms. (reflective of step 4)	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.										
Task PPS has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH and/or APCM have been included. The PPS has received agreement from those PCPs not PCMH and/or APCM certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3.	0	10	35	60	85	110	135	160	185	210
Task Step 1: The board of the project management office (PMO) conducted a strategic assessment of the areas of clinical care that are high priorities for the next three years. The assessment identified palliative care, care of patients with dementia, and patients with multiple chronic conditions as the population in greatest need and the area where the greatest gaps exist in the prevision of timely and ongoing clinical care and services.										
Task Step 2: The palliative care project team has met with Community Partners of Western New York (PPS) representatives to request recommendations of PCPs (in PCMH practices) with high Medicaid patient populations to serve as a pilot in rolling out the integration methodology. CPWNY has identified 4 MD practices targeted for initial phase of PC integration who are PCMH certified with high Medicaid patient populations. (I.e., Our Lady of Victory, Mercy Comprehensive Care Clinic, WNY Primary Care, Southgate Medical). Additional PCPs will be added to the project once the process has been solidified.										

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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 3: The project management office (PMO) will assess PCMH primary care and internal medicine practices who are caring for patients with multiple comorbid conditions including COPD, heart failure, end stage renal disease, etc. to assist in strategizing roll out. This will be accomplished through registries and communication with the clinicians at the offices. Note: ongoing activity.										
Task Step 4: The project management office (PMO) will provide education and referral linkage to palliative care services, and establish agreements with PCMH primary care practices to integrate palliative care consultation into their clinical practices. As PCMH providers are enrolled into the project, they will receive an agreement spelling out responsibilities and deliverables specific to the project.										
Task Step 5: Create introductory letter to send to identified PCP offices/clinics to integrate Palliative Care into their practice who are both PCMH Certified, as well as those who are not PCMH certified.										
Task Step 6: Develop presentation of program services, criteria and goals to be presented by DSRIP staff members to designated office and staff and implement for pilot practices , evaluating success of the education and subsequent enrollment of patients into palliative care program										
Task Step 7: Identify visit frequencies in collaboration with Primary care office and develop a time allotment for a Palliative care representative to be present in designated offices										
Task Step 8: Continue to roll out palliative care integration in an organized manner: identification of PCMH practices with high volume of Medicaid patients, education, then to offices with PCMH intent, provide intro letter, education, registry review, referral , set up time allotment for patient for palliative care.										
Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.										
Task The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice.										

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Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project 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: Currently the PMO has participating agreements with hospice in Erie and Chautauqua counties. The PMO is working to recruit Niagara county hospice. The Hospice Buffalo organization will be the lead in the integration of palliative care into primary care.										
Task Step 2: CPWNY will assemble a committee of representatives from Erie, Niagara and Chautauqua Counties with expertise in palliative care and health homes to assist with execution of DSRIP 3.g.i project strategy. The committee includes representatives from hospice, health homes, primary care providers, and CPWNY's clinical transformation and care management teams.										
Task Step 3: The PPS will conduct county-wide meetings to facilitate the development of agreements between CPWNY primary care physicians and the respective county hospice/palliative care providers.										
Task Step 4: Ongoing collaboration with representatives from Niagara and Chautauqua County Hospice to implement 3.g.i project										
Task Step 5: Meet with and create formal relationships with CBOs (e.g. MAS Transportation Co., Meals on Wheels, Lifeline (Personal Emergency Response Service), Health Homes, etc.) to serve and support DSRIP Medicaid patients. (As each county has different CBOs , relationship building and engagement will be specific to population needs to be served.)										
Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.										
Task PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form. PPS has trained staff addressing role-appropriate competence in palliative care skills.										
Task Step 1: Hospice Buffalo as a member has recommended that CPWNY adopt the Center to Advance Palliative Care evidence-based clinical care guidelines. CPWNY PPS has agreed to adopt CAPC's palliative care clinical guideline.										

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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 2: CPWNY will develop a PPS-wide protocol based on CAPC's palliative care guidelines for Erie, Niagara, and Chautauqua Counties. The development of the guideline will be based upon collaboration and agreement between the 3 hospice programs and CPWNY's medical leadership, in concert with CPWNY's PCMH practices.										
Task Step 3: CPWNY's Clinical Governance Committee will review and approve the CAPC-based clinical guideline based upon the recommendations of CPWNY's medical director in concert with hospice partners.										
Task Step 4: Present PC guidelines to designated PCMH offices (roll out effort) and staff identified above as ongoing education in-services. The ongoing training will include MOLST (Medical Orders for Life Sustaining Treatment) forms. CPWNY will use physician champion to advocate for guideline adoption. (ongoing effort)										
Task Step 5: Palliative care project team will initiate discussion with providers to complete MOLST (Medical Orders for Life Sustaining Treatment) forms with designated patients of PCP practices with a focus on designating an accountable person in the office to oversee this endeavor with appropriate documentation.										
Task Step 6: CPWNY will conduct periodic assessment (use of advanced directives, MOLST forms, volume of referrals from registry) of implementation of CPWNY's palliative care guidelines and referrals. Utilize RCE method for process improvement.										
Task Step 7: CPWNY will sustain the effort by continuously highlighting and reinforcing the value of palliative care services using physician and care team champions from both the practice community and from hospice partners. (ongoing effort)										
Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.										
Task Staff has received appropriate palliative care skills training, including training on PPS care protocols.										
Task Step 1:The delivery of appropriate palliative care requires a										

Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
palliative care team to train clinical staff to ensure the professional staff are confident in their ability to provide palliative care. CPWNY has specialized palliative care professionals as members of the PPS, who will assist in the design and development of staff training for PCMH practices and staff.										
Task Step 2: The delivery of appropriate palliative care requires a palliative care team to train clinical staff to ensure the professional staff are confident in their ability to provide palliative care. CPWNY will use specialized palliative care professionals who are appropriately trained in this area of expertise to deliver care.										
Task Step 3: CPWNY will identify PCMH practices to implement palliative care. Each PCMH practice will select staff members to receive specific palliative care trainings (on-site or webinar) consistent with the CAPC-based guidelines. For practices that do not wish to train their staff members in palliative care consultations, the hospice and palliative care partners will arrange for either in-office or home-based palliative care consultations.										
Task Step 4: CPWNY will conduct periodic assessment of patient experience with palliative care consultations as well as surveys for the palliative care professionals to determine additional training needs and/or the need to training additional staff.										
Task Step 5: CPWNY will monitor on periodic basis the frequency of palliative care consultations consistent with scale and speed.										
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.										
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.										
Task Step 1: CPWNY will assess current level of financial coverage for palliative care consultations for the Medicaid population and accompanied policies for the 5 managed care plans and Fee-For-Service.										
Task Step 2: CPWNY's PMO has existing value based Medicaid managed care contracts. The PMO will leverage these relationships to develop protocols for treatment and accompanied reimbursement. CPWNY in concert with palliative										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
care and PCMH partners will meet with health plans to review, prioritize, and address MMC coverage of palliative care services.										
Task Step 3: The PMO will leverage its medical leadership to set forth the value and appropriateness of palliative care for the population in need.										
Task Step 4: The PMO will conduct population health assessment of patients with chronic health conditions for each health plan. The PMO will identify the patients who could potentially benefit from palliative care. The PMO in collaboration with local health plans will train PCMH staff in early identification of patients and proper approach to initiating a palliative care discussion.										
Task Step 5: CPWNY will conduct periodic assessment of palliative care effectiveness and coverage. The PMO will share the assessment with the managed care plans and the other PPS in WNY.										
Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1: CPWNY will identify ICD and V codes that describe any palliative care sensitive conditions.										
Task Step 2: CPWNY will train PCMH staff to use the codes to improve identification and tracking of patients who could potentially benefit from palliative care services. Note: As a requirement of PCMH, the practices have existing tracking capability. More than half of CPWNY's primary care partners are currently PCMH.										
Task Step 3: CPWNY will develop and pilot a screening tool to assist PCP's to identify patients (as part of the protocol that is in concert with the guidelines adopted) who are appropriate for palliative care consultation/intervention. (start with pilot practices first)										
Task Step 4: CPWNY will develop a palliative care identification and tracking system within the Crimson population health management system that can be used by the practices (in addition to registries in the office) to identify the target population and to track the overall integration of palliative care within the										

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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
target population. (system check)										
Task Step 5: CPWNY in collaboration with the palliative care project team will establish metrics and create dashboards to track/manage scale and speed and DSRIP goals specific to palliative care.										
Task Step 6: CPWNY will conduct periodic assessment of palliative care patient tracking via EMR and IT platforms. (reflective of step 4)										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.										
Task PPS has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH and/or APCM have been included. The PPS has received agreement from those PCPs not PCMH and/or APCM certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3.	235	399	399	399	399	399	399	399	399	399
Task Step 1: The board of the project management office (PMO) conducted a strategic assessment of the areas of clinical care that are high priorities for the next three years. The assessment identified palliative care, care of patients with dementia, and patients with multiple chronic conditions as the population in greatest need and the area where the greatest gaps exist in the prevision of timely and ongoing clinical care and services.										
Task Step 2: The palliative care project team has met with Community Partners of Western New York (PPS) representatives to request recommendations of PCPs (in PCMH practices) with high Medicaid patient populations to serve as a pilot in rolling out the integration methodology. CPWNY has identified 4 MD practices targeted for initial phase of PC integration who are PCMH certified with high Medicaid patient populations. (I.e., Our Lady of Victory, Mercy Comprehensive Care Clinic, WNY Primary Care, Southgate Medical). Additional PCPs will be added to the project once the process has been solidified.										

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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 3: The project management office (PMO) will assess PCMH primary care and internal medicine practices who are caring for patients with multiple comorbid conditions including COPD, heart failure, end stage renal disease, etc. to assist in strategizing roll out. This will be accomplished through registries and communication with the clinicians at the offices. Note: ongoing activity.										
Task Step 4: The project management office (PMO) will provide education and referral linkage to palliative care services, and establish agreements with PCMH primary care practices to integrate palliative care consultation into their clinical practices. As PCMH providers are enrolled into the project, they will receive an agreement spelling out responsibilities and deliverables specific to the project.										
Task Step 5: Create introductory letter to send to identified PCP offices/clinics to integrate Palliative Care into their practice who are both PCMH Certified, as well as those who are not PCMH certified.										
Task Step 6: Develop presentation of program services, criteria and goals to be presented by DSRIP staff members to designated office and staff and implement for pilot practices , evaluating success of the education and subsequent enrollment of patients into palliative care program										
Task Step 7: Identify visit frequencies in collaboration with Primary care office and develop a time allotment for a Palliative care representative to be present in designated offices										
Task Step 8: Continue to roll out palliative care integration in an organized manner: identification of PCMH practices with high volume of Medicaid patients, education, then to offices with PCMH intent, provide intro letter, education, registry review, referral , set up time allotment for patient for palliative care.										
Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.										
Task The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice.										

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Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project 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: Currently the PMO has participating agreements with hospice in Erie and Chautauqua counties. The PMO is working to recruit Niagara county hospice. The Hospice Buffalo organization will be the lead in the integration of palliative care into primary care.										
Task Step 2: CPWNY will assemble a committee of representatives from Erie, Niagara and Chautauqua Counties with expertise in palliative care and health homes to assist with execution of DSRIP 3.g.i project strategy. The committee includes representatives from hospice, health homes, primary care providers, and CPWNY's clinical transformation and care management teams.										
Task Step 3: The PPS will conduct county-wide meetings to facilitate the development of agreements between CPWNY primary care physicians and the respective county hospice/palliative care providers.										
Task Step 4: Ongoing collaboration with representatives from Niagara and Chautauqua County Hospice to implement 3.g.i project										
Task Step 5: Meet with and create formal relationships with CBOs (e.g. MAS Transportation Co., Meals on Wheels, Lifeline (Personal Emergency Response Service), Health Homes, etc.) to serve and support DSRIP Medicaid patients. (As each county has different CBOs , relationship building and engagement will be specific to population needs to be served.)										
Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.										
Task PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form. PPS has trained staff addressing role-appropriate competence in palliative care skills.										
Task Step 1: Hospice Buffalo as a member has recommended that CPWNY adopt the Center to Advance Palliative Care evidence-based clinical care guidelines. CPWNY PPS has agreed to adopt CAPC's palliative care clinical guideline.										

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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: CPWNY will develop a PPS-wide protocol based on CAPC's palliative care guidelines for Erie, Niagara, and Chautauqua Counties. The development of the guideline will be based upon collaboration and agreement between the 3 hospice programs and CPWNY's medical leadership, in concert with CPWNY's PCMH practices.										
Task Step 3: CPWNY's Clinical Governance Committee will review and approve the CAPC-based clinical guideline based upon the recommendations of CPWNY's medical director in concert with hospice partners.										
Task Step 4: Present PC guidelines to designated PCMH offices (roll out effort) and staff identified above as ongoing education in-services. The ongoing training will include MOLST (Medical Orders for Life Sustaining Treatment) forms. CPWNY will use physician champion to advocate for guideline adoption. (ongoing effort)										
Task Step 5: Palliative care project team will initiate discussion with providers to complete MOLST (Medical Orders for Life Sustaining Treatment) forms with designated patients of PCP practices with a focus on designating an accountable person in the office to oversee this endeavor with appropriate documentation.										
Task Step 6: CPWNY will conduct periodic assessment (use of advanced directives, MOLST forms, volume of referrals from registry) of implementation of CPWNY's palliative care guidelines and referrals. Utilize RCE method for process improvement.										
Task Step 7: CPWNY will sustain the effort by continuously highlighting and reinforcing the value of palliative care services using physician and care team champions from both the practice community and from hospice partners. (ongoing effort)										
Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.										
Task Staff has received appropriate palliative care skills training, including training on PPS care protocols.										
Task Step 1:The delivery of appropriate palliative care requires a										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
palliative care team to train clinical staff to ensure the professional staff are confident in their ability to provide palliative care. CPWNY has specialized palliative care professionals as members of the PPS, who will assist in the design and development of staff training for PCMH practices and staff.										
Task Step 2: The delivery of appropriate palliative care requires a palliative care team to train clinical staff to ensure the professional staff are confident in their ability to provide palliative care. CPWNY will use specialized palliative care professionals who are appropriately trained in this area of expertise to deliver care.										
Task Step 3: CPWNY will identify PCMH practices to implement palliative care. Each PCMH practice will select staff members to receive specific palliative care trainings (on-site or webinar) consistent with the CAPC-based guidelines. For practices that do not wish to train their staff members in palliative care consultations, the hospice and palliative care partners will arrange for either in-office or home-based palliative care consultations.										
Task Step 4: CPWNY will conduct periodic assessment of patient experience with palliative care consultations as well as surveys for the palliative care professionals to determine additional training needs and/or the need to training additional staff.										
Task Step 5: CPWNY will monitor on periodic basis the frequency of palliative care consultations consistent with scale and speed.										
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.										
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.										
Task Step 1: CPWNY will assess current level of financial coverage for palliative care consultations for the Medicaid population and accompanied policies for the 5 managed care plans and Fee-For-Service.										
Task Step 2: CPWNY's PMO has existing value based Medicaid managed care contracts. The PMO will leverage these relationships to develop protocols for treatment and accompanied reimbursement. CPWNY in concert with palliative										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
care and PCMH partners will meet with health plans to review, prioritize, and address MMC coverage of palliative care services.										
Task Step 3: The PMO will leverage its medical leadership to set forth the value and appropriateness of palliative care for the population in need.										
Task Step 4: The PMO will conduct population health assessment of patients with chronic health conditions for each health plan. The PMO will identify the patients who could potentially benefit from palliative care. The PMO in collaboration with local health plans will train PCMH staff in early identification of patients and proper approach to initiating a palliative care discussion.										
Task Step 5: CPWNY will conduct periodic assessment of palliative care effectiveness and coverage. The PMO will share the assessment with the managed care plans and the other PPS in WNY.										
Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1: CPWNY will identify ICD and V codes that describe any palliative care sensitive conditions.										
Task Step 2: CPWNY will train PCMH staff to use the codes to improve identification and tracking of patients who could potentially benefit from palliative care services. Note: As a requirement of PCMH, the practices have existing tracking capability. More than half of CPWNY's primary care partners are currently PCMH.										
Task Step 3: CPWNY will develop and pilot a screening tool to assist PCP's to identify patients (as part of the protocol that is in concert with the guidelines adopted) who are appropriate for palliative care consultation/intervention. (start with pilot practices first)										
Task Step 4: CPWNY will develop a palliative care identification and tracking system within the Crimson population health management system that can be used by the practices (in addition to registries in the office) to identify the target population and to track the overall integration of palliative care within the										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
target population. (system check)										
Task Step 5: CPWNY in collaboration with the palliative care project team will establish metrics and create dashboards to track/manage scale and speed and DSRIP goals specific to palliative care.										
Task Step 6: CPWNY will conduct periodic assessment of palliative care patient tracking via EMR and IT platforms. (reflective of step 4)										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

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Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Project 4.a.i – Promote mental, emotional and behavioral (MEB) well-being in communities

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

Instructions :

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

• Risk: MEB media campaign fails to attain awareness levels among target audiences. Mitigation: Assess effectiveness of media campaign quarterly by obtaining baseline data in quarter or first year. Align with experts in PR and marketing fields. Collaborate with established social science evaluators and website analytics experts to gather baseline data. Track and monitor referrals to a newly designated information/referral hub as well as determine where respondents obtained referral information and how long they stay on website.
• Risk: School-based MEB prevention programs do not meet the projected level of engagement of clients and provide fewer than anticipated levels of referrals due to scheduling or engagement conflicts. Mitigation: Phase in programs over multiple years to lessen the risks of not reaching target audiences in educational settings. If school-based program schedules do not allow for engagement, target community-based locations for programming.
• Risk: Programs are not age and/or culturally appropriate. Mitigation: Provide evidence-based (SAMHSA-approved) programs at targeted locations. Work closely with partner agencies with experience with multicultural populations. Provide training to staff in cultural diversity via the International Institiute and hire staff with necessary qualifications. One limitation involves staff that do not have the adequate skill set to meet the needs of the diverse population of individuals living in the targeted geographic areas of the eight WNY counties, particularly Buffalo's West Side.
• Risk: Services are duplicated or do not reach target audience. Mitigation: Mental Health Association and ECCPASA will work closely with health plans and other organizations to ensure the project is focusing on different topical areas and is not duplicating any existing efforts. Work closely with community partners to ensure that the services provided meet the needs of those in their specific community settings. Strategies to be utilized will include regularly scheduled meetings and communication to coordinate these efforts.
• Risk: Stigma about accessing mental health or addiction treatment services. Mitigation: Lessen stigma via workplace wellness programs and media campaign. Adapt program to reflect demographic/cultural considerations. Hold focus groups among target audiences and partner with agencies experienced with cultural populations. Train staff in stigma/cultural competency. Any associated resistance to this programming will be addressed via the frequency and means that will be utilized to promote these initiatives (i.e., number of TV ads, billboards, etc.). Key messaging willl utilize the concept of social norms as well as the importance of prevention and how it translates to better emotional and behavioral health.

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone 1. Engage the community partners in a planning process to design and implement mental emotional and behavioral health programs to meet the needs of the population.	In Progress	1. Engage the community partners in a planning process to design and implement mental emotional and behavioral health programs to meet the needs of the population.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 1… CPWNY will engage the Mental Health Association of Erie County (MHA) and Erie County Consult for the Prevention of Alcohol and Substance Abuse (ECCPASA) to review the community needs assessment and to align MHA and ECCPASA with the needs of the community.	Completed	Step 1… CPWNY will engage the Mental Health Association of Erie County (MHA) and Erie County Consult for the Prevention of Alcohol and Substance Abuse (ECCPASA) to review the community needs assessment and to align MHA and ECCPASA with the needs of the community.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 2… MHA and ECCPASA were selected to lead the 8-county WNY region-wide implementation on this project in collaboration with CPWNY and Millennium PPS.	Completed	Step 2… MHA and ECCPASA were selected to lead the 8-county WNY region-wide implementation on this project in collaboration with CPWNY and Millennium PPS.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 3… The following existing evidence-based SAMHSA-approved programs were identified by CPWNY's planning leadership, in concert with MHA and ECCPASA, as being aligned with community needs assessment. They include Mental Health First Aid, Too Good for Violence, Ripple Effect, Compeer, and the Wellness Recovery Act. These programs are currently being utilized in WNY and have a proven record in reducing suicide	Completed	Step 3… The following existing evidence-based SAMHSA-approved programs were identified by CPWNY's planning leadership, in concert with MHA and ECCPASA, as being aligned with community needs assessment. They include Mental Health First Aid, Too Good for Violence, Ripple Effect, Compeer, and the Wellness Recovery Act. These programs are currently being utilized in WNY and have a proven record in reducing suicide and reducing factors leading to depression.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
and reducing factors leading to depression.								
Task Step 4… MHA and ECCPASA indicated during the planning process that the current evidence-based programs need to be expanded to meet the needs of WNY community.	Completed	Step 4… MHA and ECCPASA indicated during the planning process that the current evidence-based programs need to be expanded to meet the needs of WNY community.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 5… CPWNY is currently working with MHA and ECCPASA to identify specific programs to be expanded in which counties and developing	Completed	Step 5… CPWNY is currently working with MHA and ECCPASA to identify specific programs to be expanded in which counties and developing	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 6… Contact community partners to determine capacity/interest in partnering	Completed	Step 6… Contact community partners to determine capacity/interest in partnering	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 7… Identify specific programs/projects to achieve project goals	Completed	Step 7… Identify specific programs/projects to achieve project goals	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 8… Rank order programs/projects based on impact, feasibility and funding	Completed	Step 8… Rank order programs/projects based on impact, feasibility and funding	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 9… Structure agreements (MOU) with community partners, formulizing goals, schedule and budget	In Progress	Step 9… Structure agreements (MOU) with community partners, formulizing goals, schedule and budget	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone 2. Prioritize the delivery of programs based on needs, community impact and accessibility through identification of opportunities to integrate social determinants of health into existing and/or new projects.	In Progress	2. Prioritize the delivery of programs based on needs, community impact and accessibility through identification of opportunities to integrate social determinants of health into existing and/or new projects.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Use community needs assessment to identify priority needs and programs/projects	Completed	Use community needs assessment to identify priority needs and programs/projects	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Select programs/projects primarily from	Completed	Select programs/projects primarily from SAMHSA's approved registry	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
SAMHSA's approved registry								
Task Identify partners with expertise and experience in targeted program/project areas	In Progress	Identify partners with expertise and experience in targeted program/project areas	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Continue to assess project impact and adjust programs/projects as necessary. Project impact will be evaluated by increasing the number of Medicaid members participating in each of the 4 programs that are aligned with the community needs assessment finds and the MEB projects should force on suicide, depression, prescription drug abuse, and substance abuse.	In Progress	Continue to assess project impact and adjust programs/projects as necessary. Project impact will be evaluated by increasing the number of Medicaid members participating in each of the 4 programs that are aligned with the community needs assessment finds and the MEB projects should force on suicide, depression, prescription drug abuse, and substance abuse.	04/01/2015	09/30/2018	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Use public awareness, education and other projects to address and positively impact depression rates in the targeted population groups	In Progress	Use public awareness, education and other projects to address and positively impact depression rates in the targeted population groups	04/01/2016	03/31/2020	04/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task Use public awareness, education and other projects to address and positively impact the rate of suicide in the targeted population groups	In Progress	Use public awareness, education and other projects to address and positively impact the rate of suicide in the targeted population groups	01/01/2017	03/31/2020	01/01/2017	03/31/2020	03/31/2020	DY5 Q4
Task Use public awareness, education and other projects to address and positively impact the rate of substance use in the targeted population groups	In Progress	Use public awareness, education and other projects to address and positively impact the rate of substance use in the targeted population groups	07/01/2017	03/31/2020	07/01/2017	03/31/2020	03/31/2020	DY5 Q4
Task Use public awareness, education, and other projects to address prescription drug abuse levels in the targeted population groups	In Progress	Use public awareness, education, and other projects to address prescription drug abuse levels in the targeted population groups	10/01/2018	03/31/2020	10/01/2018	03/31/2020	03/31/2020	DY5 Q4
Milestone 3. Identify outcome metrics and report requirements for programs that will promote resiliency among participants	In Progress	3. Identify outcome metrics and report requirements for programs that will promote resiliency among participants	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Measure and make available local and State data on MEB well-being and MEB disorder prevention to increase transparency and quality on practice.	In Progress	Measure and make available local and State data on MEB well-being and MEB disorder prevention to increase transparency and quality on practice.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Use community needs assessment and NYS DOH data to establish program/project benchmarks	In Progress	Use community needs assessment and NYS DOH data to establish program/project benchmarks	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Set annual goals for program/project duration	In Progress	Set annual goals for program/project duration	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Measure program/project impact at annual intervals	In Progress	Measure program/project impact at annual intervals	04/01/2016	03/31/2020	04/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task Make program/project adjustments as necessary	In Progress	Make program/project adjustments as necessary	04/01/2016	03/31/2020	04/01/2016	03/31/2020	03/31/2020	DY5 Q4
Milestone 4. Identify how the DSRIP initiatives will increase the number of people receiving services. Project the member of participants who will be impacted by this project.	In Progress	4. Identify how the DSRIP initiatives will increase the number of people receiving services. Project the member of participants who will be impacted by this project.	09/01/2015	03/31/2020	09/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Projected numbers of participants who will be impacted by sub projects are estimated below: Skill building programs for elementary and middle school ECCPASA >= 4,600 youth Skill building programs for elementary and middle school WNY United >= 4,600 youth Teen Intervene for High School ECCPASA >= 100 youth Teen Intervene for High School Northpointe Council >= 100 youth Wellness in the workplace >= 1,500 Mental Health First Aid >= 575 CASA >= 420 Too Good for Violence = 5000	In Progress	Projected numbers of participants who will be impacted by sub projects are estimated below: Skill building programs for elementary and middle school ECCPASA >= 4,600 youth Skill building programs for elementary and middle school WNY United >= 4,600 youth Teen Intervene for High School ECCPASA >= 100 youth Teen Intervene for High School Northpointe Council >= 100 youth Wellness in the workplace >= 1,500 Mental Health First Aid >= 575 CASA >= 420 Too Good for Violence = 5000 Legal Services and Advocacy >=250 WRAP >= 630 Compeer >= 350	09/01/2015	03/31/2020	09/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Legal Services and Advocacy >=250 WRAP >= 630 Compeer >= 350 Information and Referral >= 750,000 BEST/Ripple Effects >= 4,500 Community Media Campaign = approximately 1.3 million Coalition Support/Law Enforcement Compliance Checks/Community Education = approximately 300,000		Information and Referral >= 750,000 BEST/Ripple Effects >= 4,500 Community Media Campaign = approximately 1.3 million Coalition Support/Law Enforcement Compliance Checks/Community Education = approximately 300,000						
Milestone 5. 31 organizations formally implement evidence-based practices identified by the project.	In Progress	5. 31 organizations formally implement evidence-based practices identified by the project.	09/01/2015	03/31/2020	09/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Provide administrative oversight to ensure implementation of evidence-based programs by community partners	In Progress	Provide administrative oversight to ensure implementation of evidence-based programs by community partners	09/01/2015	03/31/2020	09/01/2015	03/31/2020	03/31/2020	DY5 Q4

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
1. Engage the community partners in a planning process to design and implement mental emotional and behavioral health programs to meet the needs of the population.	
2. Prioritize the delivery of programs based on needs, community impact and accessibility through identification of opportunities to integrate social determinants of health into existing and/or new projects.	

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
3. Identify outcome metrics and report requirements for programs that will promote resiliency among participants	
4. Identify how the DSRIP initiatives will increase the number of people receiving services. Project the member of participants who will be impacted by this project.	
5. 31 organizations formally implement evidence-based practices identified by the project.	

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

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

Instructions :

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

• Risk: Incompatibility of information technology systems. Provider EMRs may not be compatible with the NYS Smokers' Quitline database and patient tracking system, which could create a problem for creating a successful direct referral system. Providers may not have electronic access to patient smoking status after Quitline intervention. Mitigation: CPWNY will work with our information technology team to build or expand exchange capability between provider EMRs and the NYS Smokers' Quitline, and to build tobacco and referral status into existing EMRs. CPWNY will enlist HEALTHeLINK to help build a general exchange capability between providers and the Quitline regardless of EMR vendor. Providers without an EMR can provide referrals through Quitline's Fax-to-Quit program, and will receive follow up on patient progress.

• Risk: Ability to engage a critical mass of providers who will adopt automatic referral programs. Without provider engagement the Quitline will have limited access to patients in need of cessation services. Mitigation: CPWNY will distribute information to its providers on behalf of the NYS Smokers' Quitline detailing the benefits and potential impact of direct referral on high-risk patients. CPWNY will enlist current providers using these services to advocate for the benefits of these programs. Priority will be placed on engaging providers who touch the highest volumes of high risk and hard to reach patients, for example those with multiple cardiac conditions or patients with mental illness. CPWNY will also work with the information technology team and the NYS Smokers' Quitline to make the referral process easy and convenient for providers.

• Risk: Ability to engage high-risk groups, such as minorities, low income patients, or those with mental illness. These patient groups are traditionally more likely to use tobacco products and less successful in their quit attempts. Inability to engage these patients will limit the impact of this project in reaching the highest need members of the DSRIP population. Mitigation: CPWNY will work with the NYS Smokers' Quitline to expand current quit messaging and quit tips services to target specific high risk populations. CPWNY and the Quitline field team will work to engage community organizations and providers that work directly with the identified high risk populations, such as mental health and substance abuse counseling services, social service providers, faith based organizations, behavioral health providers, and safety net clinics to inform and refer patients to cessation programs. CPWNY will work with Medicaid Managed Care Organizations to ensure that cost of cessation medications and nicotine replacement therapies are covered and do not require a patient copay. The NYS Smokers' Quitline will work with CPWNY to establish policies regarding additional follow up texts, phone calls, counseling appointments, and provider consults for patients identified as high risk.

• Risk: Inability to track and follow up with engaged patients. Without tracking and follow up CPWNY will be unable to gage the success and effectiveness of the program. Mitigation: CPWNY will capitalize on the NYS Smokers' Quitline's existing data management resources, which include updates on patient progress and a history of participation. CPWNY will work to incorporate information on patient histories with nicotine replacement therapies, counseling services, and success of previous quit attempts into patient records electronically through EMR modifications or manually through additions to paper records. A two-way referral system will be developed between the Quitline and providers to follow up on patients who have unsuccessful quit attempts or repeat calls. CPWNY, in partnership with HEALTHeLINK and the NYS Smokers' Quitline, will develop secure data sharing capabilities between participants.

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Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone 1. Announcement to community partners on intention to take action on this project and invitation for collaboration.	In Progress	1. Announcement to community partners on intention to take action on this project and invitation for collaboration.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify community partners with interest in promoting tobacco cessation	In Progress	Identify community partners with interest in promoting tobacco cessation	07/21/2015	01/07/2016	07/21/2015	01/07/2016	03/31/2016	DY1 Q4
Task Identify lead contact in each partner organization	In Progress	Identify lead contact in each partner organization	07/21/2015	01/07/2016	07/21/2015	01/07/2016	03/31/2016	DY1 Q4
Task Set up meeting with individual lead contacts to discuss possible collaboration	In Progress	Set up meeting with individual lead contacts to discuss possible collaboration	10/07/2015	04/07/2016	10/07/2015	04/07/2016	06/30/2016	DY2 Q1
Task Meet with lead contact of each organization to discuss needs	In Progress	Meet with lead contact of each organization to discuss needs	10/07/2015	04/07/2016	10/07/2015	04/07/2016	06/30/2016	DY2 Q1
Task Examine individual partner organization's needs and develop plan to meet those needs	In Progress	Examine individual partner organization's needs and develop plan to meet those needs	10/07/2015	07/07/2016	10/07/2015	07/07/2016	09/30/2016	DY2 Q2
Task Meet with lead contact of each organization to discuss plan and implementation	In Progress	Meet with lead contact of each organization to discuss plan and implementation	01/07/2016	07/07/2016	01/07/2016	07/07/2016	09/30/2016	DY2 Q2
Task Provide lead contact with necessary cessation-related materials	In Progress	Provide lead contact with necessary cessation-related materials	04/07/2016	10/07/2016	04/07/2016	10/07/2016	12/31/2016	DY2 Q3
Task Set up meeting with lead contact to follow-up and review plan	In Progress	Set up meeting with lead contact to follow-up and review plan	10/07/2016	03/31/2017	10/07/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone 2. Adopt tobacco-free outdoor policies.	In Progress	2. Adopt tobacco-free outdoor policies.	07/21/2015	07/07/2016	07/21/2015	07/07/2016	09/30/2016	DY2 Q2

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Work with Erie and Niagara Tobacco-Free Coalition to review and update a summary of current institutional policies regarding tobacco-free environment and tobacco-free outdoor policies.	In Progress	Work with Erie and Niagara Tobacco-Free Coalition to review and update a summary of current institutional policies regarding tobacco-free environment and tobacco-free outdoor policies.	07/21/2015	10/07/2015	07/21/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify institutions of interest	In Progress	Identify institutions of interest	07/21/2015	10/07/2015	07/21/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify resource (Web site, individual) to be contacted regarding institutional policies	In Progress	Identify resource (Web site, individual) to be contacted regarding institutional policies	10/07/2015	01/07/2016	10/07/2015	01/07/2016	03/31/2016	DY1 Q4
Task Create a database to record tobacco-free environment policy information from each institution	In Progress	Create a database to record tobacco-free environment policy information from each institution	01/07/2016	04/07/2016	01/07/2016	04/07/2016	06/30/2016	DY2 Q1
Task Obtain information from each identified institution regarding tobacco-related policies	In Progress	Obtain information from each identified institution regarding tobacco-related policies	04/07/2016	07/07/2016	04/07/2016	07/07/2016	09/30/2016	DY2 Q2
Milestone 3. Incorporate tobacco use assessment and automatic referral into Opt-to-Quit program from provider Electronic Health Record systems for smoking cessation	In Progress	3. Incorporate tobacco use assessment and automatic referral into Opt-to-Quit program from provider Electronic Health Record systems for smoking cessation	07/21/2015	03/31/2020	07/21/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify partner providers within PPS	In Progress	Identify partner providers within PPS	07/21/2015	01/07/2019	07/21/2015	01/07/2019	03/31/2019	DY4 Q4
Task Identify lead contact in each partner provider of interest	In Progress	Identify lead contact in each partner provider of interest	10/07/2015	01/07/2019	10/07/2015	01/07/2019	03/31/2019	DY4 Q4
Task Set up meeting with individual lead contacts to discuss integration of tobacco use assessment at patient visit and automatic referral to Opt-to-Quit program through NYS Smokers' Quitline (NYSSQ). "Opt to Quit" program includes counseling and referring services to all smokers including smokers with disabilities and/or mental health conditions.	In Progress	Set up meeting with individual lead contacts to discuss integration of tobacco use assessment at patient visit and automatic referral to Opt-to-Quit program through NYS Smokers' Quitline (NYSSQ). "Opt to Quit" program includes counseling and referring services to all smokers including smokers with disabilities and/or mental health conditions.	10/07/2015	10/07/2019	10/07/2015	10/07/2019	12/31/2019	DY5 Q3

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Work with office staff of interested providers to program tobacco use assessment and automatic referral to NYSSQ with current Electronic Health Record system	In Progress	Work with office staff of interested providesr to program tobacco use assessment and automatic referral to NYSSQ with current Electronic Health Record system	10/07/2015	10/07/2019	10/07/2015	10/07/2019	12/31/2019	DY5 Q3
Task Conduct trainings with medical staff regarding tobacco use assessment and referral to NYSSQ	In Progress	Conduct trainings with medical staff regarding tobacco use assessment and referral to NYSSQ	10/07/2015	10/07/2019	10/07/2015	10/07/2019	12/31/2019	DY5 Q3
Task Increase patient participation by 10% in the Opt-to-Quit program through recruitment of 2 additional providers. Note: CPWNY orginally projected 25% increase in patient participation in DY1 via recruitment of 4 additional providers and 33% increase annually in the following years. The plan is adjusted due to the delays in DSRIP timelines and the shift in DSRIP years.	In Progress	Increase patient participation by 10% in the Opt-to-Quit program through recruitment of 2 additional providers. Note: CPWNY orginally projected 25% increase in patient participation in DY1 via recruitment of 4 additional providers and 33% increase annually in the following years. The plan is adjusted due to the delays in DSRIP timelines and the shift in DSRIP years.	01/07/2016	01/07/2017	01/07/2016	01/07/2017	03/31/2017	DY2 Q4
Task Increase patient participation by 25% in the Opt-to-Quit program through recruitment of 4 additional providers	In Progress	Increase patient participation by 25% in the Opt-to-Quit program through recruitment of 4 additional providers	01/07/2017	01/07/2018	01/07/2017	01/07/2018	03/31/2018	DY3 Q4
Task Increase patient participation by 25% in the Opt-to-Quit program through recruitment of 4 additional providers	In Progress	Increase patient participation by 25% in the Opt-to-Quit program through recruitment of 4 additional providers	01/07/2018	01/07/2019	01/07/2018	01/07/2019	03/31/2019	DY4 Q4
Task Increase patient participation by 25% in the Opt-to-Quit program through recruitment of 4 additional providers	In Progress	Increase patient participation by 25% in the Opt-to-Quit program through recruitment of 4 additional providers	01/07/2019	01/07/2020	01/07/2019	01/07/2020	03/31/2020	DY5 Q4
Task Follow-up with providers regarding questions and concerns	In Progress	Follow-up with providers regarding questions and concerns	01/07/2020	03/31/2020	01/07/2020	03/31/2020	03/31/2020	DY5 Q4
Task To mitigate the risk of lack of adoption of Opt-to-Quit from providers or patients, CPWNY will	In Progress	To mitigate the risk of lack of adoption of Opt-to-Quit from providers or patients, CPWNY will also provide assistance on adopting other tobacco cessation resources such as US Public Health Services	01/07/2016	03/31/2020	01/07/2016	03/31/2020	03/31/2020	DY5 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
also provide assistance on adopting other tobacco cessation resources such as US Public Health Services Guidelines.		Guidelines.						
Milestone 4. Incorporate tobacco dependence assessment and treatment into Federally Qualified Health Centers and clinics primarily serving individuals with mental health co-morbidities (FQHCs).	In Progress	4. Incorporate tobacco dependence assessment and treatment into Federally Qualified Health Centers and clinics primarily serving individuals with mental health co-morbidities (FQHCs).	07/21/2015	03/31/2020	07/21/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify all FQHCs in PPS counties	In Progress	Identify all FQHCs in PPS counties	07/21/2015	01/07/2017	07/21/2015	01/07/2017	03/31/2017	DY2 Q4
Task Identify lead contact in each FQHC of interest	In Progress	Identify lead contact in each FQHC of interest	07/21/2015	01/07/2017	07/21/2015	01/07/2017	03/31/2017	DY2 Q4
Task Set up meeting with lead contact in each FQHC of interest to discuss current tobacco dependence assessment and treatment	In Progress	Set up meeting with lead contact in each FQHC of interest to discuss current tobacco dependence assessment and treatment	07/21/2015	01/07/2017	07/21/2015	01/07/2017	03/31/2017	DY2 Q4
Task Provide implementation plan, outlines, and materials to interested FQHC	In Progress	Provide implementation plan, outlines, and materials to interested FQHC	01/07/2016	01/07/2018	01/07/2016	01/07/2018	03/31/2018	DY3 Q4
Task Work with office staff of interested FQHC to program tobacco dependence assessment into Electronic Health Record (as appropriate)	In Progress	Work with office staff of interested FQHC to program tobacco dependence assessment into Electronic Health Record (as appropriate)	01/07/2016	01/07/2019	01/07/2016	01/07/2019	03/31/2019	DY4 Q4
Task Conduct trainings with office staff regarding tobacco dependence assessment and treatment options and plans	In Progress	Conduct trainings with office staff regarding tobacco dependence assessment and treatment options and plans	01/07/2016	01/07/2020	01/07/2016	01/07/2020	03/31/2020	DY5 Q4
Task Increase participation in Health Systems Change program with 2 additional FQHCs. Note: CPWNY originally projected 2 additional FQHCs in DY1. The plan is adjusted due to the delays in DSRIP timelines and the shift in DSRIP years. The following years will be on track regarding adopting at least 2 clinics per year.	In Progress	Increase participation in Health Systems Change program with 2 additional FQHCs. Note: CPWNY originally projected 2 additional FQHCs in DY1. The plan is adjusted due to the delays in DSRIP timelines and the shift in DSRIP years. The following years will be on track regarding adopting at least 2 clinics per year.	01/07/2016	01/07/2017	01/07/2016	01/07/2017	03/31/2017	DY2 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Increase participation in Health Systems Change program with 2 additional FQHCs	In Progress	Increase participation in Health Systems Change program with 2 additional FQHCs	01/07/2017	01/07/2018	01/07/2017	01/07/2018	03/31/2018	DY3 Q4
Task Increase participation in Health Systems Change program with 2 additional FQHCs	In Progress	Increase participation in Health Systems Change program with 2 additional FQHCs	01/07/2018	01/07/2019	01/07/2018	01/07/2019	03/31/2019	DY4 Q4
Task Increase participation in Health Systems Change program with 2 additional FQHCs	In Progress	Increase participation in Health Systems Change program with 2 additional FQHCs	01/07/2019	01/07/2020	01/07/2019	01/07/2020	03/31/2020	DY5 Q4
Task Follow-up with FQHCs regarding issues, questions, or concerns	In Progress	Follow-up with FQHCs regarding issues, questions, or concerns	01/07/2016	03/31/2020	01/07/2016	03/31/2020	03/31/2020	DY5 Q4
Task Evaluate expansion of program with other FQHCs associated with nearby counties and other PPSs	In Progress	Evaluate expansion of program with other FQHCs associated with nearby counties and other PPSs	07/07/2017	03/31/2020	07/07/2017	03/31/2020	03/31/2020	DY5 Q4
Milestone 5. Outline a policy within this PPS to query and document tobacco use status and that support for treatment is embedded in each encounter.	In Progress	5. Outline a policy within this PPS to query and document tobacco use status and that support for treatment is embedded in each encounter.	10/07/2015	03/31/2017	10/07/2015	03/31/2017	03/31/2017	DY2 Q4
Task Gather information and assess possibilities of assessing tobacco status in various projects within PPS	In Progress	Gather information and assess possibilities of assessing tobacco status in various projects within PPS	10/07/2015	07/07/2016	10/07/2015	07/07/2016	09/30/2016	DY2 Q2
Task Identifly lead contact in each project that can incorporate tobacco status assessment	In Progress	Identifly lead contact in each project that can incorporate tobacco status assessment	10/07/2015	07/07/2016	10/07/2015	07/07/2016	09/30/2016	DY2 Q2
Task Set up meeting with lead contact in each project of interest to discuss possible integration of tobacco dependence assessment within current project structure	In Progress	Set up meeting with lead contact in each project of interest to discuss possible integration of tobacco dependence assessment within current project structure	01/07/2016	10/07/2016	01/07/2016	10/07/2016	12/31/2016	DY2 Q3
Task Provide necessary materials or resources for project lead to integrate tobacco dependence assessment	In Progress	Provide necessary materials or resources for project lead to integrate tobacco dependence assessment	04/07/2016	01/07/2017	04/07/2016	01/07/2017	03/31/2017	DY2 Q4
Task	In Progress	Follow-up with each interested project regarding issues or concerns	07/07/2016	03/31/2017	07/07/2016	03/31/2017	03/31/2017	DY2 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Follow-up with each interested project regarding issues or concerns								
Milestone 6. Work with NYS DOH Bureau of Tobacco Control's 16 'Health Systems for a Tobacco-Free NY' contractors to receive technical assistance on system improvements related to tobacco use cessation.	In Progress	6. Work with NYS DOH Bureau of Tobacco Control's 16 'Health Systems for a Tobacco-Free NY' contractors to receive technical assistance on system improvements related to tobacco use cessation.	10/07/2015	01/07/2019	10/07/2015	01/07/2019	03/31/2019	DY4 Q4
Task Identify lead contact for all 16 'Healthy Systems for a Tobacco-Free NY' contractors (including one located within this PPS at Roswell Park Cancer Institute)	In Progress	Identify lead contact for all 16 'Healthy Systems for a Tobacco-Free NY' contractors (including one located within this PPS at Roswell Park Cancer Institute)	10/07/2015	04/07/2016	10/07/2015	04/07/2016	06/30/2016	DY2 Q1
Task Contact each lead individual and discuss services available and issues that need support	In Progress	Contact each lead individual and discuss services available and issues that need support	01/07/2016	01/07/2017	01/07/2016	01/07/2017	03/31/2017	DY2 Q4
Task Outline communication plan with each contractor regarding technical assistance	In Progress	Outline communication plan with each contractor regarding technical assistance	01/07/2016	10/07/2016	01/07/2016	10/07/2016	12/31/2016	DY2 Q3
Task Develop trainings for contractors regarding system improvements related to tobacco use cessation	In Progress	Develop trainings for contractors regarding system improvements related to tobacco use cessation	04/07/2016	01/07/2017	04/07/2016	01/07/2017	03/31/2017	DY2 Q4
Task Conduct trainings with contractors regarding system improvements related to tobacco use cessation	In Progress	Conduct trainings with contractors regarding system improvements related to tobacco use cessation	01/07/2017	01/07/2018	01/07/2017	01/07/2018	03/31/2018	DY3 Q4
Task Follow-up with contractors to develop maintainance plan for trainings and technical assistance	In Progress	Follow-up with contractors to develop maintainance plan for trainings and technical assistance	01/07/2018	01/07/2019	01/07/2018	01/07/2019	03/31/2019	DY4 Q4
Milestone 7. Development and dissemination of a communication strategy for patient and clinician education regarding availability of covered tobacco dependence treatment that	In Progress	7. Development and dissemination of a communication strategy for patient and clinician education regarding availability of covered tobacco dependence treatment that encourages patients to use the services.	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
encourages patients to use the services.								
Task Develop materials designed to educate providers and patients regarding Medicaid benefits for smoking cessation (i.e. medications, counseling)	In Progress	Develop materials designed to educate providers and patients regarding Medicaid benefits for smoking cessation (i.e. medications, counseling)	07/21/2015	01/07/2016	07/21/2015	01/07/2016	03/31/2016	DY1 Q4
Task Disseminate materials to FQHCs, Home Health providers, PPS partner organizations and providers, and through New York State Smokers' Quitline	In Progress	Disseminate materials to FQHCs, Home Health providers, PPS partner organizations and providers, and through New York State Smokers' Quitline	01/07/2016	03/31/2017	01/07/2016	03/31/2017	03/31/2017	DY2 Q4
Task Train counselors at New York State Smokers' Quitline about Medicaid benefits for smoking cessation so they can effectively advise callers	In Progress	Train counselors at New York State Smokers' Quitline about Medicaid benefits for smoking cessation so they can effectively advise callers	01/07/2016	03/31/2017	01/07/2016	03/31/2017	03/31/2017	DY2 Q4
Task Train other PPS providers about Medicaid benefits for smoking cessation so they can effectively advise clients. Training will be delivered via meetings, webinar, newsletter, and informational materials upon request.	In Progress	Train other PPS providers about Medicaid benefits for smoking cessation so they can effectively advise clients. Training will be delivered via meetings, webinar, newsletter, and informational materials upon request.	01/07/2016	03/31/2017	01/07/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone 8. Increase tobacco cessation rates among residents in shared multi-unit housing environments.	In Progress	8. Increase tobacco cessation rates among residents in shared multi-unit housing environments.	07/21/2015	03/31/2020	07/21/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify companies managing the largest number of multi-unit housing units and municipal housing authorities in low socio-economic status (SES) areas in PPS counties (Erie, Niagara, Chautauqua)	In Progress	Identify companies managing the largest number of multi-unit housing units and municipal housing authorities in low socio-economic status (SES) areas in PPS counties (Erie, Niagara, Chautauqua)	07/21/2015	10/07/2015	07/21/2015	03/31/2016	03/31/2016	DY1 Q4
Task Set up meeting with lead contacts to discuss current tobacco use policies and interest in promoting tobacco cessation among residents	In Progress	Set up meeting with lead contacts to discuss current tobacco use policies and interest in promoting tobacco cessation among residents	10/07/2015	07/07/2016	10/07/2015	07/07/2016	09/30/2016	DY2 Q2
Task Follow-up discussion/meeting with provision of	In Progress	Follow-up discussion/meeting with provision of materials	04/07/2016	07/07/2016	04/07/2016	07/07/2016	09/30/2016	DY2 Q2

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
materials								
Task Conduct smoking cessation clinics with residents interested in quitting	In Progress	Conduct smoking cessation clinics with residents interested in quitting	04/07/2016	03/31/2020	04/07/2016	03/31/2020	03/31/2020	DY5 Q4
Task Conduct a pre- and post-cessation clinic surveys regarding tobacco use status and quit attempts	In Progress	Conduct a pre- and post-cessation clinic surveys regarding tobacco use status and quit attempts	04/07/2016	03/31/2020	04/07/2016	03/31/2020	03/31/2020	DY5 Q4
Task Establish agreements with 3 property management firms representing approximately 5% of the multiunit housing market share to promote smoking cessation. Note: CPWNY orginally projected the establish of agreements will start in DY1. The plan is adjusted due to the delays in DSRIP timelines and the shift in DSRIP years. The following years will be on tracking regarding establishing additional agreements with property management firms.	In Progress	Establish agreements with 3 property management firms representing approximately 5% of the multiunit housing market share to promote smoking cessation. Note: CPWNY orginally projected the establish of agreements will start in DY1. The plan is adjusted due to the delays in DSRIP timelines and the shift in DSRIP years. The following years will be on tracking regarding establishing additional agreements with property management firms.	04/07/2016	04/07/2017	04/07/2016	04/07/2017	06/30/2017	DY3 Q1
Task Establish agreements with 3 property management firms representing approximately 5% of the multiunit housing market share to promote smoking cessation	In Progress	Establish agreements with 3 property management firms representing approximately 5% of the multiunit housing market share to promote smoking cessation	04/07/2017	04/07/2018	04/07/2017	04/07/2018	06/30/2018	DY4 Q1
Task Establish agreements with 3 property management firms representing approximately 5% of the multiunit housing market share to promote smoking cessation	In Progress	Establish agreements with 3 property management firms representing approximately 5% of the multiunit housing market share to promote smoking cessation	04/07/2018	04/07/2019	04/07/2018	04/07/2019	06/30/2019	DY5 Q1
Task Establish agreements with 3 property management firms representing approximately 5% of the multiunit housing market share to promote smoking cessation	In Progress	Establish agreements with 3 property management firms representing approximately 5% of the multiunit housing market share to promote smoking cessation	04/07/2019	03/31/2020	04/07/2019	03/31/2020	03/31/2020	DY5 Q4
Task Follow-up discussion/meeting with lead contact to discuss next steps, policy changes	In Progress	Follow-up discussion/meeting with lead contact to discuss next steps, policy changes	04/07/2017	03/31/2020	04/07/2017	03/31/2020	03/31/2020	DY5 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone 9. Advocate for increased coverage and promote awareness of tobacco cessation benefits for Medicaid population	In Progress	9. Advocate for increased coverage and promote awareness of tobacco cessation benefits for Medicaid population	07/21/2015	03/31/2020	07/21/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 1…The PPS project management office, Catholic Medical Partners, currently has Medicaid risk contracts (with Value Based Payment metrics) with 3 payers and is working to develop risk contracts with 2 additional health plans. This would include the majority of Medicaid population attributed to CPWNY. Please note that Catholic Medical Partners project management team has had Value Based contracts based on successful collaborative relationships in the last 10 years.	In Progress	Step 1…The PPS project management office, Catholic Medical Partners, currently has Medicaid risk contracts (with Value Based Payment metrics) with 3 payers and is working to develop risk contracts with 2 additional health plans. This would include the majority of Medicaid population attributed to CPWNY. Please note that Catholic Medical Partners project management team has had Value Based contracts based on successful collaborative relationships in the last 10 years.	11/30/2015	08/15/2016	11/30/2015	08/15/2016	09/30/2016	DY2 Q2
Task Step 2…Compile list of contacts per MCO to understand current programs and initiatives to improve tobacco cessation; including tobacco use screening, referral for cessation support and coverage of cessation materials and prescriptions.	In Progress	Step 2…Compile list of contacts per MCO to understand current programs and initiatives to improve tobacco cessation; including tobacco use screening, referral for cessation support and coverage of cessation materials and prescriptions.	11/30/2015	08/30/2016	11/30/2015	08/30/2016	09/30/2016	DY2 Q2
Task Step 3…The New York State Smokers' Quitline has the capability of identifying callers covered by Medicaid. CPWNY will work with the Quitline to identify clients in need of additional support and educational materials specifying coverage deliverables.	In Progress	Step 3…The New York State Smokers' Quitline has the capability of identifying callers covered by Medicaid. CPWNY will work with the Quitline to identify clients in need of additional support and educational materials specifying coverage deliverables.	11/30/2015	08/15/2017	11/30/2015	08/15/2017	09/30/2017	DY3 Q2
Milestone 10. Work with Roswell Park Cancer Institute to develop capability of using the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	In Progress	10. Work with Roswell Park Cancer Institute to develop capability of using the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	04/01/2015	03/30/2018	04/01/2015	03/30/2018	03/31/2018	DY3 Q4

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DSRIP Implementation Plan Project

Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 1… Assess practice EMR documentation templates for inclusion of tobacco use screening and intervention	In Progress	Step 1… Assess practice EMR documentation templates for inclusion of tobacco use screening and intervention	09/03/2015	12/20/2015	09/03/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2… The EMR systems being utilized by the majority of CPWNY's partners have tobacco prompt modules. The EMR prompts the treating provider to assess whether the patient is a current smoker or has been a smoker in the past. This allows the provider to assess the patient's current smoking status and risk of recidivism. Following the assessment provider will assist the patient through referral to the "Opt to Quit" program in use by Roswell Park Cancer Institute. CPWNY will address any gaps in tobacco prompt. "Opt to Quit" program includes counseling and referral services to all smokers including smokers with disabilities and/or mental health conditions.	In Progress	Step 2… The EMR systems being utilized by the majority of CPWNY's partners have tobacco prompt modules. The EMR prompts the treating provider to assess whether the patient is a current smoker or has been a smoker in the past. This allows the provider to assess the patient's current smoking status and risk of recidivism. Following the assessment provider will assist the patient through referral to the "Opt to Quit" program in use by Roswell Park Cancer Institute. CPWNY will address any gaps in tobacco prompt. "Opt to Quit" program includes counseling and referral services to all smokers including smokers with disabilities and/or mental health conditions.	09/03/2015	12/20/2015	09/03/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Develop and deploy standard templates for providers identified by gap analysis to support evidence based guidelines and protocols, including referral to Opt to Quit program or 5 As for tobacco cessation among providers looking to incorporate more cessation support into their standard of care	In Progress	Step 3. Develop and deploy standard templates for providers identified by gap analysis to support evidence based guidelines and protocols, including referral to Opt to Quit program or 5 As for tobacco cessation among providers looking to incorporate more cessation support into their standard of care	09/01/2016	03/30/2017	09/01/2016	03/30/2017	03/31/2017	DY2 Q4
Task Step 4. Work with RPCI to develop training for CPWNY practitioners and staff on referring patients to Opt to Quit program and tobacco control 5 As	In Progress	Step 4. Work with RPCI to develop training for CPWNY practitioners and staff on referring patients to Opt to Quit program and tobacco control 5 As	10/01/2016	03/30/2018	10/01/2016	03/30/2018	03/31/2018	DY3 Q4
Task Step 5. CPWNY will assess referrals for smoking cessation on quarterly basis and	In Progress	Step 5. CPWNY will assess referrals for smoking cessation on quarterly basis and compare to baseline data on smoking. Results will be communicated through quarterly reports and improvements	10/01/2016	03/30/2018	10/01/2016	03/30/2018	03/31/2018	DY3 Q4

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DSRIP Implementation Plan Project

Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
compare to baseline data on smoking. Results will be communicated through quarterly reports and improvements will be made using Rapid Cycle improvement and Change Management strategy.		will be made using Rapid Cycle improvement and Change Management strategy.						
Task Step 6. CPWNY, in collaboration with Roswell Park Cancer Institute, will provide periodic training and educational materials on tobacco control to both patient and PPS partners. (This action will be ongoing)	In Progress	Step 6. CPWNY, in collaboration with Roswell Park Cancer Institute, will provide periodic training and educational materials on tobacco control to both patient and PPS partners. (This action will be ongoing)	10/01/2016	03/30/2018	10/01/2016	03/30/2018	03/31/2018	DY3 Q4

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
1. Announcement to community partners on intention to take action on this project and invitation for collaboration.	
2. Adopt tobacco-free outdoor policies.	
3. Incorporate tobacco use assessment and automatic referral into Opt-to-Quit program from provider Electronic Health Record systems for smoking cessation	
4. Incorporate tobacco dependence assessment and treatment into Federally Qualified Health Centers and clinics primarily serving individuals with mental health co-morbidities (FQHCs).	
5. Outline a policy within this PPS to query and document tobacco use status and that support for treatment is embedded in each encounter.	
6. Work with NYS DOH Bureau of Tobacco Control's 16 'Health Systems for a Tobacco-Free NY' contractors to receive	

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Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
technical assistance on system improvements related to tobacco use cessation.	
7. Development and dissemination of a communication strategy for patient and clinician education regarding availability of covered tobacco dependence treatment that encourages patients to use the services.	
8. Increase tobacco cessation rates among residents in shared multi-unit housing environments.	
9. Advocate for increased coverage and promote awareness of tobacco cessation benefits for Medicaid population	
10. Work with Roswell Park Cancer Institute to develop capability of using the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

DSRIP Implementation Plan Project

Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

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 'Sisters of Charity Hospital of Buffalo, New York ', that all information provided on this Quarterly report is true and accurate to the best of my knowledge, and that, following initial submission in the current quarterly reporting period as defined by NY DOH, changes made to this report were pursuant only to documented instructions or documented approval of changes from DOH or DSRIP Independent Assessor.**

Primary Lead PPS Provider:	SISTERS OF CHARITY HOSP
Secondary Lead PPS Provider:	
Lead Representative:	Peter U Bergmann
Submission Date:	03/16/2016 04:41 PM

Comments:

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Sisters of Charity Hospital of Buffalo, New York (PPS ID:46)

Status Log				
Quarterly Report (DY,Q)	**Status**	**Lead Representative Name**	**User ID**	**Date Timestamp**
DY1, Q3	Adjudicated	Peter U Bergmann	emcgill	03/31/2016 05:17 PM
DY1, Q3	Submitted	Peter U Bergmann	pb370560	03/16/2016 04:41 PM
DY1, Q3	Returned	Peter U Bergmann	emcgill	03/01/2016 05:16 PM
DY1, Q3	Submitted	Peter U Bergmann	pb370560	02/02/2016 02:54 PM
DY1, Q3	In Process		ETL	01/03/2016 08:01 PM

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Comments Log			
Status	**Comments**	**User ID**	**Date Timestamp**
Adjudicated	The IA has adjudicated the DY1 Q3 Quarterly Report.	emcgill	03/31/2016 05:17 PM
Returned	The IA is returning the DY1Q3 Quarterly Report to the PPS for Remediation.	emcgill	03/01/2016 05:16 PM

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Section	Module Name	Status
Section 01	IPQR Module 1.1 - PPS Budget Report (Baseline)	Completed
	IPQR Module 1.2 - PPS Budget Report (Quarterly)	Completed
	IPQR Module 1.3 - PPS Flow of Funds (Baseline)	Completed
	IPQR Module 1.4 - PPS Flow of Funds (Quarterly)	Completed
	IPQR Module 1.5 - Prescribed Milestones	Completed
	IPQR Module 1.6 - PPS Defined Milestones	Completed
	IPQR Module 1.7 - IA Monitoring	
Section 02	IPQR Module 2.1 - Prescribed Milestones	Completed
	IPQR Module 2.2 - PPS Defined Milestones	Completed
	IPQR Module 2.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 2.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 2.5 - Roles and Responsibilities	Completed
	IPQR Module 2.6 - Key Stakeholders	Completed
	IPQR Module 2.7 - IT Expectations	Completed
	IPQR Module 2.8 - Progress Reporting	Completed
	IPQR Module 2.9 - IA Monitoring	
Section 03	IPQR Module 3.1 - Prescribed Milestones	Completed
	IPQR Module 3.2 - PPS Defined Milestones	Completed
	IPQR Module 3.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 3.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 3.5 - Roles and Responsibilities	Completed
	IPQR Module 3.6 - Key Stakeholders	Completed
	IPQR Module 3.7 - IT Expectations	Completed
	IPQR Module 3.8 - Progress Reporting	Completed
	IPQR Module 3.9 - IA Monitoring	
Section 04	IPQR Module 4.1 - Prescribed Milestones	Completed
	IPQR Module 4.2 - PPS Defined Milestones	Completed

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Section	Module Name	Status
	IPQR Module 4.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 4.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 4.5 - Roles and Responsibilities	Completed
	IPQR Module 4.6 - Key Stakeholders	Completed
	IPQR Module 4.7 - IT Expectations	Completed
	IPQR Module 4.8 - Progress Reporting	Completed
	IPQR Module 4.9 - IA Monitoring	
Section 05	IPQR Module 5.1 - Prescribed Milestones	Completed
	IPQR Module 5.2 - PPS Defined Milestones	Completed
	IPQR Module 5.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 5.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 5.5 - Roles and Responsibilities	Completed
	IPQR Module 5.6 - Key Stakeholders	Completed
	IPQR Module 5.7 - Progress Reporting	Completed
	IPQR Module 5.8 - IA Monitoring	
Section 06	IPQR Module 6.1 - Prescribed Milestones	Completed
	IPQR Module 6.2 - PPS Defined Milestones	Completed
	IPQR Module 6.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 6.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 6.5 - Roles and Responsibilities	Completed
	IPQR Module 6.6 - Key Stakeholders	Completed
	IPQR Module 6.7 - IT Expectations	Completed
	IPQR Module 6.8 - Progress Reporting	Completed
	IPQR Module 6.9 - IA Monitoring	
Section 07	IPQR Module 7.1 - Prescribed Milestones	Completed
	IPQR Module 7.2 - PPS Defined Milestones	Completed
	IPQR Module 7.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 7.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 7.5 - Roles and Responsibilities	Completed

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Section	Module Name	Status
	IPQR Module 7.6 - Key Stakeholders	Completed
	IPQR Module 7.7 - IT Expectations	Completed
	IPQR Module 7.8 - Progress Reporting	Completed
	IPQR Module 7.9 - IA Monitoring	
Section 08	IPQR Module 8.1 - Prescribed Milestones	Completed
	IPQR Module 8.2 - PPS Defined Milestones	Completed
	IPQR Module 8.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 8.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 8.5 - Roles and Responsibilities	Completed
	IPQR Module 8.6 - Key Stakeholders	Completed
	IPQR Module 8.7 - IT Expectations	Completed
	IPQR Module 8.8 - Progress Reporting	Completed
	IPQR Module 8.9 - IA Monitoring	
Section 09	IPQR Module 9.1 - Prescribed Milestones	Completed
	IPQR Module 9.2 - PPS Defined Milestones	Completed
	IPQR Module 9.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 9.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 9.5 - Roles and Responsibilities	Completed
	IPQR Module 9.6 - Key Stakeholders	Completed
	IPQR Module 9.7 - IT Expectations	Completed
	IPQR Module 9.8 - Progress Reporting	Completed
	IPQR Module 9.9 - IA Monitoring	
Section 10	IPQR Module 10.1 - Overall approach to implementation	Completed
	IPQR Module 10.2 - Major dependencies between work streams and coordination of projects	Completed
	IPQR Module 10.3 - Project Roles and Responsibilities	Completed
	IPQR Module 10.4 - Overview of key stakeholders and how influenced by your DSRIP projects	Completed
	IPQR Module 10.5 - IT Requirements	Completed
	IPQR Module 10.6 - Performance Monitoring	Completed
	IPQR Module 10.7 - Community Engagement	Completed

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Section	Module Name	Status
	IPQR Module 10.8 - IA Monitoring	
Section 11	IPQR Module 11.1 - Workforce Strategy Spending	Completed
	IPQR Module 11.2 - Prescribed Milestones	Completed
	IPQR Module 11.3 - PPS Defined Milestones	Completed
	IPQR Module 11.4 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 11.5 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 11.6 - Roles and Responsibilities	Completed
	IPQR Module 11.7 - Key Stakeholders	Completed
	IPQR Module 11.8 - IT Expectations	Completed
	IPQR Module 11.9 - Progress Reporting	Completed
	IPQR Module 11.10 - Staff Impact	Completed
	IPQR Module 11.11 - IA Monitoring	

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

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

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Section	Module Name / Milestone #	Review Status	
Section 01	Module 1.1 - PPS Budget Report (Baseline)	Pass & Complete	
	Module 1.2 - PPS Budget Report (Quarterly)	Pass & Ongoing	
	Module 1.3 - PPS Flow of Funds (Baseline)	Pass & Complete	
	Module 1.4 - PPS Flow of Funds (Quarterly)	Pass (with Exception) & Ongoing	IA
	Module 1.5 - Prescribed Milestones		
	Milestone #1 Complete funds flow budget and distribution plan and communicate with network	Pass & Ongoing	
Section 02	Module 2.1 - Prescribed Milestones		
	Milestone #1 Finalize governance structure and sub-committee structure	Pass & Complete	
	Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Pass & Complete	
	Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	Pass & Complete	
	Milestone #4 Establish governance structure reporting and monitoring processes	Pass & Complete	
	Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	Pass & Ongoing	
	Milestone #6 Finalize partnership agreements or contracts with CBOs	Pass & Ongoing	
	Milestone #7 Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	Pass & Ongoing	
	Milestone #8 Finalize workforce communication and engagement plan	Pass & Ongoing	
	Milestone #9 Inclusion of CBOs in PPS Implementation.	Pass & Ongoing	
Section 03	Module 3.1 - Prescribed Milestones		
	Milestone #1 Finalize PPS finance structure, including reporting structure	Pass & Complete	
	Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	Pass & Ongoing	
	Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Pass & Complete	
	Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	Pass & Ongoing	
	Milestone #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	Pass & Ongoing	

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Section	Module Name / Milestone #	Review Status	
	Milestone #6 Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	Pass & Ongoing	
	Milestone #7 Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	Pass & Ongoing	
	Milestone #8 >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	Pass & Ongoing	
Section 04	Module 4.1 - Prescribed Milestones		
	Milestone #1 Finalize cultural competency / health literacy strategy.	Pass & Complete	
	Milestone #2 Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	Pass & Ongoing	
Section 05	Module 5.1 - Prescribed Milestones		
	Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	Pass & Ongoing	
	Milestone #2 Develop an IT Change Management Strategy.	Pass & Ongoing	
	Milestone #3 Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	Pass & Ongoing	
	Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	Pass & Ongoing	
	Milestone #5 Develop a data security and confidentiality plan.	Pass & Ongoing	
Section 06	Module 6.1 - Prescribed Milestones		
	Milestone #1 Establish reporting structure for PPS-wide performance reporting and communication.	Pass & Ongoing	
	Milestone #2 Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	Pass & Ongoing	
Section 07	Module 7.1 - Prescribed Milestones		
	Milestone #1 Develop Practitioners communication and engagement plan.	Pass & Ongoing	
	Milestone #2 Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	Pass & Ongoing	
Section 08	Module 8.1 - Prescribed Milestones		
	Milestone #1 Develop population health management roadmap.	Pass & Ongoing	
	Milestone #2 Finalize PPS-wide bed reduction plan.	Pass & Ongoing	
Section 09	Module 9.1 - Prescribed Milestones		
	Milestone #1 Perform a clinical integration 'needs assessment'.	Pass & Ongoing	
	Milestone #2 Develop a Clinical Integration strategy.	Pass & Ongoing	

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

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

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	care providers. c. Ensure real time notification to a Health Home care manager as applicable		
	Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	Pass & Ongoing	
	Milestone #4 Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)	Pass & Ongoing	
	Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
2.b.iv	Module 2.b.iv.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.b.iv.3 - Prescribed Milestones		
	Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	Pass & Ongoing	
	Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	Pass & Ongoing	
	Milestone #3 Ensure required social services participate in the project.	Pass & Ongoing	
	Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	Pass & Ongoing	
	Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Pass & Ongoing	
	Milestone #6 Ensure that a 30-day transition of care period is established.	Pass & Ongoing	
	Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
2.c.ii	Module 2.c.ii.2 - Patient Engagement Speed	Fail	
	Module 2.c.ii.3 - Prescribed Milestones		
	Milestone #1 Implement telemedicine services, aimed at reducing avoidable hospital use by increasing patient access to services not otherwise available and/or increasing specialty expertise of primary care providers and their staff in order to increase availability of scarce specialty services.	Pass & Ongoing	
	Milestone #2 Provide equipment specifications and rationale for equipment choice (including cost of acquisition, maintenance and sustainability of service).	Pass & Ongoing	
	Milestone #3 Define service area and participating providers, with clear delineation between telemedicine hub sites versus spoke sites.	Pass & Ongoing	

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	Milestone #4 Procure service agreements for provision of telemedicine services such as specialty services, participating primary care and nurse triage monitoring.	Pass & Ongoing	
	Milestone #5 Develop standard service protocols, as well as consent and confidentiality standards meeting all federal and state requirements.	Pass & Ongoing	
	Milestone #6 Coordinate with Medicaid Managed Care Organizations to develop and ensure service authorization and payment strategies are in place to support sustainability of patient care uses.	Pass & Ongoing	
	Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
3.a.i	Module 3.a.i.2 - Patient Engagement Speed	Fail	
	Module 3.a.i.3 - Prescribed Milestones		
	Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Pass & Ongoing	
	Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Pass & Ongoing	
	Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Pass & Ongoing	
	Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #5 Co-locate primary care services at behavioral health sites.	Pass & Ongoing	
	Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Pass & Ongoing	
	Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Pass & Ongoing	
	Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #9 Implement IMPACT Model at Primary Care Sites.	Pass & Ongoing	
	Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Pass & Ongoing	
	Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Pass & Ongoing	
	Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	Pass & Ongoing	
	Milestone #13 Measure outcomes as required in the IMPACT Model.	Pass & Ongoing	
	Milestone #14 Provide "stepped care" as required by the IMPACT Model.	Pass & Ongoing	
	Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
3.b.i	Module 3.b.i.2 - Patient Engagement Speed	Fail	

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Project ID	Module Name / Milestone #	Review Status	
	Module 3.b.i.3 - Prescribed Milestones		
	Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Pass & Ongoing	
	Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	Pass & Ongoing	
	Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Pass & Ongoing	
	Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	Pass & Ongoing	
	Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	Pass & Ongoing	
	Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Pass & Ongoing	
	Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	Pass & Ongoing	
	Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	Pass & Ongoing	
	Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	Pass & Ongoing	
	Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	Pass & Ongoing	
	Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	Pass & Ongoing	
	Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	Pass & Ongoing	
	Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	Pass & Ongoing	
	Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	Pass & Ongoing	
	Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	Pass & Ongoing	
	Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	Pass & Ongoing	
	Milestone #18 Adopt strategies from the Million Hearts Campaign.	Pass & Ongoing	
	Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	Pass & Ongoing	
	Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	Pass & Ongoing	

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3.f.i	Module 3.f.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.f.i.3 - Prescribed Milestones		
	Milestone #1 Implement an evidence-based home visitation model, such as the Nurse Family Partnership, for pregnant high- risk mothers including high-risk first time mothers.	Pass & Ongoing	
	Milestone #2 Develop a referral system for early identification of women who are or may be at high-risk.	Pass & Ongoing	
	Milestone #3 Establish a quality oversight committee of OB/GYN and primary care providers to monitor quality outcomes and implement new or change activities as appropriate.	Pass & Ongoing	
	Milestone #4 Use EHRs or other IT platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #5 Identify and engage a regional medical center with expertise in management of high-risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center).	Pass & Ongoing	
	Milestone #6 Develop a multidisciplinary team of experts with clinical and social support expertise who will co-manage care of the high-risk mother and infant with local community obstetricians and pediatric providers.	Pass & Ongoing	
	Milestone #7 Develop service MOUs between multidisciplinary team and OB/GYN providers.	Pass & Ongoing	
	Milestone #8 Utilize best evidence care guidelines for management of high risk pregnancies and newborns and implement uniform clinical protocols based upon evidence-based guidelines.	Pass & Ongoing	
	Milestone #9 Ensure that all PPS safety net providers are actively sharing EHR systems or other IT platforms with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	Pass & Ongoing	
	Milestone #10 Ensure that EHR systems or other IT platforms used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Pass & Ongoing	
	Milestone #11 Use EHRs or other IT platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #12 Develop a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaboratives (MICHC) program; access NYSDOH-funded CHW training program.	Pass & Ongoing	
	Milestone #13 Employ a Community Health Worker Coordinator responsible for supervision of 4 - 6 community health workers. Duties and qualifications are per NYS DOH criteria.	Pass & Ongoing	
	Milestone #14 Employ qualified candidates for Community Health Workers who meet criteria such as cultural competence, communication, and appropriate experience and training.	Pass & Ongoing	
	Milestone #15 Establish protocols for deployment of CHW.	Pass & Ongoing	
	Milestone #16 Coordinate with the Medicaid Managed Care organizations serving the target population.	Pass & Ongoing	
	Milestone #17 Use EHRs or other IT platforms to track all patients engaged in this project.	Pass & Ongoing	
3.g.i	Module 3.g.i.2 - Patient Engagement Speed	Fail	
	Module 3.g.i.3 - Prescribed Milestones		

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	Milestone #1 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.	Pass & Ongoing	
	Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	Pass & Ongoing	
	Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	Pass & Ongoing	
	Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	Pass & Ongoing	
	Milestone #5 Engage with Medicaid Managed Care to address coverage of services.	Pass & Ongoing	
	Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.	Pass & Ongoing	
4.a.i	Module 4.a.i.2 - PPS Defined Milestones	Pass & Ongoing	
4.b.i	Module 4.b.i.2 - PPS Defined Milestones	Pass & Ongoing	