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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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Quarterly Report - Implementation Plan for Care Compass Network

Year and Quarter: DY1, Q2 **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.iv	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions	Completed
2.b.vii	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)	Completed
2.c.i	Development of community-based health navigation services	Completed
2.d.i	Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care	Completed
3.a.i	Integration of primary care and behavioral health services	Completed
3.a.ii	Behavioral health community crisis stabilization services	Completed
3.b.i	Evidence-based strategies for disease management in high risk/affected populations (adult only)	Completed
3.g.i	Integration of palliative care into the PCMH Model	Completed
4.a.iii	Strengthen Mental Health and Substance Abuse Infrastructure across Systems	Completed
4.b.ii	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer	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	33,827,204	36,048,681	58,295,242	51,620,214	33,827,204	213,618,544
Cost of Project Implementation & Administration	**13,831,928**	**25,791,713**	**18,366,747**	**17,278,634**	**8,375,104**	**83,644,126**
Administrative Costs	1,758,177	2,909,088	2,976,044	3,045,025	3,116,098	13,804,432
Project Costs	12,073,751	22,882,625	15,390,703	14,233,609	5,259,006	69,839,694
Revenue Loss	**0**	**5,420,976**	**14,094,538**	**22,768,102**	**31,441,663**	**73,725,279**
Hospitals	0	4,980,382	12,948,994	20,917,607	28,886,218	67,733,201
Physicians	0	440,594	1,145,544	1,850,495	2,555,445	5,992,078
Internal PPS Provider Bonus Payments	**3,030,303**	**5,454,546**	**4,242,425**	**3,636,364**	**3,636,364**	**20,000,002**
Cost of non-covered services	**1,736,842**	**2,315,790**	**2,315,790**	**2,315,790**	**2,315,790**	**11,000,002**
Other	**1,767,324**	**4,708,172**	**7,613,705**	**6,741,907**	**4,418,034**	**25,249,142**
Expected Loss Due to Unmet Goals	1,767,324	4,708,172	7,613,705	6,741,907	4,418,034	25,249,142
Total Expenditures	**20,366,397**	**43,691,197**	**46,633,205**	**52,740,797**	**50,186,955**	**213,618,551**
Undistributed Revenue	**13,460,807**	**0**	**11,662,037**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
sculley	Other	44_MDL0105_1_1_20151214092623_Initial_Feedback_from_the_IA_12-1-15_v2.xlsx	File captures results from discussion with the IA on 12/8/15. The CCN budget submission in section 1.1 is sufficient. No edits or document submissions are required at this time.	12/14/2015 09:27 AM

Narrative Text :

NYS Confidentiality – High

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Module Review Status

Review Status	IA Formal Comments
Pass & Complete	

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Care Compass Network (PPS ID:44)

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
33,827,204	213,618,544	33,122,838	212,914,178

Budget Items	Quarterly Amount - Update		Remaining Balance in Current DY	Percent Remaining in Current DY	Cumulative Remaining Balance	Percent Remaining of Cumulative Balance
	DY1, Q1 ($)	DY1, Q2 ($)				
Cost of Project Implementation & Administration	**360,264**	**344,102**	**13,127,562**	**94.91%**	**82,939,760**	**99.16%**
Administrative Costs	210,264	237,899				
Project Costs (Domains 2-4)	0	0				
Domain 1 Projects	150,000	106,203				
Revenue Loss	**0**	**0**	**0**		**73,725,279**	**100.00%**
Hospitals	0	0				
Physicians	0	0				
Internal PPS Provider Bonus Payments	**0**	**0**	**3,030,303**	**100.00%**	**20,000,002**	**100.00%**
Cost of non-covered services	**0**	**0**	**1,736,842**	**100.00%**	**11,000,002**	**100.00%**
Other	**0**	**0**	**1,767,324**	**100.00%**	**25,249,142**	**100.00%**
Expected Loss Due to Unmet Goals	0	0				
Total Expenditures	**360,264**	**344,102**				

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
sculley	Other	44_MDL0117_1_2_20151214092948_Initial_Feedback_from_the_IA_12-1-15_v2.xlsx	File captures results from discussion with the IA on 12/8/15. The CCN budget submission in section 1.2 is sufficient. No edits or document submissions are required	12/14/2015 09:30 AM

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Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
			at this time.	

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 1.3 - PPS Flow of Funds (Baseline)

Instructions :

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

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

Funds Flow Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	33,827,203.64	36,048,681.10	58,295,241.52	51,620,213.86	33,827,203.64	213,618,544
Practitioner - Primary Care Provider (PCP)	1,096,320	1,755,193	1,010,457	875,796	504,552	5,242,318
Practitioner - Non-Primary Care Provider (PCP)	2,006,788	3,802,098	2,495,996	2,198,980	1,394,997	11,898,859
Hospital	0	6,875,981	14,030,054	22,084,789	26,495,190	69,486,014
Clinic	258,881	398,093	285,307	303,552	256,945	1,502,778
Case Management / Health Home	123,824	194,650	139,628	149,678	126,425	734,205
Mental Health	3,710,451	5,864,020	5,420,044	5,611,955	4,744,297	25,350,767
Substance Abuse	29,407	36,468	25,877	25,216	21,906	138,874
Nursing Home	2,447,526	3,632,545	2,954,386	2,772,084	2,329,046	14,135,587
Pharmacy	14,253	22,812	16,375	17,659	14,890	85,989
Hospice	420,133	610,843	486,305	455,126	381,321	2,353,728
Community Based Organizations	5,035,439	7,666,215	5,979,141	5,597,137	4,691,091	28,969,023
All Other	1,719,210	5,808,317	3,860,140	3,591,126	2,492,467	17,471,260
Total Funds Distributed	**16,862,232.00**	**36,667,235.00**	**36,703,710.00**	**43,683,098.00**	**43,453,127.00**	**177,369,402**
Undistributed Revenue	**16,964,971.64**	**0.00**	**21,591,531.52**	**7,937,115.86**	**0.00**	**36,249,142**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
sculley	Other	44_MDL0106_1_1_20151214093102_Initial_Feedback_from_the_IA_12-1-15_v2.xlsx	Per CCN/IA discussion on 12/8/15 - this section is not applicable to the Q2 report, consistent with DOH messaging on 12/7/15. No edits or document submissions are required at this	12/14/2015 09:31 AM

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Narrative Text :

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
33,827,204	213,618,544	33,827,204	213,618,544

Funds Flow Items	Quarterly Amount - Update		Percent Spent By Project											DY Adjusted Difference	Cumulative Difference
			Projects Selected By PPS												
	DY1 Q1	DY1 Q2	2.a.i	2.b.iv	2.b.vii	2.c.i	2.d.i	3.a.i	3.a.ii	3.b.i	3.g.i	4.a.iii	4.b.ii		
Practitioner - Primary Care Provider (PCP)	0	0	0	0	0	0	0	0	0	0	0	0	0	1,096,320	5,242,318
Practitioner - Non-Primary Care Provider (PCP)	0	0	0	0	0	0	0	0	0	0	0	0	0	2,006,788	11,898,859
Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	69,486,014
Clinic	0	0	0	0	0	0	0	0	0	0	0	0	0	258,881	1,502,778
Case Management / Health Home	0	0	0	0	0	0	0	0	0	0	0	0	0	123,824	734,205
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	3,710,451	25,350,767
Substance Abuse	0	0	0	0	0	0	0	0	0	0	0	0	0	29,407	138,874
Nursing Home	0	0	0	0	0	0	0	0	0	0	0	0	0	2,447,526	14,135,587
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	14,253	85,989
Hospice	0	0	0	0	0	0	0	0	0	0	0	0	0	420,133	2,353,728
Community Based Organizations	0	0	0	0	0	0	0	0	0	0	0	0	0	5,035,439	28,969,023
All Other	0	0	0	0	0	0	0	0	0	0	0	0	0	1,719,210	17,471,260
Total Expenditures	**0**	**0**													

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
sculley	Other	44_MDL0118_1_2_20151214093213_Initial_Feedback_from_the_IA_12-1-15_v2.xlsx	Per CCN/IA discussion on 12/8/15 - this section is not applicable to the Q2 report, consistent with DOH messaging on 12/7/15. No edits or document submissions are required at this	12/14/2015 09:32 AM

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Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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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	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1 - Prepare an initial PPS Level budget for Administration, Revenue Loss, Project Costs, Incentives & Contingencies.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - Create a funds flow and distribution plan that is transparent and incentivizes the providers to meet the various requirements of DSRIP	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3 - Distribute funds flow and distribution plan to Finance Committee for initial review	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4 - Review feedback from Finance Committee, revise funds flow along with distribution plan and adjust accordingly.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5 - Distribute plan to PPS leadership for review and adjust accordingly.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6 - Distribute finalized funds flow and distribution plan to Finance Committee for approval.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7 - Distribute funds flow and distribution	In Progress	See Narrative.	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
plan to PPS Network partners.									
Task Step 8 - Hold education sessions for PPS partners on the funds flow and distribution plan in order to promote transparency and build trust among the network.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Complete funds flow budget and distribution plan and communicate with network	This Milestone is due for completion at DY1, Q3 and has eight associated steps for implementation. One of these steps is due DY1, Q2 and is being reported as Complete. The development of the Care Compass Network funds flow and distribution plan process began in April of 2015, but truly began in earnest in July of 2015. The Care Compass Network approach for Funds Flow and Distribution planning occurred in two stages. One stage included a ground-up budget approach, filling in known costs such as administrative, identifying expected cost categories, and building a framework through which information from the project teams and implementation plans could be incorporated. The second stage included the development of a 'waterfall' approach to allow for transparent display of how CCN valuation dollars were allocated to the various budgets/cost centers (e.g., administrative, revenue loss, project costs, incentives, & contingencies) as identified by the bottom-up approach. The CCN Finance Manager worked with each of the project leads from August to the beginning of September to determine expected costs, investments, or other resource allocations on a project by project basis. The following timeline was used in the creation of the funds flow model: 07/15/2015 & 08/03/2015 – Waterfall Concept & Guiding Principles Determined

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	08/27/2015 – Finance Committee Meeting to Review the Master Budget Matrix 09/11/2015 – Finalization of inputs from Project Leads, Project Management Office, and IT 09/15/2015 – Review of Budget Items by Legal Counsel 09/22/2015 – Initial Review of Budget Model by Finance Committee (Scheduled) 10/01/2015 – Final Review and Approval by Finance Committee (Scheduled) 10/13/2015 – Board of Directors Approval After meeting with each of the project leads to determine project budgets, a meeting was held on September 9, 2015 with the Director of Project Management, the Executive Director, and the Chair of the Clinical Governance Committee to identify synergies between project budgets and confirm accuracy, completeness, and reasonableness of initial budgeted expenses. One notable result of this stage of the review was a 15% contingency line-item in each project to account for the significant unknown variables, such as the results of the pending CRFP application as well as completion of the IT landscaping exercise which is due for completion in DY1,Q4. These represent two major components of the CCN budget. Having major cost centers reviewed by the responsible CCN parties at a detail level, the CCN Finance Manager prepared the initial PPS budget for Administration, Revenue Loss, Project Costs, Incentives, and Contingencies and worked with the Chair of the Finance Committee on September 14 and 28 for distribution to the Finance Committee on September 22 (Step 1). The remaining steps to implementation have been in progress throughout Q2 and have since been completed in DY1, Q3 or are on target for completion by the end of DY1, Q3. Of note, the CCN Funds Flow methodology and budget were presented to the Board of Directors on October 13, 2015 and approved.

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

IPQR Module 1.7 - IA Monitoring

Instructions :

The IA has added guidance to modules 1,2,3, and 4.

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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 Step 1 - Establish a Board of Directors, governed by bylaws, responsible for the direction and financial stability of the PPS. The Board of Directors shall initially include each of the six CEO's of the partnering health systems and federally qualified health centers. In addition, five board members shall be seated after nomination from the Community Based Organizations Stakeholder group (PAC).	Completed	Complete - The Care Compass Network Board of Directors was seated as a full board on April 8, 2015. The full board includes the CEOs of the PPS six member organizations as well as five board members voted from the PPS Stakeholders, as facilitated through the PAC Executive Council. Additionally, the PPS Executive Director is the 12th member of the board and serves as a non-voting member. During the April 8 and May 12 board meetings all past board actions were ratified by the fully seated board, including adoption of CCN Bylaws.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 2 - Define and establish four primary operating committees which report to the board of directors, including the Finance Governance Committee, IT & Data Governance Committee, Clinical Governance Committee, and Compliance/Audit Committee.	Completed	See Narrative.	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	In Progress	This milestone must be completed by 12/31/2015. Clinical Quality Committee charter and committee structure chart	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1 - Following requirements prescribed by	Completed	See Narrative.	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
the STRIPPS Bylaws, establish a Clinical Governance Committee framework, which is responsible for overall PPS Clinical Governance. The Clinical Governance Committee will include a direct reporting relationship to the Board of Directors and include a multi-disciplinary group of clinical professionals, from across the PPS, including 12 members from partner organizations - three per Regional Performing Unit ("RPU").									
Task Step 2 - For each of the four PPS Regional Performing Units (RPUs), establish a RPU Quality Committees, which will report to the overarching PPS Clinical Governance Committee. Each RPU Clinical Quality Committee shall be comprised of 6-10 members.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3 - Ensure the Clinical Governance Framework includes adequate RPU based Quality Committees (subcommittees to the PPS level Clinical Governance Committee), with a suggested minimum framework as follows: a. Behavioral Health Committee (with specific focus on projects 3ai Integration of Primary Care and Behavioral Health, 3aii Crisis Stabilization, and 4aiii Infrastructure). b. Disease Management Committee (with specific focus on projects 2biv Care Transitions, 2bvii INTERACT, 3bi Chronic Disease CVD, 3gi Palliative Care, and 4bii Chronic Disease/COPD). c. Onboarding Committee (with specific focus on projects 2ci Navigation, 2di Project 11, consenting, and outreach).	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4 - Leverage the regional expertise and relationships of the Coordinating Council and	Completed	See Narrative.	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
Regional Performing Unit (RPU) Leads and their associated teams, reporting to the CBO Engagement Council, to identify any recommendations to the RPU Quality Committee framework based on regional need. To supplement pre-existing regional healthcare knowledge, the RPU Leads should also leverage the results of the Pre-Engagement Survey to better identify the capabilities and readiness of providers and CBO members in their respective RPU.									
Task Step 5 - Leverage the regional expertise and relationships of the Coordinating Council and Regional Performing Unit (RPU) Leads and their associated teams, reporting to the CBO Engagement Council, to identify a slate of candidates for each subcommittee to the Clinical Governance Committee. The member slate should be ratified by the Stakeholders / PAC, as well as the PAC Executive Council, who will present the slates to the Board of Directors for final approval.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6 - Establish a Charter for each RPU Clinical Quality Committee, outlining roles, responsibilities (including monitoring, metrics, etc.), reporting requirements, and participation requirements.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7 - Each of the three recommended RPU Quality Committees (e.g., Behavioral Health Committee, Disease Management Committee, and Onboarding Committee) shall nominate a representative to the Clinical Governance Committee, to achieve three RPU representatives on the Clinical Governance	In Progress	See Narrative.	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
Committee, representative of a multi-disciplinary group. The member slate should be ratified by the Stakeholders / PAC, as well as the PAC Executive Council, who will present the slates to the Board of Directors for final approval.									
Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	Completed	This milestone must be completed by 9/30/2015. Upload of bylaws and policies document or committee guidelines.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task Step 1 - Establish bylaws to serve as a guide for the authority, operations, and functionality of the Board of Directors, as well as define Committees which shall report to the Board of Directors. In addition, the bylaws will contain language which outlines the structure of the Committees, including the number of seats, purpose/goals, and requirements. Once completed, the bylaws will be reviewed and adopted by the Board of Directors.	Completed	Complete - The Care Compass Network Board of Directors was seated as a full board on April 8, 2015. The full board includes the CEOs of the PPS six member organizations as well as five board members voted from the PPS Stakeholders, as facilitated through the PAC Executive Council. Additionally, the PPS Executive Director is the 12th member of the board and serves as a non-voting member. During the April 8 and May 12 board meetings all past board actions were ratified by the fully seated board, including adoption of CCN Bylaws.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - Before establishing each Committee which reports to the Board of Directors, establish a methodology for seating positions which considers the RPU needs by domain, such as Stakeholder and technical/clinical expertise representation, to be included. The Board of Directors will review and approve the Committee resolutions for prior to seats being filled.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3 - Once completed, the governance documents, including bylaws, meeting minutes, and related attachments or amendments shall be uploaded to the PPS SharePoint for central access by PPS members.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #4 Establish governance structure reporting and monitoring processes	In Progress	This milestone must be completed by 12/31/2015. Governance and committee structure document, including description of two-way reporting processes and governance	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							
Task Step 1 - Develop a governance and committee governance structure reporting and monitoring process, as defined PPS bylaws and supplemented by PowerPoint presentation ("governance and committee structure document"), which aligns with the bylaws requirements and allows for two-way reporting processes and the governance monitoring process.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2 - Include in each regular board meeting a placeholder for each standing Committee (IT Governance, Clinical Governance, Finance Governance, and Compliance & Audit Committees) to present updates. In addition, standard materials to support the Board of Directors meeting will include agenda, report from each Committee, report from the PAC Executive Council, report from the Coordinating Council, and report from the Executive Director.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3 - Following each meeting, the related materials will be uploaded to the established PPS SharePoint for central access by PPS partner organizations.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4 - Following each meeting, the Committee chairperson, Executive Director, and other responsible persons will provide Committee updates reflective of the Board of Directors meeting.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 5 - The PPS Project Management Office (PMO), or alternate designee, will monitor the PPS governance and committee structures and	In Progress	In Process - The Board of Directors was fully seated in Q1 and committees which report to the board are scheduled for completion in Q2. Each committee is permitted by Bylaws to establish the necessary subcommittee structure to achieve	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
reporting developments. A dashboard will be created and managed by the PMO which monitors performance, such as the achievement of two-way reporting during each monthly/quarterly cycle, obtention of minutes, agendas, and other materials. As needed, updates, including identification and communication of missing reports, will be communicated through the associated Committees and/or Committee chairs so changes can obtain the appropriate approval(s) and PPS SharePoint documentation can be updated to align with the current governance model.		their goals. Once seated in Q2, and subcommittee structures have been finalized, the governance and committee governance structure process documents will be finalized and made available to PPS members. Once overall structures are in place the PMO or alternate designess will finalize the dashboard for performance management purposes. On track for completion by DY1, Q3 as scheduled.							
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	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task Step 1 - Establish a PPS Communication Workgroup to oversee the development of PPS internal and external communications, such as public facing website, PPS newsletter, PPS SharePoint (including structure, content framework, and delegation of access/rights).	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - The PPS Communications Workgroup consisting of provider and CBO representatives within the PPS will develop a five year Community Engagement Plan, which includes milestones for each DSRIP quarter.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3 - The PPS Communications Workgroup will take the draft five year plan to the key stakeholders for content review. This will allow for adequate representation from across the PPS	In Progress	See Narrative.	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
based on RPU, project, etc. A focus will be to ensure communications with both PPS public and non-public provider organizations, such as schools, churches, homeless services, housing providers, law enforcement, transportation/dietician services, etc. are included. At minimum the review teams should include RPU leadership, CBO Council, PAC Executive Council, and the stakeholders/ PAC meeting.									
Task Step 4 - Leveraging input from the various constituents, the PPS Communications Workgroup will present the revised five year plan to the PPS Stakeholders / PAC group for review and approval.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5 - The PPS Communications Workgroup will present the Stakeholders/PAC approved five year plan to the Board of Directors for final review and approval.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6 - Once finalized, associated documentation and plans will be posted to the appropriate forums (for example, the PPS Public Facing Website for delivery of non-provider and public information and PPS SharePoint for internal stakeholder communications) for archiving and communication purposes.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #6 Finalize partnership agreements or contracts with CBOs	In Progress	Signed CBO partnership agreements or contracts.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task Step 1 - Establish CBO Council which will lead the CBO facilitation process as related to the various DSRIP requirements. The CBO Council should include membership allocated by RPU.	Completed	Complete - Starting 5/12/15 the CBO Engagement Council convened and includes representation from across each RPU. From the CBO Engagement Council leads were nominated for each RPU and efforts have begun to coordinate engagement with Stakeholders from across the	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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		PPS. During Q1, the CBO Engagement Council achieved the development and distribution of the Pre Engagement Survey, as coordinated with input from the IT consultants from WeiserMazars, the Coordinating Council (PPS Project Leads), and the Stakeholders PAC meeting.							
Task Step 2 - The CBO Council should coordinate the development of a CBO contact list for each Regional Performing Unit (RPU). The list should consider impacting factors, such as overlapping RPU and/or overlapping PPS involvement.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3 - Leveraging the CBO Contact List, an outreach plan for CBO contracting should be developed at the RPU level.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4 - In conjunction with the development of the outreach plan, the PPS will assist CBOs with a Readiness Assessment to identify CBO current state with regards to DSRIP plans.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5 - Using the output from the outreach plan and readiness assessment, the PPS will develop performance based measures for inclusion with each CBO partnership agreement. The performance based measures will align the CBOs DSRIP participation with the PPS funds flow model and infrastructure or service/performance related terms of the partnership agreement.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6 - Present draft partnership agreements (e.g., performance contracts) to each identified CBO for review and negotiation.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7 - Consider input and negotiations with CBOs to finalize and execute contracts.	In Progress	See Narrative.	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
Task Step 8 - Migrate contracts to the contract management process to allow for ongoing contract monitoring at the RPU level.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #7 Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	In Progress	Agency Coordination Plan.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task Step 1 - Establish CBO Council which will lead the CBO facilitation process as related to the various DSRIP requirements. The CBO Council should include membership allocated by RPU.	Completed	Complete - Starting 5/12/15 the CBO Engagement Council convened and includes representation from across each RPU. From the CBO Engagement Council leads were nominated for each RPU and efforts have begun to coordinate engagement with Stakeholders from across the PPS. During Q1, the CBO Engagement Council achieved the development and distribution of the Pre Engagement Survey, as coordinated with input from the IT consultants from WeiserMazars, the Coordinating Council (PPS Project Leads), and the Stakeholders PAC meeting.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - The CBO Council should coordinate the development of a CBO contact list for each Regional Performing Unit (RPU). The list should consider impacting factors, such as overlapping RPU and/or overlapping PPS involvement as well as the inclusion of critical factors within each region including but not limited to local government agencies, state agencies, and both nonprofit and private community-based organizations (CBOs).	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3 - Leveraging the CBO Contact List, an outreach plan for CBO contracting should be developed at the RPU level accounting for the scope and diversity of organizations listed. This task will be executed by the PPS RPU Provider	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Relations professionals. The role of public sector agencies should be identified at this time.									
Task Step 4 - In conjunction with the development of the outreach plan, the PPS will assist CBOs with a Readiness Assessment to identify CBO current state with regards to DSRIP plans.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5 - Using the output from the outreach plan and readiness assessment, the PPS will develop performance based measures for inclusion with each CBO partnership agreement. The performance based measures will align the CBOs DSRIP participation with the PPS funds flow model and infrastructure or service/performance related terms of the partnership agreement.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6 - Draft partner agreements (e.g., performance contracts) which include any legislative steps and/or regulatory compliance (as appropriate).	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7 - Present draft partnership agreements (e.g., performance contracts) to each identified CBO for review and negotiation.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 8 - Consider input and negotiations with CBOs to finalize and execute contracts.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 9 - Migrate contracts to the contract management process to allow for ongoing contract monitoring at the RPU level.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	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	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	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
Task Step 1 - Conduct dialogue to create mutually acceptable guidelines among key stakeholders regarding workforce requirements and sensitivities. Upon development the guidelines should be approved by the Board of Directors.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - Commission a workforce communications sub-committee that has inclusive membership including representation from groups such as PPS union(s), PPS board member(s), workforce team member(s), etc. which will be responsible for the development of the workforce communication and engagement plan. This sub-committee will also be commissioned to include communication with external stakeholders such as local government and state agencies (e.g., OASAS) in its communication and engagement plan in addition to the PPS' internal stakeholders represented during the planning process.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3 - Consolidate specific workforce changes within the PPS; incorporating speed and scale projections by position, a recruitment plan for new hires (see Detailed Gap Analysis), retraining/re-deployment strategies (see Compensation and Benefit Analysis), training timelines (see Training Strategy) and the creation of a Communication and Engagement Plan. The plan should include quarterly milestones to be achieved relative to the Communication and Engagement Plan for the duration of the DSRIP program	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4 - Generate a workforce Transition Roadmap, based on inputs from the Workforce	In Progress	See Narrative.	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
implementation plan, the Target Workforce State, and the Detailed Workforce Gap Analysis.									
Task Step 5 - Workforce communication and engagement plan (e.g., Transition Roadmap) is approved by the governing body.	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #9 Inclusion of CBOs in PPS Implementation.	In Progress	Explain your plans for contracting with CBOs and their continuing role as your PPS develops over time; detail how many CBOs you will be contracting with and by when; explain how they will be included in project delivery and in the development of your PPS network.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 2 - Distribute the PPS Contract to CBO members. Utilize PPS Provider Relations professionals to coordinate the overall contracting process.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3 - Create a contracting management system to track CBO contracts pursued by the PPS, contract terms (dates), and aligned with which project(s) they have been engaged for.	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 1 - Through PPS Provider Relations staff and involvement from the CBO Engagement Council identify gaps in CBO involvement at the RPU level. This may include leveraging results of the CBO Engagement Council Pre Engagement Survey, as well as Partner Organization List.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize governance structure and sub-committee structure	sculley	Meeting Materials	44_MDL0203_1_2_20151214091148_CCN_12-15-15_Governance.pdf	We have uploaded the Board of Directors meeting minutes from August - September 2015 that were signed by the Secretary of the CCN Board of Directors as requested by the IA 12/1/15.	12/14/2015 09:11 AM
	rachaelm	Other	44_MDL0203_1_2_20151030162236_Contact Lists.xlsx	Additional Documentation - Supplemental contact lists for committees (readability issues in PDF).	10/30/2015 04:22 PM
	rachaelm	Other	44_MDL0203_1_2_20151030162038_Governance Reporting.pdf	As per reporting requirements for Milestone 1, packet including organization charts, contact information, charters, and evidence of Board approval of committees.	10/30/2015 04:20 PM
	rachaelm	Meeting Materials	44_MDL0203_1_2_20151030140055_Governance Meeting Schedules (DOH Template).xlsx	As per reporting requirement for Milestone 1, evidence of meetings for committees using Meeting Schedule Template.	10/30/2015 02:00 PM
Finalize bylaws and policies or Committee Guidelines where applicable	rachaelm	Screenshots	44_MDL0203_1_2_20151030113630_Sharepoint screenshots.pdf	Additional supporting document - Screenshots of CCN's SharePoint site including meeting minutes/materials and policies/procedures uploaded for partners and stakeholders to-date.	10/30/2015 11:36 AM
	rachaelm	Policies/Procedures	44_MDL0203_1_2_20151030113323_CCN_Bylaws.pdf	As per reporting requirements for Milestone 3, Care Compass Network's Bylaws inclusive of Policies / Guidelines for committees (additional reporting requirement for Milestone 3).	10/30/2015 11:33 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize governance structure and sub-committee structure	Complete – As of 9/30/15, CCN has completed the requirements for this milestone. The Care Compass Network Board of Directors was seated as a full board on April 8, 2015 (Step 1). The full board includes the CEOs of the PPS six member organizations as well as five board members voted from the PPS Stakeholders, as facilitated through the PAC Executive Council. Additionally, the PPS Executive Director is the 12th member of the board and serves as a non-voting member. During the April 8 and May 12 board meetings all past board actions were ratified by the fully seated board, including adoption of CCN Bylaws. As outlined in PPS Bylaws, the PPS is comprised of four committees which report to the Board of Directors (Step 2). These include the Finance Governance Committee, Clinical Governance Committee, IT Informatics & Data Governance Committee, and the Compliance & Audit Committee. At the July 14, 2015 Board of Directors meeting the Finance Governance Committee slate was approved by the board. At the August 11, 2015 Board of Directors meeting the IT & Data Governance Committee slate was approved by the board. At the September 8, 2015 Board of Directors meeting the Compliance & Audit Committee slate as well as the Clinical Governance Committee slate were both approved by the Board of Directors.
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	At the August 11, 2015 Board of Directors meeting the Clinical Governance Committee structure was presented and approved by the board (Step 1). Under the direction of the Clinical Governance Committee Chair, David Evelyn, MD (VP for Medical Affairs, Cayuga Medical Center) each RPU established quality

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	subcommittees as deemed necessary for respective their region. The North RPU chose 4 subcommittees (Onboarding, Disease Management, Behavioral Health and PCMH). The South and West RPU's both chose 3 subcommittees (Onboarding, Disease Management and Behavioral Health). The East RPU is using existing workgroups in Delaware and Chenango counties to develop one single quality subcommittee that reports to the Clinical Governance Committee (Step 2). Each of the 4 RPU's nominated 3 candidates for the Clinical Governance Committee, with each of the 3 candidates participating on one of the quality subcommittees in the RPU (e.g., Behavioral Health, Disease Management, Onboarding) (Step 3). These 12 candidates were presented to the Stakeholders at the August 21, 2015 meeting (Step 7) for their review along with a short biography of each candidate. The Stakeholders unanimously accepted the slate of 12 candidates which was then presented to the Board of Directors for their approval. At the September 8, 2015 Board of Directors meeting the Clinical Governance Committee slate of 12 was approved by the board. As per the Care Compass Network Governance Structure, the Clinical Governance Committee reports to the Board of Directors and presents a report at the Board of Directors monthly meetings. Within each RPU meeting the quality sub-committee framework was created based on the RPU regional need. For example, in the East RPU they chose to use existing workgroups in Delaware and Chenango counties to develop one single quality subcommittee based on the regional need (Step 4). Additionally, the candidates for each committee slate were actively discussed in the RPU meetings. RPU Leads report to the Coordinating Council and CBO Engagement Councils on regular weekly cycles. Dialogue and discussion occurs at these weekly meetings and is then taken into the RPUs by the Leads. The slate of candidates for each of the quality sub-committees is planned to be presented to the Stakeholders for ratification at the October 30, 2015 meeting and then to the Board of Directors for final approval at the November 10, 2015 board meeting (Step 5). The quality subcommittees began meeting in October. The Clinical Quality subcommittee charters outlining roles, responsibilities, reporting requirements and participation requirements are being presented and reviewed during the initial subcommittee meetings being held throughout the PPS (Step 6). Note the remaining steps 2, 5-6 remain in progress and are on target to be reported as Complete in the Q3 report.
Finalize bylaws and policies or Committee Guidelines where applicable	Complete - The Care Compass Network Board of Directors was seated as a full board on April 8, 2015. The full board includes the CEOs of the PPS six member organizations as well as five board members voted from the PPS Stakeholders, as facilitated through the PAC Executive Council. Additionally, the PPS Executive Director is the 12th member of the board and serves as a non-voting member. During the April 8 and May 12 board meetings, all past board actions were ratified by the fully seated board including adoption of CCN Bylaws (Step 1). Step 1 of this milestone was reported as complete in the Q1 report and remains Complete. Regarding PPS Bylaws, there were two minor amendments to the Bylaws were presented and approved by the Board of Directors during the June 9, 2015 meeting. The CCN Bylaws were updated July 8, 2015 to reflect the two amendments. The updated Bylaws were approved by the Board of Directors July 9, 2015. The methodologies for seating the Four Committees which report to the Board of Directors were presented (Step 2). The Finance Governance Committee structure/seating methodology and candidates were presented and approved by the Board of Directors during the May 12 and July 14 meetings respectively. The Clinical Governance Committee structure/seating methodology and candidates were presented and approved by the Board of Directors during the July 14 and September 8 meetings, respectively. The IT, Informatics, and Data Governance structure/seating methodology and candidates were presented and approved by the Board of Directors during the July 14 and September 8 meetings, respectively. The Compliance and Audit Committee structure/seating methodology and candidates were presented and approved by the Board of Directors during the August 11 and September 8 meetings, respectively. The PPS SharePoint site has been created and users added from across the PPS since late 2014 (Step 3). The SharePoint has been used actively going back to the PPS DSRIP application stage and contains many project planning related documents. At the end of DY1, Q2 the CCN team made significant updates to the SharePoint site to better encompass the functionality of CCN operations in the execution stage of DSRIP (as compared to the planning stage for which it was

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	previously better suited). The SharePoint updates were communicated to the PAC Executive Council at the September 25, 2015 meeting, the Coordinating Council at the September 28, 2015 meeting and subsequently to the Stakeholders at the October 2, 2015 meeting. On SharePoint there is a Policies and Procedures folder containing Care Compass Network bylaws in addition to several policies and procedures such as CCN Conflict of Interest policy, CCN Mandatory Annual Training policy etc. Additionally, the meeting minutes from Board of Director meetings, Coordinating Council meetings, CBO Engagement Council meetings, PAC Exec/Stakeholder meetings as well as various supporting committee meeting minutes are also available on SharePoint. (Please refer to screenshots of listed policies, meeting minutes available on SharePoint)
Establish governance structure reporting and monitoring processes	In Progress - There was one task scheduled to be completed for Governance Milestone 4 in DY1, Q2 (Step 4) regarding the communication of Board updates to CCN Committees following Board meetings. As of Q2 this Step is being reported as Complete. On August 19, 2015 the CCN Director of Project Management distributed a notification to each of the approved (or pending Board approval), Chairpersons for each of the four primary CCN Committees (e.g., Finance, IT, Compliance, & Clinical Governance) requesting that a 'Board Follow-up' line item be added to each agenda. As has become normal operating procedures at CCN, each Committee Chair, the Executive Director, and Director of Project Management attend each board meeting in its entirety and are suited to provide the Board Follow-up notes to the Committee on an as needed basis. As noted in Milestone 4 each committee was approved throughout various stages of Q2 and began to hold initial meetings in the Q2 and Q3 timeframe. Attached are the supporting Finance Committee meeting minutes from the September 22 meeting showing board follow-up discussion comments from the September 8 meeting. Note the remaining steps 1-3 &5 remain in progress and are on target to be reported as Complete in the Q3 report.
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 - There was one task scheduled to be completed for Governance Milestone 5 in DY1, Q2 (Step 1) regarding establishing a PPS Communication Workgroup. As of Q2 this Step is being reported as Complete. The PPS Communications Workgroup was formed in October 2014 with 5 members from across the PPS who meet at least twice a month. The PPS SharePoint site was launched in September 2014 and is actively in use across the PPS to communicate contact lists, meeting presentations, meeting minutes as well as a calendar to communicate the various committee meetings held throughout the PPS (Step 1). Care Compass Network is actively encouraging the members throughout the PPS to access/use SharePoint. Moving into Q3 SharePoint will continue to be used to communicate protocols, workflow and project implementation status across the PPS. A public Care Compass Network website (www.carecompassnetwork.org) was created and launched in June 2015 and is continually updated to post information relative to both providers in the PPS who provide services as well as beneficiaries who receive services. In Q3 we will be launching a monthly PPS newsletter. All of these pieces together will play an integral piece within the 5 year Community Engagement Plan. Note the remaining steps 2-6 remain in progress and are on target to be reported as Complete in the Q3 report.
Finalize partnership agreements or contracts with CBOs	In Progress - Step 1 of this milestone was listed as completed in Q1 and there is no change here. Our CBO Engagement Council continues to meet weekly and has membership allocated across all RPU's. The contact list was generated during the application period and includes the list of all partnering organizations. The contact list has been continually updated. In order to divide this list into RPU the CBO Engagement Council devised and used the Pre-Engagement Survey to provide the predominant county their organization provides services to (Step 2). From this self-indicated county, RPU designation was chosen. Inputs to the development of this list occurred in Q2 and information for the list was also gathered from RPU based Stakeholder meetings. This list includes local government agencies such as Family and Children Services of Ithaca, Family Health Network of Central New York, Mental Health Association of Southern Tier, Mental Health Association of Tompkins County, Broome County Health Department, Chemung Public Health Department, Chenango County Department of Public Health, Cortland County Health Department, Delaware County Public Health Services, Schuyler County Community Services, Tioga County Department of Social Services, NYS Office for People with Developmental Disabilities, YMCA of Broome County and Tompkins Office for the Aging to name a few. Additionally in Q3 RPU Contact Lists were posted to SharePoint for central access throughout the PPS. Moving forward into Q3 the original contact list will be replaced by the PPS contracting dashboard specifically listing RPU, Facility/Project Champions and contact information for each project the facility is participating in as well as

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	additional reporting information. Note the remaining steps 3-8 remain in progress and are on target to be reported as Complete in the Q3 report.
Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	In Progress - Step 1 of this milestone was listed as completed in Q1 and there is no change here. Our CBO Engagement Council continues to meet weekly and has membership allocated across all RPU's. The contact list was developed and includes the list of all partnering organizations. In order to divide this list into RPU the CBO Council devised and used the Pre-Engagement Survey to provide the predominant county their organization provides services to. From this self-indicated county, RPU designation was chosen. Inputs to the development of this list occurred in Q2 and information for the list was also gathered from RPU based Stakeholder meetings (Step 2). This list includes local government agencies such as Family and Children Services of Ithaca, Family Health Network of Central New York, Mental Health Association of Southern Tier, Mental Health Association of Tompkins County, Broome County Health Department, Chemung Public Health Department, Chenango County Department of Public Health, Cortland County Health Department, Delaware County Public Health Services, Schuyler County Community Services, Tioga County Department of Social Services, NYS Office for People with Developmental Disabilities, YMCA of Broome County and Tompkins Office for the Aging to name a few. Additionally in Q3 RPU Contact Lists were posted to SharePoint for central access throughout the PPS. Moving forward into Q3 the original contact list will be replaced by the PPS contracting dashboard specifically listing RPU, Facility Champions and contact information for each project the facility is participating in as well as additional reporting information. Note the remaining steps 3-9 remain in progress and are on target to be reported as Complete in the Q3 report.
Finalize workforce communication and engagement plan	There were two tasks scheduled to be completed for Governance Milestone 8 in DY1, Q2 (Step 1&2). As of Q2 both of these Steps are being reported as Complete. The Workforce Development and Transition Team (WDTT) has been established and has solicited membership from the PPS Stakeholders, such as during the 6/12/15 meeting. The 5 guiding principles prepared by the WDTT were presented to and approved by the Board of Directors at the September 8 meeting (Step 1). One of the guiding principles was specifically to reserve seats in key employee and stakeholder groups, at minimum the Workforce Committee and the PAC Executive Committee, for union representatives. The first Workforce Communications Subcommittee team meeting was held September 17, 2015. A workforce representative participated in two Communications Committee meetings. The Workforce Communication Subcommittee was initially formed with representatives from three institutions, two Community Based Organizations, two local government units and one Union with local presence (Step 2). Additional representatives will be identified as needed, for example based on the outputs of key Workforce Strategy plans which are targeted for completion by DY1, Q4. Initial efforts of this group will focus on a Workforce Communication Plan with later plans developed for external stakeholders. The outline of a communication plan has been developed and includes identification of groups to be targeted, selection of message delivery mode, potential timelines for delivery of message, draft content of communications, determination of who should deliver workforce message. Further work defining the details identified within the outline will continue in an effort to entirely develop the Workforce Communication & Engagement Plan. Initial draft of a power point explaining DSRIP/CCN has been developed. Information about DSRIP/CCN is available on the CCN for both workers and external stakeholders. Note the remaining steps 3-5 remain in progress and are on target to be reported as Complete in by their assigned due date.
Inclusion of CBOs in PPS Implementation.	

Milestone Review Status

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

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Milestone Review Status

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

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.

A key risk to the development and execution of the Governance Worktream will be the risk of an organization's lack of understanding or vision around their future role in DSRIP. To mitigate the risk, the PPS will implement tools and programs to promote DSRIP education and make available internal consultants with links to outside resources. Education tools such as a public facing website, workshops, or guest speakers hosted through the Stakeholders/PAC meeting, and the assignment of RPU Leads and Provider Relations professionals, assigned to each RPU, will be critical to the mitigation of this risk.

A secondary risk facing the development and execution of the Governance Worktream is the current state position of some CBO members, in particular those that are not prepared to make a DSRIP related decision. DSRIP decisions may include their ability or requirements to enter into participation agreements/contracts with the PPS as related to DSRIP timetables as well as other external factors which would impact their ability to make DSRIP related decisions (e.g., lack of DSRIP education, burdensome internal governance). Similar to the first mitigation plan mentioned above, a key step to reduce this risk exposure will be to provide education forums to the CBO members to promote dissemination of DSRIP requirements. The CBO Council will develop RPU based CBO outreach plans and readiness assessments with the intent of reaching out to CBO's where they are and making resources available to them to help promote their participation in DSRIP.

A third risk facing the development and execution of the Governance Workstream is the large nine county territory and regional approach of the PPS. There is a risk that as local RPUs mature and operationalize over the five year period they may begin to segregate or create regional silos, relationships, or otherwise which may become misaligned with overall PPS efforts. To mitigate this risk, the PPS will assign a strong Project Manager, staffed at the central PPS office, to oversee the RPU functionality and be responsible for completion of established milestones. In addition, the PPS will assign a Provider Relations professional to each RPU with specific focus on maintaining provider education, contracts, and ability to meet contractual terms (e.g., achievement of patient consents, surveys, etc.). These members will be imbedded with existing Project Leads/team meetings, Coordinating Councils, CBO Engagement Councils, and other discussions as appropriate to ensure the PPS level focus and direction is maintained at each individual RPU organized level. Additionally, we have created a position, "Project Management Coordinator", which has been designed to work for each RPU and promote the cross-pollination between Project Managers and align PPS needs at the RPU level.

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.)

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As compared to other DSRIP related workstreams the Governance Workstream does not have as many major dependencies. However, two primary and leading dependencies with direct impact to the Governance Workstream include:

1) The Governance Workstream requirement for the establishment of provider agreements/contracts is directly dependent on Financial Sustainability Workstream. This interdependency will be further facilitated through the PPS Funds Flow model.
2) The Governance Workstream's broad requirement for development of PPS representation, communication, and engagement is directly dependent on many of the requirements and plans established by project 2.a.i. For example, project 2.a.i. outlines detailed plans for patient reception of healthcare & community support, patient integration with the IDS, transition towards value-based payment reform, etc. These plans from project 2.a.i. will help serve as a baseline for how some Governance Workstream plans are developed.

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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
South RPU Lead	Robin Kinslow-Evans, Interim Executive Director / Care Compass Network	Responsible for alignment of RPU needs at the Governance Level and Coordination of Common Projects where PPS overlap occurs.
North RPU Lead	Amy Gecan, Director System Integration and Operations / Cayuga Medical Center	Responsible for alignment of RPU needs at the Governance Level and Coordination of Common Projects where PPS overlap occurs.
East RPU Lead	Greg Rittenhouse, VP, COO, Home Care / UHS	Responsible for alignment of RPU needs at the Governance Level and Coordination of Common Projects where PPS overlap occurs.
West RPU Lead	Laura Manning / Guthrie Robin Stawasz / CareFirst	Responsible for alignment of RPU needs at the Governance Level and Coordination of Common Projects where PPS overlap occurs.
Project Managers	Dawn Sculley, Emily Pape / Care Compass Network	Alignment of RPU project needs from staffing, resource, timing, and contracting basis - as coordianted with Provider Relations professionals. Responsible for performance and consolidation of results monthly to the Project Management Office (PMO).
Provider Relations Professionals	Julie Rumage, Jessica Grenier / Care Compass Network	Responsible for maintenance of Partner Organization list for accuracy, completeness, and pertinence to the PPS. Will also coordinate PPS contracting efforts and provide CBO and provider education.
Project Management Coordinator	Rachael Mott, Project Management Coordinator / Care Compass Network	Responsible for alignment of RPU needs at the Governance Level and Coordination of Common Projects where PPS overlap occurs, including sustainment of vision for how all regions come together to achieve milestones.
Director, Project Management	Mark Ropiecki, Director PMO / Care Compass Network	Responsible for overall vision for PPS Project Management Office, with outputs including plan delivery and quarterly consolidation of results to DOH/IA.
Executive Director	Robin Kinslow-Evans, Interim Executive Director / Care Compass Network	Reports to the Board of Directors and promotes alignment of standards across the PPS/RPUs, Overall PPS Guidance.
PPS Compliance Team	Ann Homer, Interim Consultant, Rebecca Kennis, PPS Compliance Officer	Responsible for overall development and maintanence of PPS Compliance program, including items such as training, data security, user agreements, privacy, and technology compliance with reports to the Board of Directors.
Board of Directors	Chair - Matthew Salanger, President and CEO / UHS Vice Chair - Kathryn Connerton, President and CEO / Our Lady of	General management of the affairs, property, and business of the Corporation.

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
	Lourdes Hospital	
IT & Data Governance Committee	Co-Chair - Bob Duthe, CIO / Cayuga Medical Center Co-Chair, Rob Lawlis, Executive Director / Cayuga Area Plan	Responsible for development of PPS IT strategy and implementation of PPS IT requirements. Overall responsibility for PPS IT plan reports to the Board of Directors.
Clinical Governance Committee	Chair - Dr. David Evelyn, Chief Medical Officer / Cayuga Medical Center	Responsible for development of Clinical Governance Structure and coordination with PPS stakeholders, including RPU Leads, to successfully seat regional Quality Committees. Overall responsibility for PPS Clinical Governance reports to the Board of Directors.
Finance Committee	Chair - David MacDougall / UHS	Responsible for Funds Flow Model, Financing Input to Contracts & Performance Metrics. Overall responsibility for Finance Governance reports to the Board of Directors.
Legal Counsel	Bond, Shoeneck, & King	Responsible for contracts and regulatory guidance.
PAC Executive Council	Lenore Boris, JD, PhD, PAC Executive Council Chair	The PAC Executive Council is responsible for the overall coordination of PPS information to the PPS Stakeholders group. The PAC Executive council is also responsible for reporting PPS Stakeholder updates to the Board of Directors. This also include seating of Stakeholder members to the Board of Directors.
CBO Engagement Council	Robin Kinslow-Evans, Interim Executive Director	The CBO Engagement Council is an interim council responsible for the integration of RPU Leads and their associated teams as they plan the development of RPUs. This allows for the development of RPU operations to coordinate at the PPS level. Primary goals include the identification of PPS members within each RPU, identification of education concerns and development of education opportunities at the PPS and local RPU level.

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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		
Providers	CBO / PAC Member	Responsible for partnership agreement/contract, workforce transition, education, and PPS PAC representation.
Public Agencies	CBO / PAC Member	Responsible for partnership agreement/contract, workforce transition, education, and PPS PAC representation.
Medicaid Beneficiaries	Beneficiaries	Responsible for community engagement plan/outreach.
Long-Term Care Providers	CBO / PAC Member	Responsible for partnership agreement/contract, workforce transition, education, and PPS PAC representation.
Social Service Agencies	CBO / PAC Member	Responsible for partnership agreement/contract, workforce transition, education, and PPS PAC representation.
Patients	Beneficiary	Responsible for community engagement plan/outreach, website, and publications.
Overlapping PPS (FLPPS, Leatherstocking, Central NY PPS, Westchester PPS)	Coordinated Project Plan Implementation in shared regional areas	Responsible for scheduled touch points, coordinated project approach (e.g., for 7 of 11 overlapping projects), and identifying potential for joint operations.
PPS Member Organizations (Hospital Health Systems, Affiliates, & FCQH)	PPS PAC Representation, PPS Board Representation. Includes UHS, Lourdes, Guthrie, Cayuga Medical Center, Cortland Regional Medical Center, Family Health Network	Responsible for partnership agreement/contract, workforce transition education, PPS PAC representation, and PPS Board representation.
External Stakeholders		
NYS Department of Health (DOH)	Key Stakeholder	Responsible for quarterly reports, and patient outcomes.
OASAS	Key stakeholder	Responsible for PPS updates and inclusion of recent guidances.
OMH	Key Stakeholder	Responsible for PPS updates and inclusion of recent guidances.
MCOs/ACOs	Key Stakeholder	Responsible for annual outreach and discussions.
County Law Enforcement Agencies	Support and Guide, Participant	Responsible for alignment of procedures with DSRIP goals.

IPQR Module 2.7 - IT Expectations

Instructions :

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

The development of an IT infrastructure to support the needs of the PPS in the "performance years" will be a critical need to be focused on from the start of DSRIP. The CBO readiness assessment will help to benchmark current CBO capabilities, along with the subsequent development of performance based partnership agreements will be vital tools for moving towards the development of an IT infrastructure that allows for creation of the multi-faceted requirements of DSRIP.

IPQR Module 2.8 - Progress Reporting

Instructions :

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

The success of the Governance Workstream will be measured in several ways, including:

1 - Successful provider agreements/contracts from across each RPU in support of various PPS performance and DSRIP goals.
2 - Establishment and finalization (e.g., successful seating) of a PPS Governance model.

IPQR Module 2.9 - IA Monitoring

Instructions :

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Section 03 – Financial Stability

IPQR Module 3.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize PPS finance structure, including reporting structure	Completed	This milestone must be completed by 12/31/2015. PPS finance structure chart / document, signed off by PPS Board.	04/01/2015	12/31/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task Step 1 - Create organizational chart for functions related to finance including the roles and responsibilities of the Finance Committee. Note: The chart should clearly articulate and define the financial relationship model between the application Lead Entity (UHS) and the STRIPPS NewCo ("Care Compass Network").	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - PAC Executive Council to solicit nine nominations for the Finance Committee.	Completed	Complete - The PAC Executive Council reviewed the requested skillset of potential Finance Committee members during the June 5, 2015 PAC Executive Council meeting. A call for nominations from the Stakeholders group was subsequently presented during the Friday 6/12/15 Stakeholders meeting (attached slide 9 of 33).	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 3 - PAC to discuss and rank order the slate of nine nominations.	Completed	Complete - Once the full slate was prepared, the bios for the Stakeholders slate were distributed to the PAC Executive council on 6/24/15 (attached) for final review by the PAC Executive Council and ranking prior to submission to the Stakeholders group for confirmation at the 6/26/15 meeting. Following approval by the Stakeholders, the Finance Committee slate was presented to the Board of Directors during the July 14, 2015 meeting for action. To note continued progress beyond Q1 and this step to	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	AV
		implementation, the Board of Directors voted and approved five members from the Stakeholders list to the Finance Committee during the July 14, 2015 meeting.							
Task Step 4 - Board of Directors to approve five from the slate of nine to officially seat the Finance Committee.	Completed	See Narrative.	04/01/2015	07/14/2015	04/01/2015	07/14/2015	09/30/2015	DY1 Q2	
Task Step 5 - Finance Committee to set a tentative schedule of future meetings.	Completed	See Narrative.	04/01/2015	08/03/2015	04/01/2015	08/03/2015	09/30/2015	DY1 Q2	
Task Step 6 - Present finance organizational chart to PPS Board of Directors for approval.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	In Progress	This milestone must be completed by 3/31/2016. Network financial health current state assessment (to be performed at least annually). The PPS must: - identify those providers in their network that are financially fragile, including those that have qualified as IAAF providers; -- define their approach for monitoring those financially fragile providers, which must include an analysis of provider performance on the following financial indicators: days cash on hand, debt ratio, operating margin and current ratio; -- include any additional financial indicators that they deem necessary for monitoring the financial sustainability of their network providers	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task Step 1 - Prepare a list of all providers in the PPS including Provider Type, Safety-Net Status, IAAF, VAP, PCMH, Contact Info, etc.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2 - Prepare an initial Financial Assessment Survey including inquiries regarding the following financial indicators: days cash on hand, debt ration, operating margin, current ratio, etc.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3 - Distribute Financial Assessment Survey to Finance Committee for review and input	In Progress	See Narrative.	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
regarding what other key indicators should be reviewed.									
Task Step 4 - Review feedback from Finance Committee and finalize Financial Assessment Survey accordingly.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5 - Distribute Survey to all members of the PPS using finalized Financial Assessment Survey.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6 - Compile Survey results into complete data set.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7 - Analyze survey results and identify those providers who are financially fragile based on indicators that finance committee agreed to.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 8 - Prepare report of those providers who are financially fragile and present results to Finance Committee.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 9 - For those providers who are identified as "Financially fragile" based on survey analysis, open dialogue between finance manager and provider to review the results of the survey.	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 10 - Finance manager to determine if provider is truly Financially Fragile or if explanations are acceptable and provider is truly stabile.	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 11 - If provider is still deemed Financially Fragile, provider to supply Finance Manager with plan on how provider plans on to move towards Financial Stability.	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task	In Progress	See Narrative.	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
Step 12 - Financial Assessment Survey will be required quarterly for those who are deemed Financially Fragile until the Finance Manager deems they have reached Financially Stability for a period of time.									
Task Step 13 - Financial Assessment Survey will be disbursed annually.	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	In Progress	This milestone must be completed by 12/31/2015. Finalized Compliance Plan (for PPS Lead).	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1 - Compliance Officer to complete a 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 PPS Lead and the NewCo (STRIPPS, dba: Care Compass Network).	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2 - Develop written policies and procedures that define and implement the code of conduct and other required elements of the PPS Lead compliance plan that are within the scope of responsibilities of the PPS Lead and the NewCo (STRIPPS, dba: Care Compass Network).	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3 - Obtain confirmation from PPS network providers that they have implemented a compliance plan consistent with the NY State Social Services Law 363-d.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4 - Develop requirements to be included in the PPS Provider Operating Agreement that the network providers will maintain a current compliance plan to meet NY State requirements for a provider.	In Progress	See Narrative.	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
Task Step 5 - Obtain Executive Body approval of the Compliance Plan and Implement the plan.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	In Progress	This milestone must be completed by 3/31/2016. Value-based payment plan, signed off by PPS board	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task Step 1 - Establish VBP committee comprised of members from PPS constituency with representation from all provider types. VBP Committee will seek to follow & leverage industry wide VBP Prepatory Strategies via HANYS.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - Cultivate pathways between VBP Committee and the rest of the system in order to survey and educate current landscape of existing VBP arrangements amongst PPS providers in PPS.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3 - Create education and communication plan, including the myriad components intrinsic to VBP, particularly the different strata of risk.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4 - Secure educational resources for outreach endeavors.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 5 - Carry out education and outreach endeavors for PPS providers ensuring a thorough understanding of the various VBP models and methods. Coordinate regional payor forums with providers in the region.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6 - Create a readiness self-assessment survey (High, Moderate, Low) for individual providers within the PPS to assess the varying	In Progress	See Narrative.	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
levels of evolution as movement towards fully implemented VBP occurs. The self-assessment survey will include the following (per the state): 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. Level of assistance needed to negotiate plan options with Medicaid Managed Care (High, Moderate, Low).									
Task Step 7 - Distribute the readiness self-assessment survey to all providers to establish accurate baseline.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 8 - Collect, assemble, and analyze readiness self-assessment survey results.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 9 - Prepare Initial VBP Baseline Assessment based on readiness self-assessment survey results and dialogue from providers.	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 10 - Disseminate preliminary results of readiness self-assessment survey analysis for review by PPS Providers.	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 11 - Update, revise and finalize VBP Baseline Assessment based on Providers & Boards review.	In Progress	See Narrative.	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
Task Step 12 - PPS Board to sign off on preference for PPS providers to contract with MCO's at their own discretion.	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	In Progress	This milestone must be completed by 12/31/2016. Value-based payment plan, signed off by PPS board	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	YES
Task Step 1 - Obtain clarification of VBP requirements from NYS Department of Health and guidance from legal counsel, as well as Department of Justice in regards to the requirements.	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 2 - Analyze the NYSDOH data related to the risk-adjusted cost of care, as well as the potential (shared) savings, at both the total population level as per care bundle and subpopulation per the VBP Roadmap, in order to identify best possible opportunities for PPS providers in their move towards VBP.	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 3 - Expand upon VBP Baseline Assessment creating a matrix of existing mechanisms both helping and hindering the implementation of the VBP model, including NYS VBP Roadmap, existing ACO and MCO models, and other VBP models in the current marketplace.	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 4 - Analyze matrix of existing mechanisms both helping and hindering the implementation of VBP at the provider level of our PPS in order to identify which providers are best equipped to lead the movement towards VBP based on their current level of VBP engagement.	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 5 - Identify within the PPS providers who fall	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	

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into one of three tiers: 1) Established - Providers currently utilizing VBP models 2) Enthusiastic and/or Equipped - Providers who are eager to pursue the movement towards VBP models and/or equipped to do so based on the helping/hindering matrix 3) Providers who need additional resources in order to start the movement towards utilizing a VBP model.									
Task Step 6 - Coordinate regional payor forums with PPS providers.	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 7 - Re-assess current landscape of VBP adoption throughout PPS by updating VBP Baseline Assessment, reviewing new information if available from the state and feedback from PPS Providers and MCOs regarding the payor forums, as well as lessons learned from early adopters.	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 8 - Perform Gap Analysis based on updated matrix of PPS landscape.	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 9 - Coordinate additional regional payor forums with PPS providers based on Gap Analysis.	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 10 - Collectively review the level of VBP engagement and continue to encourage open dialogue among the PPS providers regarding VBP models and adoption.	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	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 11 - Update, modify and finalize VBP Adoption Plan.									
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
Task TBD	On Hold	Note - On Hold while awaiting milestone DSRIP reporting year and quarter to be set.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
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
Task TBD	On Hold	Note - On Hold while awaiting milestone DSRIP reporting year and quarter to be set.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
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
Task TBD	On Hold	Note - On Hold while awaiting milestone DSRIP reporting year and quarter to be set.	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
Finalize PPS finance structure, including reporting structure	sculley	Meeting Materials	44_MDL0303_1_2_20151214092407_CCN_12-15-15_Governance.pdf	We have uploaded the Board of Directors meeting minutes from August - September 2015 that were signed by the Secretary of the CCN Board of Directors as requested by the IA 12/1/15.	12/14/2015 09:24 AM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	rachaelm	Meeting Materials	44_MDL0303_1_2_20151029172517_Finance Committee - Meeting Schedule Template.xlsx	As per reporting requirements for Milestone 1, a schedule for Finance Committee meetings using the "Meeting Schedule Template" provided.	10/29/2015 05:25 PM
	rachaelm	Other	44_MDL0303_1_2_20151029172356_CCN + Finance Structure + Org Chart.pptx	As per reporting requirements for Milestone 1, finance structure identifying roles and organization charts for governing body and subcommittees, as applicable.	10/29/2015 05:23 PM
	rachaelm	Meeting Materials	44_MDL0303_1_2_20151029153747_BOD DY1Q2 Meeting Minutes.pdf	As per reporting requirements for Milestone 1, evidence of board approval of the various committees - Meeting minutes reflect approval.	10/29/2015 03:37 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize PPS finance structure, including reporting structure	This Milestone is due for completion at DY1, Q3 and has six associated steps for implementation targeted for completion by DY1, Q2. During the Q2 report each of the steps, as well as the associated Milestone are being reported as Complete. The PPS hired a full-time Finance Manager in May of 2015, and formally seated the Finance Committee in July of 2015. Towards meeting this step to implementation, the PPS Bylaws detail those core requirements of the Finance Committee and several presentations to the Board of Directors have occurred which illustrating the corresponding committees which report to the board. The final organizational chart which includes financial relationships was finalized in Q2 as scheduled at the September 8 Board of Directors meeting (Step 1), concurrent with Finance Committee review and development of budget and funds flow guidance. The PAC Executive Council reviewed the requested skillset of potential Finance Committee members during the June 5, 2015 PAC Executive Council meeting. A call for nominations from the Stakeholders group was subsequently presented during the Friday 6/12/15 Stakeholders meeting (Step 2), reported previously in the Q1 report submission as Complete. Once a full slate of candidates was prepared from the Stakeholders, the bios for the Stakeholders slate were distributed to the PAC Executive council on 6/24/15 (attached) for final review by the PAC Executive Council and ranking via blind vote (Step 3) prior to submission to the Stakeholders group for confirmation at the 6/26/15 meeting. Following approval by the Stakeholders, the Finance Committee slate, including the members solicited from the Stakeholders was presented to the Board of Directors during the July 14, 2015 meeting and was approved (Step 4). To note continued progress beyond Q1 and this step to implementation, the Board of Directors voted and approved five members from the Stakeholders list to the Finance Committee during the July meeting. The CCN Board of Directors had officially seated the Finance Committee at their July meeting (minutes attached). At their first meeting in August of 2015, the Finance Committee set about generating their schedule until June of 2016 (attached) (Step 5). In the September Board of Directors meeting, the finance organizational chart was presented and approved, completing this milestone (Minutes attached) (Step 6).
Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	This Milestone is due for completion at DY1, Q4 and has 13 associated steps for implementation targeted for completion between DY1, Q3 and DY1, Q4. The PPS initially created a Partner Organization database of PPS members (Step 1) based off of information from the DSRIP application period. As time has progressed, we have been adding to our list as organizations have come forward expressing their interest via the letter of attestation to participate with Care Compass Network. They will be formally added to the PPS' performance network during the open enrollment period in MAPP, currently due for completion on 11/20/15. As of 9/30, the PPS began developing plans to use a similar assessment tool like that used to assess the financial stability of PPS Lead Organizations during the application period (Step 2). To ensure compliance with the annual financial assessment survey, the requirement for completion is being written in to

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	Partner Organization contracts when they sign up with Care Compass Network to do the work of our 11 projects. The assessment tool is scheduled to be reviewed by the Finance Committee at its regular monthly meeting on October 29th, 2015,(Steps 3-4) after which distribution of the survey and compiling of the results shall commence (Step 5)in time to complete those steps which are due by December 31st, 2015, and then the following set of steps (Steps 6-13) due in March of 2016 to complete this milestone. Overall progress of the steps and Milestone are on track with no barriers identified which would prevent completion by the respective due dates.
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	This Milestone is due for completion at DY1, Q3 and has five associated steps due in the same quarter. Each Step is being reported as In Progress for DY1, Q2 with no major issues or barriers which would hinder implementation efforts. The Compliance Officer of Care Compass Network reviewed NY Social Services Law 363-d upon hire in August to determine the scope and requirements of a compliance program based upon the DSRIP related requirements that are within the scope of responsibilities of the PPS Lead and NewCo. A Compliance Plan was developed and presented to the Compliance and Audit Committee during its monthly meeting on October 7, with agreement from the committee members. As a result this task (Step 1) will be reported as complete during the Q3 report. Written compliance policies and procedures were completed and approved by the Board of Directors in March, June, and July. Going forward the Compliance Officer and the Compliance and Audit Committee will review these policies against the maturation of the DSRIP program and related guidance's as well as the operating environment of Care Compass Network and update or modify existing policies or develop new policies to ensure policies and procedures reflect the ongoing needs of the PPS. These will be updated (as appropriate) and approved prior to the due date of this milestone in DY1, Q3 (Step 2). As part of the contracting process with PPS network providers, which is scheduled to commence in DY1, Q3, confirmation of a Compliance Program consistent with the NY State Social Services Law 33-6 for each network provider will be obtained (Step 3). The standard contract includes requirements that network providers will maintain a current Compliance Program to meet NY State requirements for a provider (Step 4). Furthermore, Care Compass Network is preparing a Compliance Program education and training program to guide Community Based Organizations that have not had the need for a Compliance Program prior to DSRIP activities. The Board of Directors has approved the plans for the Compliance Program and will formally approve the completed Compliance Program of Care Compass Network prior to the milestone due date (Step 5).
Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	This Milestone is due for completion at DY1, Q4 and has 12 associated steps for implementation targeted for completion between DY1, Q2 and DY1, Q4. The Finance Committee discussed the Value-Based Payment (VBP) planning efforts, including summary of items prepared by HANYS as well as CCN commitment as outlined in the DSRIP application during the August 3 meeting. The Finance Committee agreed on August 3 to coordinate the establishment of the VBP subcommittee chaired by John Collett, CFO, Cayuga Medical Center which was seated and met on August 10. The VBP subcommittee is comprised of membership representing hospitals, homecare agencies, skilled nursing homes, outpatient services, and CBOs (Step 1). Throughout Q2 the VBP subcommittee completed three meetings, the outcomes and minutes from which were subsequently presented at the following Finance Committee meeting. As part of the DY1Q2 deliverables, the VBP Committee has cultivated pathways (Step 2) between the committee and the rest of the system in order to survey and educate the current landscape of existing VBP arrangements amongst providers within the PPS. An education and communication plan was created and reviewed at the VBP committee meeting on 09/14/2015 (Step 3) and approved by the VBP subcommittee on 09/14/2015, being based on the VBP roadmap as released on July 22nd, 2015 by New York State Department of Health. On September 30th, 2015 a contract was executed with a vendor who has a high level of expertise and experience in Value-Based Payment arrangements, securing educational resources for the outreach endeavors with the anticipation of completing those

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	endeavors by December 31st, 2015 (Step 4). Successful completion of the endeavors is defined as a VBP presentation at each of the RPUs (North/South/East/West) as well as the PAC (Total 5 times). The PAC presentation will be a recorded webinar and made available on the Care Compass Network website for those who were unable to attend an in-person presentation. Future steps to implementation are on target for completion. The readiness self-assessment survey is scheduled for review by the Value-Based Payment Committee on October 19th, 2015 and will be open for a comment period through October 30th, 2015, after which the survey will be sent to partner organizations in November for returns to be collected, assembled, and analyzed by the DY1, Q3 requirement. Additional steps will follow as identified in the implementation plan for this milestone. Overall progress of the steps and Milestone are on track with no barriers identified which would prevent completion by the respective due dates.
Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	This Milestone is due for completion at DY2, Q3 comprised of 11 associated steps to implementation, none of which are due in the DY1, Q2 timeframe. As a framework towards achieving this milestone, the PPS Finance Committee and Value Based Payment (VBP) subcommittee, which reports to the Finance Committee, were established in Q2. Related VBP roadmap planning and education associated with Financial Sustainability Milestone 4 remain in progress and are on target for completion by the DY1, Q4 due date. Additionally, in Q2 the VBP subcommittee has reviewed upcoming project plan deliverables, the final VBP roadmap issued July 23, 2015, the communication and education plan for the PPS, and has also participated on several information sessions such as a HANYS call and attending the PPS meeting in Rye Brook, NY. The VBP subcommittee has been meeting at minimum monthly and is scheduled to continue doing so throughout DY1. Overall progress towards meeting this milestone is on track with no barriers identified.
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 & Ongoing	
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.

The first risk centers upon provider buy-in, openness, and cooperation within the DSRIP project in an effort to maintain financial sustainability. Success is inherently built upon trust existing between the PPS and its partners. Therefore, if we do not achieve buy-in and its subsequent result, openness, we will be significantly hindered in monitoring and sustaining the financial wherewithal of the PPS' partners. In an effort to mitigate this risk, through the Practitioner Engagement Plan we will establish educational resources, regularly held information meetings, and transparent communication lines between all entities involved. A funds distribution plan will be created and disseminated among the PPS partners to ensure clarity, vision, and confidence.

Our second risk deals with the potential for Medicaid Managed Care Organizations not negotiating in good faith with the providers within Care Compass Network. This will impact the overall success of the PPS' providers' movement towards value based payments. Flexibility, integrity, and willingness to collaborate with Care Compass Network's providers is essential, especially when there is the potential for MCOs to hold fast to self-serving levels of reimbursement rates due to market dominance. To mitigate this potential risk, we plan on providing open forums between MCOs and our providers in order to promote healthy dialogue and cooperation, while ensuring confidentiality amongst Care Compass Network members.

As the Care Compass Network progresses towards achieving DSRIP's goals, developing a process for analyzing provider performance and its alignment with the flow of funds are imperative. The analysis of provider performance must be comprehensive yet clean, in order to avoid any confusion and provide a clear picture to the administration and its partners. This will allow the Finance and Clinical Domains to determine where resources need to be supplemented and/or diverted in order to maximize the impact on the patient population of the Care Compass Network as well as minimize any repercussions.

Our final risk regards the inability to firmly grasp both the financial sustainability ends and means of DSRIP due to the ambiguity of DSRIP information provided by the State. This impacts our project's goals by significantly hindering our ability to prepare and sufficiently scale our financial efforts in a sustainable way. Without a proper end in sight and to-date-porous means to get there, we are limited in our capacity to fully implement. Our mitigating strategy is to mimic the model established for health homes, limit fixed costs, and, above all else, to remain financially flexible.

IPQR Module 3.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

There are four primary interdependencies with other workstreams, as related to the Financial Sustainability workstream, including:

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• Governance – The support of the Board is pivotal to ensuring the cooperation and buy-in of the partners within the Care Compass Network as the Finance Domain works to maintain financial sustainability and develop the flow of funds.

• Reporting Requirements - The financial success of the PPS is directly tied to meeting the reporting requirements. In order to complete these reports, data will have to be pulled from many sources, including providers, RHIOs and the Department of Health.

• DSRIP Projects – As the Care Compass Network works to engage and intervene for the beneficiaries, the projects that have been selected are to enhance the available toolkit. Understanding which tool is applicable and how to augment the coordination of care in a sustainable manner are integral to the flow of funds.

• Workforce – In order to redesign the coordination of care in a sustainable manner, workforce and finance must work with the partners of Care Compass Network to identify opportunities of training and redeploying current resources in revised roles.

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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
Finance Manager	Bob Carangelo / Care Compass Network	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 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. 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. Primary contact for the PPS 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.
Financial Analysts	Multiple - Currently Consultants	Responsible for assisting in the continuity of operations of the data aspects of the Finance Office and providing assistance to the Finance Office as it relates to data analysis, acquisition and reporting. This position will be responsible for developing and distributing the defined report data set(s) to the designated stakeholders. This position(s) will be responsible for working with the Finance Manager and Finance Committee to determine and monitor the reporting protocols/requirements for the PPS providers, the governing body, and DOH.
Accounts Payable Staff	Purchased Services - UHS AP Department	Coordinated by the CCN Finance Manager, the AP service acquired through UHS, Inc. is responsible for the day-to-day operations of the Accounts Payable function, including drafting policies and procedures when needed, monitoring the accounts

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		payable system, and implementing PPS protocols around reporting and AP check write related to the DSRIP funds distribution.
Reporting Analyst(s)	Multiple	Responsible for the preparation of reporting requirements for review by the responsible party, including the Finance Manager, RPU Project Manager, etc.
Banking Staff	Purchased Services - UHS	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.
PPS Compliance Officer	Rebecca Kennis, Care Compass Network Compliance Officer	Responsible for overall development and maintanence of PPS Compliance program, including items such as training, data security, user agreements, privacy, and technology compliance with reports to the Board of Directors.
External Auditor	TBD - RFP in Process	External auditors reporting to the Finance Committee. The firm will perform the audit of the PPS and PPS Lead related to DSRIP services according to the audit plan approved by the PPS governing body. External Auditors to be selected by the Compliance and Audit Committee in DY1.

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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		
Robin Kinslow-Evans, Interim Executive Director	PPS DSRIP Executive Director	The DSRIP Executive Director has overarching responsibility for oversight of the DSRIP initiative for the PPS
Mark Ropiecki, Director Project Management	PPS Project Management Director	PMO oversight and leadership for finance related projects, VBP strategy, and for the overall implementation plan deliverables that affect finance function reporting
Dawn Sculley, Project Manager - South RPU & Emily Pape, Project Manager - West RPU	PPS Project Managers	Collaboration with finance re: PPS Project Implementation, status of projects, reporting required to meet DOH requirements.
Robin Kinslow-Evans, Interim Executive Director	South RPU Lead	Alignment of RPU needs at the Governance Level, Coordination of Common Projects where PPS overlap occurs, general oversight of project implementation efforts at the local level.
Amy Gecan, Director System Integration and Operations (Cayuga Medical Center)	North RPU Lead	Alignment of RPU needs at the Governance Level, Coordination of Common Projects where PPS overlap occurs, general oversight of project implementation at the local level.
Greg Rittenhouse, VP, COO, Home Care (UHS)	East RPU Lead	Alignment of RPU needs at the Governance Level, Coordination of Common Projects where PPS overlap occurs, general oversight of project implementation efforts at the local level.
Laura Manning (Guthrie)	West RPU co-lead	Alignment of RPU needs at the Governance Level, Coordination of Common Projects where PPS overlap occurs, general oversight of project implementation efforts at the local level.
Robin Stawasz (CareFirst)	West RPU co-lead	Alignment of RPU needs at the Governance Level, Coordination of Common Projects where PPS overlap occurs, general oversight of project implementation efforts at the local level.
Ann Homer, Corporate Compliance and Privacy Officer, Family Health Network	PPS Compliance Officer Advisor	Consulting arrangement to help provide oversight of PPS Compliance Plan and related training, education, and reporting requirements of the plan.
Rebecca Kennis, Care Compass Network Compliance Officer	PPS Compliance Officer	PPS Compliance Officer responsible for overall development and implementation of the Compliance function. Also provides Data Security and Privacy Officer roles.
Internal Audit	TBD	Oversight of internal control functions; completion of audit

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
	Manager Internal Audit	processes related to funds flow, network provider reporting, and other finance related control processes
PPS Finance Committee	Dave MacDougall, Care Compass Network Finance Committee Chair	Board level oversight and responsibility for the PPS Finance function; Review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; collaboration with the Compliance Committee for audit and compliance related processes.
PPS Human Resources	UHS Human Resources	The PPS purchases HR services from the UHS, Inc. Human Resources department. Services include training materials, recruitment, support services such as time clock management, and development of PPS related HR programs and policies.
Matthew Salanger, UHS CEO, Care Compass Network Board of Directors Chair	Boards of Directors for PPS Network Partners	The PPS Board of Directors retains general power to manage and control the affairs, property, and business of the corporation and have the full power by majority vote, unless otherwise noted within the Bylaws. The Board of Directors has full authority with respect to the distribution and payment of monies received and owed by the corporation from time to time, subject to the rights of the Members.
Multiple	PPS Partner Organization Leaders (e.g., CEOs, Executive Directors, etc.)	PPS 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
External Stakeholders		
New York State Department of Health	NY DOH defines the DSRIP requirements	The PPS Lead and PPS finance function has responsibility for the overall administration of DSRIP reporting to DOH and the funds flow process.
PPS Stakeholders	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.

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
To Be Determined in DY1	PPS External Audit Function	Provision of annual and quarterly (when needed) review of PPS internal control, operations, and financials.

IPQR Module 3.7 - IT Expectations

Instructions :

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

The Finance and IT Governance Domains will work together on the development of sharing data and analytics to measure the Care Compass Network's partners' financial sustainability as well as performance in a quick, clean and compliant process. The population health team will support the clinical and finance domains in the education and outreach as Care Compass Network's partners' move towards Value Based Payment arrangements as well as analyzing the impact of the different projects. To support these functions the IT access across the PPS should promote collaboration of PPS financial sustainability data and reports and project reporting, etc. In addition, the IT systems will need to be adequate to support and monitor financial sustainability (e.g., PPS financial analysis reports, performance metrics reporting, PPS specific financial statements, etc.).

IPQR Module 3.8 - Progress Reporting

Instructions :

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

As the Care Compass Network progresses towards the various requirements of the DSRIP Projects, Population Health, Finance and the PMO Director will work together to analyze the performance of the Network's partners. If a provider's performance is deemed unsatisfactory, the PMO director, Clinical Domain and Finance will develop a new strategy in order to remedy the situation. If any changes are required to be made to the flow of funds, the strategy must be presented and signed off on by both the Finance Committee and Governance Board.
The Finance Manager will annually perform a financial survey of the Network's partners in order to monitor the financial sustainability. The results of the survey will be prepared in a summary report and presented to the Finance Committee for review. For those providers who are financially fragile, the Finance Office will work with the provider on a plan to move towards financial stability.
Both the Financial Sustainability and performance analysis will be developed into dashboards and shared with the Finance committee and Governance Board on an on-going basis.

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.	In Progress	This milestone must be completed by 12/31/2015. Cultural competency / health literacy strategy signed off by PPS Board. The strategy should: -- Identify priority groups experiencing health disparities (based on your CNA and other analyses); -- Identify key factors to improve access to quality primary, behavioral health, and preventive health care -- Define plans for two-way communication with the population and community groups through specific community forums -- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors); and -- Identify community-based interventions to reduce health disparities and improve outcomes.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1 - Establish Cultural Competency Committee (CCC) to meet regularly and be responsible for overseeing cultural competency and health literacy throughout the DSRIP project timeline.	Completed	Complete - The Cultural Competency workgroup was active for most of 2015 and the Chair (Annie Bishop) announced a call for members to the Stakeholders group on 6/12/15 (see attached, slide 7). The first meeting of the CCN Cultural Competency Committee occured on 6/26/15. Also attached is a copy of the distribution which was sent following the meeting, including a copy of the CCN implementation plan to the Cultural Competency Committee members.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - CCC to review CNA to identify	Completed	See Narrative.	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
priority/focus groups with outstanding health disparities and needs.									
Task Step 3 - CCC to identify recurring themes and key factors from the CNA which are suggested to improve access to primary/behavioral/preventive health care.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4 - Obtain sign off on strategy to ensure standardized PPS Partner Evaluation, Implementation and Training of Cultural Competency and Health Literacy by PPS Board.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 5 - CCC to establish forum for bidirectional communication with community members and community groups.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 6 - PPS to require participation in organizations Cultural Competency/Health Literacy Evaluation, Implementation and Training with Partners through contracting process.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7 - CCC to team up with Workforce Development Team and PPS Partner Human Resources/Employee Development departments to administer PPS contractually required Nathan Kline Assessment Survey (NKAS) survey.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 8 - CCC to train on and implement member-specific relevant evidence-based cultural competency/health literacy tools and assessments which are expected to promote positive health outcomes and promote self-management (example: Cultural and Linguistic Appropriate Services ("CLAS"), and others).	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 9 - CCC to monitor ongoing incoming NKAS	In Progress	See Narrative.	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
results from PPS partners and reflect on newly identified cultural competency/health literacy issues. CCC will use this information and discuss relevance for ongoing training content and training strategy.									
Task Step 10 - CCC and Project Management Office to incorporate Nathan Kline Cultural Competency Assessment results into ongoing regular (at least annually) PPS Cultural Competency and Health Literacy Training and Evaluation Requirements.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 11 - CCC to work with Communications Team to disseminate ongoing messages regarding Cultural and Linguistic Appropriate Services (CLAS) Standards and other Cultural Competency/Health Literacy topics to all PPS Partners to address importance of accessibility of services.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 12 - Establish process with DSRIP Projects/Project Management Office for the CCC to review any project-specific materials prior to community distribution for health literacy (language) appropriateness to maximize potential resonance with target demographic to improve health outcomes. CCC to encourage the use of community navigators (Community Health Advocates from Project 2.c.i.) and the teach-back approach with front line staff when working with community members.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 13 - Submit progress via quarterly reports to NYS.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Develop a training strategy focused on	In Progress	This milestone must be completed by 6/30/2016. Cultural competency training strategy, signed off by PPS Board. The	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	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
addressing the drivers of health disparities (beyond the availability of language-appropriate material).		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							
Task Step 1 - Obtain sign off on cultural competency and health literacy training strategy by PPS Board.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 2 - Collect and aggregate incoming region-specific cultural competency/health literacy needs identified from contracted PPS Partners in their Nathan Kline Cultural Competency Assessments and the PPS CNA.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3 - Identify region-neutral, overarching concepts of Cultural Competency and patient engagement strategies.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4 - Combine both region-neutral and region-specific concepts of Cultural Competency and patient engagement strategies. These concepts to include, but are not limited to: bias, stereotyping, language barriers, geographical implications, race, educational level as it pertains to literacy/health literacy, etc.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5 - CCC to work with PPS Workforce Development Team, PPS Partner Human Resources/Employee Development departments, and Communication Team to create a standardized checklist of required training to be completed by all front line and management staff of all PPS Partners on a regular basis.	In Progress	See Narrative.	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
Task Step 6 - Ensure ongoing training is addressed in each CCC meeting agenda.	In Progress	See Narrative.	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

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize cultural competency / health literacy strategy.	In Progress - A Cultural Competency/Health Literacy workgroup was established and met throughout 2014 as part of the DSRIP application and planning process. A formal Cultural Competency and Health Literacy Committee (CCC) was later developed with expanded membership from the initial application workgroup and became formally active during the DY1, Q2 timeframe in 2015. The Cultural Competency Chair (Annie Bishop, Administrative Manager UHS Medicaid Health Home) leveraged several methods for seating and advertising the committee, including the PPS-wide Stakeholders meeting on June 12, 2015 and again on September 18, 2015. The first meeting of the expanded CCN Cultural Competency Committee occurred on June 26, 2015 (Complete - Step 1). The Cultural Competency Committee (CCC) reviewed the Community Needs Assessment on July 17, 2015, identifying key words and reoccurring themes (Complete - Step 3) in order to inform the cultural competency and health literacy strategy in regards to the needs of specific priority or focus groups as well as improving access to primary/behavioral/preventative health care (Complete - Step 2). The CCC also developed the cultural competency and health literacy strategy in DY1, Q2, informed by the findings of the Community Needs Assessment and presented this to the Board of Directors on August 11, 2015 for informational purposes and then was approved by the Board of Directors on September 8, 2015 (Complete - Step 4). The strategy outlines standardization of partner evaluation and training. Additionally, the Cultural Competency Committee (CCC) has initiated bi-directional communication with community members through the candidate seating process whereby members were sought from the PPS Stakeholders meeting, which includes PPS participants from across the nine county territories (Complete - Step 5). This topic continues as a point of discussion for CCC meetings. Moreover, the CCC has begun to utilize the RMS panel to solicit input from beneficiaries. The CCC will work with the Care Compass Network (CCN) Communications Team to establish an electronic bidirectional forum on the CCN website for Cultural

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	Competency and Health Literacy topics. In progress toward future deliverables, Steps 6-13 remain in process and are on target for completion for the DY1, Q3 report. The Care Compass Network Partner Agreement was distributed to partners for 30-day review in August. Terms are in the process of being finalized but include the requirement of Cultural Competency and Health Literacy training and implementation PPS-wide. The Cultural Competency Committee (CCC) is currently reaching out to partner organizations to evaluate existing training materials, identify gaps, and address these in upcoming Care Compass Network Cultural Competency and Health Literacy training efforts. The committee has also requested to review clinical policies and procedures to ensure their cultural appropriateness which will begin in DY1, Q3. Finally, the committee chair maintains regular contact with the Project Management Office (PMO) to ensure efforts are communicated, coordinated, and on track to meet targets outlined in our implementation plans.
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	In Progress – With the Cultural Competency and Health Literacy strategy completed and approved on time (DY1, Q2) as well as Steps 6-13 on track for completion in DY1, Q3 as per Milestone 1, Milestone 2 is also on track for its projected DY1, Q2 completion as the Nathan Kline Assessment Survey (NKAS) results are received following the execution of contracts in DY1, Q3. With the information received from the NKAS, the Cultural Competency Committee (CCC) may begin to develop a training strategy informed by the results of the Community Needs Assessment and its findings regarding health disparities. Furthermore, the NKAS will allow for particular gaps to be identified at the organizational level, facilitating an efficient and tailored approach to training Care Compass Network (CCN) partners. To support the close-knit relationship between Workforce and Cultural Competency and Health Literacy projects, the Workforce project lead continues to attend CCC meetings. Additionally, the Workforce vendor, Iroquois Health Alliance (IHA), has begun an assessment of training needs by DSRIP project. This will enable the relationship required to execute Step 5 and create a comprehensive checklist of training requirements. Overall, Milestone 2 is on track for completion by the DY2, Q1 target.

Milestone Review Status

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

(1) Cultural Competency Committee Formation - There exists a strong need/risk associated with the successful PPS development regarding cultural competency and related PPS collaboration efforts to include membership from a broad spectrum. Without this committee and representation, the PPS may not properly represent the nine county region or needs of the PPS as identified by the Community Needs Assessment. Without this committee, STRIPPS risks losing sight of cultural competency throughout the DSRIP timeframe. To mitigate this risk, STRIPPS will establish a Cultural Competency Committee (CCC) which will be responsible for the promotion of Cultural Competency and Health Literacy. To ensure committee establishment, the CCC will be promoted at various STRIPPS meetings, such as the existing Stakeholder/ PAC Meetings, to promote the CCC and foster voluntary membership by PPS participants. STRIPPS will also look to established cultural competency groups (e.g., at the RPU level) to partake in the CCC.

(2) Stakeholder Buy-In - Another risk in STRIPPS' Cultural Competency/Health Literacy strategy is the ability to obtain buy-in from both the community members and the front-line health care provider staff. Both Medicaid beneficiaries and professionals working at CBOs or health care services will need to appreciate the impact that sensitivity to cultural competency needs and health literacy gaps can have on patient outcomes. STRIPPS will mitigate this risk of a lack of buy-in by providing education and awareness campaigns through the use of ongoing training for providers, CBOs, and ongoing dialogue about cultural sensitivity issues with community member focus groups through RMS. The CCC will also periodically develop materials for presentation to the Stakeholders / PAC meeting to promote PPS wide awareness of related issues.

(3) Cultural Competency Participation - Another risk that exists with deploying a PPS-wide Cultural Competency training is reluctance from front-line staff and others required to participate in the training sessions. STRIPPS will need to mitigate the risk that exists with our partner network to implement training and or participate in training related to cultural competency and health literacy. It will be imperative that all participating providers are involved in the ongoing, targeted education set forth by the PPS. STRIPPS providers who already give Cultural Competency trainings may perceive this as an additional requirement. It is possible that resistance will surface preventing successful deployment and training of this important topic. A mitigation strategy for this risk is to leverage existing training programs already in place at PPS organizations and leverage where possible. To achieve the desired outcomes, we will collaborate with PPS partners to ensure that these existing trainings incorporate the sensitivities detected by the CNA (as applicable). This way, employees will only be required to do one Cultural Competency training which aligns to the PPS Cultural Competency training.

(4) Geographic Disparity - Regional differences within STRIPPS, notably with the vast geography of the area, lends to the need for ongoing updates to the STRIPPS Cultural Competency training. Due to these variances, a risk exists for outdated training which may no longer be applicable to the diversity in the STRIPPS area. The CCC will regularly use the CNA and the PPS marketing research vendor to monitor changes to the demographics of the area and include these changes in trainings. The CCC will also leverage the PPS Communications Coordinator to ensure communications across the RPUs and PPS are aligned where possible. In addition, the CCC will leverage the PPS Project Management Coordinator to ensure implementation efforts are aligned from a PMO perspective, at the RPU level, and standardized at the PPS level as possible.

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IPQR Module 4.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

As Cultural Competency and Health Literacy are an essential component of planning and delivering DSRIP goals, we have identified a spread of interdependencies for multiple Workstreams, as follows:
(1) Project Teams -- will work with the Project Teams on developed materials for beneficiary distribution to ensure health literacy level is appropriate and confirm cultural sensitivity/effectiveness of materials.
(2) Practitioner Engagement -- will need support from providers across the area to be open to modifying their practices and adhere to cultural competency training. Implementing health literacy sensitive literature for beneficiaries will also be an important part of practitioner engagement. Having a provider base which embraces Cultural Competency will be imperative to the success of the Cultural Competency initiatives from the CCC.
(3) Communications Team -- will work with Communications Team to ensure topic of Health Literacy and Cultural Competency is an ongoing, promoted effort throughout the PPS and all partner organizations.
(4) Finance -- will work with the Finance team to approve and purchase Cultural Competency evaluation tools, such as the NKAS and CLAS standards. Will also need involvement from Finance for funding marketing materials and other necessary items.
(5) Workforce Development Team -- will work with the Workforce Development Team for promotion of ongoing cultural competency training for redeployed workforce, and to educate frontline and background PPS workforce on importance of cultural competency and health literacy.
(6) Information Technology (IT) -- will need the assistance of IT to deploy training, to track training results (e.g., attendance or otherwise), and to provide reports on training.
(7) Performance Reporting -- will need involvement from the Performance Reporting team to provide feedback to the RPUs and to send STRIPPS reportable data (training data) to NYS.
(8) Population Health -- will need involvement from Population Health team to monitor baseline metrics, changes in the demographics, and other data sets such as the diversity of a STRIPPS RPU.
(9) PPS Governance -- will leverage the Governance structure from the PPS to obtain a draft of quality Cultural Competency policies, as well as final policy approval. In addition, we will leverage the PPS Governance structure to prepare and approve a Cultural Competency Strategy and overall Training Strategy.
(10) Current PPS Human Resources/Employee Development Departments -- will work with these departments to ensure training is implemented and enforced throughout DSRIP timeframe. With the help of members from our CBO Council, which will help create RPU based training opportunities, we will leverage HR/ED teams to confirm training strategies are effective and inline with any pre-existing related training efforts. When possible, DSRIP related trainings will leverage existing training platforms.
(11) Stakeholders / PAC - will require cooperation from the PAC as Stakeholders of DSRIP concerted efforts for the Medicaid beneficiary population to promote positive health outcomes, and reduce ED/inpatient hospitalizations in a culturally competent manner for both the PPS geographic region as well as the PPS' related DSRIP goals.

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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
Workforce Development Team (WDTT)	Lenore Boris / SUNY Upstate Binghamton Clinical Campus	Responsible for ongoing training.
Cultural Competency Committee	Anne Bishop / UHS Multiple Members	Responsible for regular meetings and establishment of training.
Provider Engagement Team	Regional Performance Unit Provider Relations Staff / Care Compass Network	Responsible for Provider Education, Agreements/Contracts, and functioning as a central source for Provider PPS/DSRIP related questions.
Communications Team	Christina Boyd / UHS	Responsible for ongoing Cultural Competency Messages to PPS.
PPS Partner Employee Development	CBO Council	Responsible for PPS Partner employee development, and establishment of training.
Additional Partners	All PPS Partners	Need to take Nathan Kline Cultural Competency Assessment.

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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		
Stakeholders / PAC	Support / Enforce training	Responsible for supporting provided education, training, and Cultural Competency related PPS updates.
Project Teams	Attend initial meeting to establish process, submit patient materials to CCC for approval	Responsible for support/enforcement/discipline when needed, preparing Quarterly Reports and submitting these to the PMO for Governance Reporting & State Submissions.
PPS	Support financially, facilitate training, set policies and procedures, support training and tracking of training. Integrate RPU level leadership to align the Cultural Comp workstream with formation of each RPU.	Responsible for support/enforcement/discipline when needed, preparing Quarterly Reports and submitting these to the PMO for Governance Reporting & State Submissions.
External Stakeholders		
Community Based Organizations (CBOs)	Implement policies and procedures, Participate in the CCC, Guide training as needed in their organization.	Responsible for support, enforcement, and training as well as providing education when needed.
Multiple external	Support and Guide, Participant	Responsible for meaningful involvement to support and guide the content of the Cultural Competency training and awareness campaigns as well as promoting operating in diverse geographies.

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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.

Cultural Competency is reliant upon a shared IT infrastructure for the reporting of Cultural Competency Training. It is possible that the training itself will also be administered for this workstream with a single, shared IT infrastructure, though it is also possible that each Regional Performance Unit (RPU) will be able to implement trainings through their own, currently established systems. Initially, PPS wide trainings will be developed for distribution at the PPS level through existing forums, such as the Stakeholders/PAC meetings, however as we evolve into future DSRIP years the focus will shift so trainings can become more RPU centric and customized at the RPU level as appropriate. However, the option to execute education and presentations at the Stakeholders/PAC level will remain as a constant for PPS level announcements, as will the communication of information through the public facing website or blast communications from the PPS Communications Coordinator. The effectiveness of priority education or awareness campaigns can be measured as needed through utilization of the RMS research panel.

IPQR Module 4.8 - Progress Reporting

Instructions :

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

The PPS will look to continually re-evaluate cultural competency and sensitivity to health literacy through the usage of the Nathan Kline Cultural Competency Assessment. Comparing results of DY5 Nathan Kline Cultural Competency Assessment reports to initial, DY0 reports from all PPS partners will be able to show a qualitative progression of cultural competency across the region. Additionally, RMS, STRIPPS' market research vendor, will serve as a vehicle for obtaining provider feedback which will be imperative to adjusting and updating cultural competency training throughout the DSRIP timeline. This research can be geared to provide valuable information to measure the effectiveness of provider feedback on strategies and training. Post-training assessment and evaluation will also be used to obtain feedback and to react to recommendations to modify training to ensure relevance to the cultural characteristics of our population.

IPQR Module 4.9 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Section 05 – IT Systems and Processes

IPQR Module 5.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	In Progress	Detailed IT current state assessment. Relevant QEs (RHIOs/HIEs) should be involved in performing this assessment.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1 - Establish an IT Governance structure in accordance with CCN bylaws and with appropriate representation across PPS entities & areas of expertise. The IT Governance Structure will be approved by the CCN Board.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - Perform data gathering of the IT environment and specifically in terms of the capabilities of all the participating PPS members, and conduct needs assessment.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3 - Develop high level IT vision which appropriately incorporates and addresses data analytics, population health, EMR technology, telehealth, & home monitoring.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4 - Perform gap analysis that identifies the ability of the current IT environment to support and achieve the organization's desired outcomes.	In Progress	See Narrative.	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
Task Step 5 - Identify and define relevant alternative IT strategies in order for the organization to attain the identified IT Vision, support the organization's strategic DSRIP goals, and successfully address the findings/recommendations of the needs/gap analysis.	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6 - Develop IT strategic plan and associated Action Plan that includes the timeframe in which the component projects should be initiated, the anticipated elapsed time, the required resources, and the dependencies with other initiatives as well as the associated costs.	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #2 Develop an IT Change Management Strategy.	In Progress	IT change management strategy, signed off by PPS Board. The strategy should include: -- Your approach to governance of the change process; -- A communication plan to manage communication and involvement of all stakeholders, including users; -- An education and training plan; -- An impact / risk assessment for the entire IT change process; and -- Defined workflows for authorizing and implementing IT changes	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1 - Develop plan to imbed change management strategy into provider relations function.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 -Develop charter for change management advisory group, including periodic monitoring of the effectiveness of the change management process.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3 - Review gap analysis and understand types of changes potentially needed.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4 - Develop a communication plan to	In Progress	See Narrative.	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
communicate the approved required changes through a variety of mechanisms to ensure all PPS members have been notified.									
Task Step 5 - Develop training and education strategy on the change management process and required approvals.	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6 - Establish process for authorizing and implementing IT changes in accordance with CCN bylaws and subsequent guidance from the IT & Data Governance Committee.	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #3 Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	In Progress	Roadmap document, including current state assessment and workplan to achieve effective clinical data sharing and interoperable systems where required. The roadmap should include: -- A governance framework with overarching rules of the road for interoperability and clinical data sharing; -- A training plan to support the successful implementation of new platforms and processes; and -- Technical standards and implementation guidance for sharing and using a common clinical data set -- Detailed plans for establishing data exchange agreements between all providers within the PPS, including care management records (completed subcontractor DEAAs with all Medicaid providers within the PPS; contracts with all relevant CBOs including a BAA documenting the level of PHI to be shared and the purpose of this sharing).	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task Step 1 - Leverage the needs assessment of the IT strategy and define specific data exchange and system interoperability requirements.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2 - Develop plan to incorporate data sharing agreements and consent agreements with all participating organizations.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3 - Define data governance structure.	In Progress	See Narrative.	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
Task Step 4 - Develop training strategy.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5 - Develop a communication plan.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6 - Develop technical architecture to ensure interoperability among all PPS systems.	In Progress	See Narrative	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7 - Evaluate business continuity and data security, confidentiality and integrity controls.	In Progress	See Narrative	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 8 - Develop transition plan to migrate paper-based providers to electronic data exchange.	In Progress	See Narrative	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
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	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1 - Perform an IT needs assessment for existing /new attributed members.	Completed	See Narrative	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - Perform a gap analysis of existing patient engagement outreach programs, strategies and mechanisms.	In Progress	See Narrative	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3 - Develop an action plan for new engagement channels.	In Progress	See Narrative	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4 - Develop metrics to ensure successful beneficiary engagement.	In Progress	See Narrative	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5 - Establish progress reports on beneficiary engagement.	In Progress	See Narrative	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #5 Develop a data security and confidentiality plan.	In Progress	Data security and confidentiality plan, signed off by PPS Board, including: -- Analysis of information security risks and design of controls to mitigate risks -- Plans for ongoing security testing and controls to be rolled	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 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
		out throughout network.							
Task Step 1 - Evaluate the existing data security and confidentiality plans and identify gaps to meet the needs of the PPS.	In Progress	See Narrative	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2 - Leverage data governance and data exchange policies to ensure data security and confidentiality.	In Progress	See Narrative	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3 - Develop plan for mitigating identified data security and confidentiality risks/vulnerabilities.	In Progress	See Narrative	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4 - Develop plan to monitor security and confidentiality on an ongoing basis, including progress reports.	In Progress	See Narrative	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5 - Develop a communication strategy and training plan for security and confidentiality.	In Progress	See Narrative	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop a data security and confidentiality plan.	sculley	Other	44_MDL0503_1_2_20151214144608_Initial_Feedback_from_the_IA_12-1-15_v2.xlsx	Per CCN/IA discussion on 12/8/15 - There has been no substantive change since the Q2 report was submitted and as such, no updated form is required.	12/14/2015 02:46 PM
	rachaelm	Other	44_MDL0503_1_2_20151029163330_PPS template in lieu of SSPs 10.2.15_CareCompassNetwork.docx	PPS Template in lieu of SSPs as referenced in Milestone 5 Narrative.	10/29/2015 04:33 PM

NYS Confidentiality – High

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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).	The IT Systems & Processes Milestone 1 is comprised of six steps to implementation, two of which are scheduled for completion in DY1, Q2 and are being reported as such. The overall Milestone is due for completion DY1, Q4 and is on target for completion by this date. In DY1, Q2 Care Compass Network (CCN) has adopted an IT Governance structure which meets CCN bylaws and has appropriate representation across the PPS entities and areas of expertise. In July, the CCN Board of Directors approved the IT Informatics and Data Governance committee structure. This structure consists of three subcommittees (Change Management (with four RPU subcommittees), the IT Workgroup Subcommittee Workgroup, and the Technology Advisory Subcommittee (with Technical and Clinical IT Workgroups) (Step 1). Furthermore, in August the Board of Directors approved the slate for IT Informatics and Data Governance Committee. CCN has engaged the IT consultants from WeiserMazars to assist in the development of an overall IT Systems and Processes roadmap. WeiserMazars developed an IT focused survey for major CCN partners to further assess the PPS' current IT capabilities and identify the IT needs of the PPS (Step 2). The surveys were distributed to the RPU Leads for distribution to the associated partners by respective RPU in mid-August. Following the completion of the surveys, the WeiserMazars team aggregated results and presented a detailed overview to the IT Technical Workgroup at the 10/1/15 meeting. The Chair of the IT Committee later presented the reports to the Board of Directors on 10/13/15. The PPS remains on track for completion of the remaining steps and milestone by the associated DY1, Q3 and DY1, Q4 due dates.
Develop an IT Change Management Strategy.	The IT Systems & Processes Milestone 2 is comprised of six steps to implementation, two of which are scheduled for completion in DY1, Q2 and are being reported as such. The overall Milestone is due for completion DY1, Q4 and is on target for completion by this date. Care Compass Network (CCN) has in place a plan which embeds change management into our provider relations function by allowing change management to function at the local Regional Performance Unit level. The Board of Directors approved the IT Committee structure, inclusive of RPU based change management sub-committees at the July 14, 2015 meeting (Step 1). CCN has similarly established a Provider Relations framework also based on RPU. These experienced professionals will work directly within the RPU framework, assisting each RPU leader to successfully execute CCN projects and delivery system changes in each area. Following approval of the IT structure by the Board of Directors in July, the charter for the change management sub-committee was drafted on August 12, 2015 (Step 2). A key function of the Change Management subcommittee (and four RPU subcommittees) will be to provide input and report out findings and recommendations on a regular basis to the IT Informatics and Data Governance committee, thereby providing periodic monitoring of the effectiveness of CCN's change management process. The remaining steps to implementation within this Milestone remain on target for completion by the respective due dates.
Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	The IT Systems & Processes Milestone 3 is comprised of eight steps to implementation, all of which are scheduled for completion in DY1, Q3. For the DY1, Q2 report each of these steps is being reported as In Progress. Each step is on target for completion by the due date of DY1, Q3.
Develop a specific plan for engaging attributed members in Qualifying Entities	The IT Systems & Processes Milestone 4 is comprised of five steps to implementation, of which one is scheduled for DY1, Q2 completion and is being reported as such. CCN has engaged the IT consultants from WeiserMazars to assist in the development of an overall IT Systems and Processes roadmap. WeiserMazars developed an IT focused survey for major CCN partners to further assess the PPSs current IT capabilities and identify the IT needs of the PPS. The surveys were distributed to the RPU Leads for distribution to the associated partners by respective RPU in mid-August (Step 1). The surveys focused on technical components including items such as RHIO connectivity, RHIO services utilized, IT Systems, IT Specification, existing IT related barriers, system versions, related installation dates, Population Health capabilities, analytic capabilities, care coordination capabilities, tele-health & tele-monitoring capabilities, and self-identified potential use of systems/infrastructure to meet DSRIP goals. Following the completion of the surveys, the WeiserMazars team aggregated results and presented a detailed overview to the IT Technical Workgroup at the 10/1/15 meeting. The Chair of the IT Committee later presented the reports to the Board of Directors on 10/13/15. The PPS remains on track for completion of the remaining steps and milestone by the associated DY1, Q3 and DY1, Q4 due dates.
Develop a data security and confidentiality plan.	The IT Systems & Processes Milestone 5 is comprised of five steps to implementation, all of which are scheduled for completion in DY1, Q3. For the DY1, Q2 report each of these steps is being reported as In Progress. Each step is on target for completion by the due date of DY1, Q3. Care Compass Network is currently working toward receiving Medicaid beneficiary claims data from the Department of Health and is expecting to complete this process by the end of DY1, Q3. At that time, we will also submit the IA, SC, CM, and AC System Security Plan workbooks. For the DY1, Q2 reporting, we are submitting the "PPS Template in lieu of SSPs" document.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	In preparation for receiving the beneficiary data, we are in the process of purchasing and installing a server to house the data, as well as contracting with Spohn for a security audit of the server setup and environment. Furthermore, we are completing our written policies and procedures to support a secure environment for maintaining confidential systems and data.

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	This milestone is Pass and Ongoing pending final review of security workbooks by DOH.

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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.

(1) IT Governance Structure - One risk to implementation will be gaining the cooperation of providers in the network to align the organizations IT priorities within the PPS. To mitigate this risk we will establish provider education opportunities, promoted through the CBO Council and the Provider Relations function to raise awareness of how PPS infrastructure benefits other incentive/penalty programs (e.g., meaningful use) to gain prioritization. Our PPS will also leverage provider contracts, facilitated through the funds flow model and provider relations, to provide payment incentives for participation.

(2) RHIO Capacity - The RHIOs may not have the resources and capacities in place in time to support the infrastructure development to support the needs of one (or many) PPS. The mitigating strategy for this potential bottleneck will be to identify and secure when necessary alternative information submission methods which will satisfy the DSRIP requirements for select providers.

(3) Technical Workforce - There is a risk that available technical resources available to the New York market will become limited and/or experience pricing inflations due to the urgency and magnitude of DSRIP efforts. As a primary mitigation plan we will pursue and encourage state-wide solutions to address the common theme and cross-over risk across the NY PPS population. In addition, we will collaborate with overlapping PPS to pursue talent sharing arrangements as an effort to both reduce costs and obtain the requisite talent resources. Another mitigation strategy will be to closely collaborate with regional partners, such as those who have had multiple shifts to their EMR profiles to identify leading practices in key areas to promote the development of efficient and effective strategies, such as development of reporting infrastructures and creation of strategic plans (e.g., focus efforts based on population centers). This may also include close collaboration with the RHIO's, as strategic partners who will be in the position of serving multi-PPS members.

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.)

It Systems & Processes are dependent upon the following organizational workstreams:

(1) Financial Sustainability - There is a direct dependency on the IT implementation plan with the funds flow model, specifically driven by specific sections of the CRFP application and related timing.

(2) Performance Reporting - Some reporting can be automatically performed through claims data, while some reporting will be achieved through new capabilities implemented as a result of DSRIP. There exists a major dependency on the ability to report concurrent with the successful

integration of systems and development quality of data which can be used for reporting purposes.

(3) Project Plans - The executing, timing, and prioritization of the IT workplan is reliant on stable projects for which technology can be built around. Further evolution of project plans, guidance's, and timeframes (e.g., the stability of project plans) will each impact the IT workplans.

(4) IT is dependent on each of the STRIPPS stakeholders synergy in operation implementation.

(5) The Provider Relations function will be central to the communication and management of IT needs with CBO's in the PPS. This includes both the development of consistent IT competency across PPS, including identification of the right RPU IT competencies.

(6) The IT implementation plan is also dependent to n the detailed Funds Flow methodology, which is supported by PPS policies, procedures, and other guidance's. This will serve as the framework from which PPS stakeholders and CBO's incenting will be performed.

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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
Governance Development / Chief Information Officer	WeiserMazars Consulting Service (TBD at a future date)	Responsible for IT Governance, IT Landscaping - (Needs/Gap Assessment), Change Management, and IT Architecture.
Data Security & Information Technology Officer	TBD	Responsible for data security and confidentiality plan, Data Exchange Plan, and DEAA oversight.
Project Management Lead	Mark Ropiecki / Care Compass Network	Responsible for development and monitoring of Project Portfolio, Risk Register, Vendor Contracts, and Progress Reports.
IT Project Manager	Currently Consultants, Will be PPS Staffed once the IT Roadmap engagement is completed	Responsible for Execution and Management of Project Portfolio, Risk Register, Vendor Contracts, Progress Reports, and Collaboration with IT Workgroup(s) & Provider Relations.
IT Governance Committee Co-Chairs	Rob Lawlis / CAP Bob Duthe / Cortland Regional	Responsible for Application Strategy & Data Architecture.
IT Workgroup	Multiple	Responsible for development of detailed IT workplans and current state assessments.
PPS Provider Relations and Outreach Coordinator	Julie Rumage	Responsible for PPS provider relations, including contracting and education. In this role the Provider Relations team will also work as a primary point of contact for contracted entities and distribute PPS materials such as IT related plans or education resources. Further, this role will facilitate questions appropriately within the PPS IT governance structure.

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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		
All PPS Partners	Interface between PPS IT Strategy and front-line end users	Responsible for input into system design, testing, and training strategy.
RPU Project Managers	Oversight of EHR interfaces and interoperability	Responsible for patient engagement plan and reports to the Clinical Governance Committee and RPU Quality Committees.
PPS Compliance Officer	Plan Approver	Responsible for data security plan and reports to the Compliance & Audit Committee.
External Stakeholders		
RHIOs (all three)	Multiple	Responsible for roadmap for delivering new capabilities.
PCMH Vendors	Multiple	Responsible for roadmap for delivering new capabilities.

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IPQR Module 5.7 - Progress Reporting

Instructions :

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

Care Compass Network will measure the success of the Information Technology (IT) Implementation Plan through the IT & Data Governance Committee which will establish expectations with the responsible parties of each milestone task and direct the responsible parties to supply key performance metrics and reports on a monthly basis. At the close of each month, the IT Workgroup Subcommittee will report the percent completion of each IT Implementation Plan task, which will establish the percent completion of each associated milestone to the IT & Data Governance Committee. The Committee will report the performance of the overall IT plan to the Board of Directors and will be responsible for developing a communication strategy for sharing the information on a regular basis with its PPS members.

The percent completion analysis will be performed by actively monitoring two high level categories:
(1) the percent of required IT infrastructure both implemented and operational for each of the participating members; and
(2) the percent of participating members on track with their unique implementation plan(s).

The performance reports will include (as appropriate) analysis of enablement of key data sharing capabilities, required analytics, and enhanced clinical workflows. Additional reports will be utilized to regularly monitor and track the progress of the IT Implementation Plan rollout, by the various IT Workgroups and Committee, including:

- Annual update of the IT Implementation Action Plan – PPS member adoption of IT infrastructure, enablement of clinical workflows, sharing of key clinical information, use of tele-health and tele-monitoring technologies and application of population health analytics
- Annual Data Security Assessment
- Monthly Workforce Training Report
- Monthly Project Portfolio 'Earned Value' report for all IT related projects within DSRIP project portfolio
- HIE Usage Report

IPQR Module 5.8 - IA Monitoring

Instructions :

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Section 06 – Performance Reporting

IPQR Module 6.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Establish reporting structure for PPS-wide performance reporting and communication.	In Progress	Performance reporting and communications strategy, signed off by PPS Board. This should include: -- The identification of individuals responsible for clinical and financial outcomes of specific patient pathways; -- Your plans for the creation and use of clinical quality & performance dashboards -- Your approach to Rapid Cycle Evaluation	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task Step 1 - Identify and establish Regional Performing Units (RPU's) throughout STRIPPS.	Completed	Complete - Through collaboration with the CCN leadership team (Executive Director, Project Leads, Governance teams) the Care Compass Network created a model in Q1 which identifies Regional Performing Units (RPUs) through which PPS related efforts can be achieved at a local level. The RPU structure was presented to the PPS Stakeholders during the 4/17/15 meeting (see attached). Also, the Clinical Governance Chair Dr. David Evelyn incorporated the RPU model into the proposed Clinical Governance Committee framework by created Clinical Governance Quality Committees which operate by specialty at the RPU level. This model was presented to the Board of Directors during the 6/9/15 meeting (see attached agenda and Clinical Governance materials). Additionally, the functionality of the RPUs has since been incorporated to the CBO Engagement Council which during the meetings in May and June began to identify PPS members by RPU, create RPU teams/leaders, and develop the PPS PreEngagement Survey which was including shaping PPS constituents at the RPU level to better	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	AV
		facilitate operations, such as training and outreach efforts.							
Task Step 2 - Establish a PPS level Clinical Governance Committee with membership of 3 members from each of the Four RPU's to discuss Clinical Quality and performance measure.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3 - The PPS will perform a current state assessment of existing reporting processes at the RPU level .	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4 - Develop RPU level Performance Measurement system based on medical record/Salient Reporting, as well as for those process measures that our project development groups are identifying as drivers of the outcomes we aim to realize.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 5- Within each RPU, there will be project based multidisciplinary representation of 6-10 members . These RPU level individuals will serve as the key leads who will hold the RPU partners accountable for the realization and continuous improvement of the multi-disciplinary care pathways underlying their respective projects.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 6- PPS-wide standardized care practices to be established by the Clinical Governance Committee and monitored at the RPU level.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 7 - Establish process for PPS to share/communicating state provided data (accessed through the MAPP Tool, Salient Tool and process measures) to providers through existing templates and Excel files as a short-term solution.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task	Completed	See Narrative.	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
Step 8 - Finalize arrangements with RPU providers to exchange key information (including additional quality and process metrics) with centralized PPS level analytics dept.									
Task Step 9 - Establish regular two-way reporting structure to govern the monitoring of performance based on both claims-based, non-hospital CAHPS DSRIP metrics and population health metrics (including MAPP PPS-specific Performance Measurement Portal and other process metrics). Results will be gathered by PPS Analytics and reported to the RPU's for performance management, and ultimately reported to the PPS Clinical Governance Committee.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 10 - Finalize layered PPS-wide reporting structure: from the individual providers, through RPU, up to the PPS PMO and up to Clinical, IT and Financial Governance Council at the PPS Board. Performance and improvement information available (including, MAPP, Salient SIM tool and Excel spreadsheet for other process metrics) will be maximally integrated into this reporting structure. This reporting structure will define how providers are to be held accountable for their performance against PPS-wide, statewide and national benchmarks.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 11 - Develop performance reporting dashboards, with different levels of detail for reports to the RPU's, PMO, the Clinical Quality, Finance, IT Committees and the PPS Board. The monthly Executive Board dashboard reports will be shown on overall performance of the PPS. The various dashboards will be linked and will have drill-down capabilities.	In Progress	See Narrative.	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
Milestone #2 Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	In Progress	Finalized performance reporting training program.	04/01/2015	12/31/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1 - After performing current state analyses and designing workflows, the PPS Workforce Strategy Team will create a dedicated training team to integrate new reporting processes and clinical metric monitoring workflows into retraining curriculum at the RPU level.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - This training team will integrate Lean, Six Sigma and other performance improvement programs into performance reporting/ Rapid Cycle Evaluation (RCE) training regime at the RPU level.	In Progress	See Narrative.	04/01/2015	09/30/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3 - Develop training module to provider champions, critical stakeholders and partners at the RPU level; use their feedback to refine training program throughout the network, including specific program for new hires.	In Progress	See Narrative.	04/01/2015	09/30/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4 - Develop schedule to roll out training to all RPU sites across the PPS network, using training at central hubs for smaller providers; specific thresholds will also be defined for minimum numbers to undertake training.	In Progress	See Narrative.	04/01/2015	09/30/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5 - In collaboration with the PPS PMO, the training team will identify decision-making providers, partners and staff at each RPU to train in advance of PPS-wide training; these individuals will become performance management champions in their individual providers / sites and will work alongside the practitioner champions for those sites.	In Progress	See Narrative.	04/01/2015	12/31/2015	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
Task Step 6 - Roll out training to RPUs/provider sites.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	03/31/2016	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
Establish reporting structure for PPS-wide performance reporting and communication.	rachaelm	Implementation Plan & Periodic Updates	44_MDL0603_1_2_20151029173337_Performance Reporting DY1Q2 Narrative.docx	Performance Reporting Narrative - Due to the size of the update for Milestone 1 in DY1, Q2.	10/29/2015 05:33 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish reporting structure for PPS-wide performance reporting and communication.	Due to the length of the narrative, this section has been uploaded as a document.
Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	In Progress – This Milestone was scheduled for completion by DY1, Q3 including six associated steps for implementation, four of which were scheduled for completion by DY1, Q2. Care Compass Network is updating the due date for each of these tasks and Milestone to DY1, Q4 to align the approach with changes processed in DY1, Q2 related to the Workforce Strategy project. The first step for Performance Reporting Milestone 2 indicates "After performing current state analysis and designing workflows, the PPS Workforce Strategy Team will create a dedicated training team to integrate new reporting processes and clinical metric monitoring workflows into retraining curriculum at the RPU level." This step (Step 1) is foundational to the following steps in this milestone, which leverage the training team developed as a result of Step 1. On September 2, 2015, Peggy Chan distributed a message to PPS Leads indicating that the "due dates for Domain 1 Workforce deliverables have been revised and will be due DY1, Q4." As a result of this change, the completion of Workforce Strategy activities which served as pre-requisites to Performance Reporting Milestone 5 were updated from DY1, Q2 to DY1, Q4 deliverables. For example, the Care Compass Network Workforce Strategy Milestone 5 included several steps which were also initially due in DY1, Q2, including Milestone 5, "Develop training strategy", Step 1 - "…examine target state training/retraining needs to support DSRIP goals by project and position…" and Step 3 - "…examine PPS-training/retraining capacity to support DSRIP goals by conducting a survey of existing training programs available and identify gaps in current training capacity versus target state training needs...". The overall Care Compass Network achievement and implementation of these steps remains In Progress and are on target for completion by DY1, Q4. Given the overview above, the steps and milestone have been reclassified as DY1, Q4 deliverables.

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Milestone Review Status

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

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IPQR Module 6.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

The cornerstones for effective performance reporting/management are: (1) a culture devoted to optimizing outcomes for patients; (2) clear responsibilities and accountability of staff for these outcomes; (3) optimizing and standardizing processes; and (4) continuous measurement of outcomes and the process-metrics that drive them. To accomplish these ambitious goals, our PPS must overcome address the following leading risks:

(1 & 2) PPS Geographic Presence & Differing Levels of Readiness- Our PPS has large a geographic foot print (200 miles * 100 miles) approx., with a population center in Broome County which contains approximately 30% of PPS attributed lives, with the remainder residing in eight other counties. The geographic spread of the PPS network is compounded by the longstanding professional independence of many providers and the different reporting cultures and workflows they have in place (e.g., IT systems, lack of IT systems, etc.). Designing and implementing a standard reporting workflow that will functionally work for the entire PPS, which includes members with varying levels of cultural resistance, commitment, DSRIP interest, and organization/leadership styles, will be a significant risk. Further, there are three RHIO's who connect providers in the PPS, however most IT connectivity happens in the Broome county and fades very quickly once moving into more rural areas. To mitigate these risks, we will pursue enhancement of IT connectivity of Skilled Nursing Facilities (SNFs) and other non-healthcare providers. We will also promote education and awareness around IT/infrastructure concepts such as Value Based Payments, which is a relatively new concept that will be vital towards the development of our performance monitoring system and allow for clear lines of accountability for patient care outcomes. The CBO Council will be leveraged to develop a CBO outreach plan based on providers by RPU. Further, the RPU Provider Relations Professionals and RPU Project Management leads will be vital in the coordination and alignment of IT milestone development as related to the entire nine county STRIPPS geographic region.

Our governance forms a structure with specific individuals / teams given responsibility for embedding performance reporting processes, and clear accountability for specific outcomes, whether on a project-by-project basis or across the whole PPS. There are many enthusiastic providers and strong performers amidst our partners, but the current fragmentation in the provider, IT connectivity and payment environment undermines our ability to create a common, outcomes-focused culture that spans organizational boundaries.
We will set the tone from the top of the PPS. The core members of the PPS, represented on its Governance Committees will be responsible for communicating the vision of a network in which providers only accept the highest standards of excellence for patient outcomes. Our training program will also be centered on this vision.
Our approach to creating these lines of accountability will be designed to ensure that front-line practitioners have the autonomy to determine which measures require the most focus, without overloading PPS leadership with more data and information than they can meaningfully process. Top-down designated accountability will need to be matched by strong provider engagement, to ensure that the performance reports which flow upwards are relevant to both the PPS leadership and to the improvement of patient care.
The provider engagement work, led by our Provider Relations Professionals, will be an important factor in mitigating this risk. They will be responsible for incentivizing providers throughout the network to participate in the PPS performance reporting systems, both professionally (improving quality of care) and financially.

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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.)

(1) Our success with Performance Reporting has significant dependence on our Governance workstream. Without effective leadership and a clearly defined organizational structure, with clear responsibilities and lines of accountability, our ability to create a common culture and to embed performance reporting structures and processes will be severely hampered.

(2) The Workforce Strategy workstream is also an important factor in our efforts to developing a consistent performance reporting culture and to embed the performance reporting framework we will establish. Training on the use of these systems – as well as the vision of STRIPPS (dba: Care Compass Network) as an organization where practitioners don't accept less than excellent quality – will need to be a central part of our broader training strategy for all the staff who are impacted by our workforce transformation.

(3) The success of performance reporting relies on quick and accurate transfers of vital performance information. If providers cannot gather the right information, or an oversight committee fails to gather and distribute the aggregated data in a timely manner, the data will not be reported in such a way that it can be acted upon to improve clinical outcomes and ultimately improve performance throughout the network. A crucial dependency for our successful implementation of a performance reporting culture and processes is the work of the STRIPPS IT Transformation Group to customize existing systems and implement the new IT systems that will be required to support our reporting on patient outcome metrics.

(4) Practitioner Engagement and Clinical Integration will both be absolutely crucial to the success of our efforts to create a common performance culture throughout the PPS network, and to embed the new performance reporting practices within business-as-usual clinical practice.

(5) Finally, the financial Funds Flow model will be a major dependency for the Performance Reporting workstream. Performance metrics across the entire PPS will be modeled based on the Funds Flow model, which will be derived primarily on a pay for performance model.

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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
RPU Project Managers	Dawn Sculley (South) & Emily Pape (West), Care Compass Network	Responsible for identification and tracking of metrics related to projects, including their role in the performance reporting structures and processes in place for PPS level Clinical Governannce Committee.
RPU Team members	Coordinating Council	Responsible for quality of clinical protocols, outcomes, and financial results per project as well as the realization and continuous improvement of the multi-disciplinary care pathways underlying their respective projects.
Provider Relations Staff	Julie Rumage & Jessica Grenier, Care Compass Network	Responsible for spreading and embedding common culture of continuous performance monitoring and improvement throughout Practitioner Professional Peer Groups. Responsible to PPS Clinical Governance Quality Committee for provider involvement in performance monitoring processes.
PPS IT and Data Analytics Group	Multiple	Responsible for ensuring the implementation, support, and updating of all IT and reporting systems to support performance monitoring framework. Also responsible for ensuring that the systems used provide valuable, accurate, and actionable measurement for providers and staff.
South RPU Lead	Robin Kinslow-Evans, Interim Executive Director (Care Compass Network)	Responsible for identification and tracking of metrics related to projects, including their role in the performance reporting structures and processes in place for PPS level Clinical Governannce Committee.
North RPU Lead	Amy Gecan, Director System Integration and Operations (Cayuga Medical Center)	Responsible for identification and tracking of metrics related to projects, including their role in the performance reporting structures and processes in place for PPS level Clinical Governannce Committee.
East RPU Lead	Greg Rittenhouse, VP, COO, Home Care (UHS)	Responsible for identification and tracking of metrics related to projects, including their role in the performance reporting structures and processes in place for PPS level Clinical Governannce Committee.
West RPU Leads	Laura Manning (Guthrie) & Robin Stawasz (CareFirst)	Responsible for identification and tracking of metrics related to

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		projects, including their role in the performance reporting structures and processes in place for PPS level Clinical Governannce Committee.

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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		
PPS IT Staff	Reporting and IT System maintenance	Respondible for monitoring, tech support, and the upgrading of IT and reporting systems.
Providers	Organizations immediately responsible for delivering on the performance monitoring processes established across the PPS.	Responsible for promoting a culture of excellence and employing standardized care practices to improve patient care outcomes.
PPS Governance Body	Ultimately responsible for PPS meeting or exceeding our targets.	Responsible for prioritizing and improving patient care and financial outcomes for the entire PPS - Acts as a high-profile, organization-wide champion for a common culture, standardized reporting processes, care guidelines, and operating procedures. Additionally, the governing body is responsible for monthly executive meetings with patient outcomes as the main agenda item and reviewing patient outcome reports prepared by the sub-Committees.
PPS Finance Governance Committee	Responsible for collecting, analyzing, and handling financial outcomes from performance management system.	Responsible for electing key decision-makers to champion the performance management cause within the DSRIP projects and interfacing with the Clinical Quality Committee.
PPS Clinical Quality Governance Committee	Ultimately responsible for all clinical quality improvement across the whole network.	Responsible for monthly Executive Report for the Governance Body which includes patient care metrics updates as well as electing several key decision makers to champion the performance management cause within the DSRIP projects and interfacing with the Finance Committee.
External Stakeholders		
Managed Care Organizations (MCOs)	Providing data to the PPS, shared savings	Responsible for providing key information to the PPS and arranging shared shavings agreements with the PPS in the later stages of DSRIP.
Community Based Organizations (CBO's)	Non health care providers who serve target population	The RHIO's should help in connecting CBO's to PPS. The Interfaces with CBO datasources would help in obtaining nonclinical data for PPS. Some of the measures are reportable and process measures would help in tracking the metrics.
County Dept. of Health or Mental Health	Healthcare Organizations which are not Hospitals, Primary	Responsible for providing timely clinical data to PPS on usage and

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Organizations	Care/Speciality Care clinics.	types of services.
County Law Enforcement Agencies	Community bodies which serve target population	Provide data to PPS on crisis intervention and diversion from ED.

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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.

Our PPS will be using a number of IT solutions to accurately measure, monitor, and report on DSRIP and non-DSRIP metrics. Our IT Performance Transformation Group (PTG) will be responsible for interfacing with the clinical and finance leads of the DSRIP projects to ensure that dashboards, reports, and metrics-gathering software are accurate and have no usability issues.
Initially, existing performance reporting structures within the larger provider organizations in the PPS will be leveraged to provide the staff and IT infrastructure needed to build up the evolving PPS-wide Performance Measurement system as planned. In the interim, a system of Excel files transferred from the state's MAPP tool and Salient's SIM tool, to the leading workstream committee, through the project leads, and down to the individual providers will serve as a bridge before the robust final system is fully ready for deployment. We are currently considering several options for the procurement of PPS-wide performance reporting systems, including collaborative buying solution with our neighboring PPS's. The final system will have to have the capabilities to aggregate information on projects & care processes from the providers to the workstream lead, and from the state to the providers, in a way that is accessible, while also sufficiently secure to protect patient information.

IPQR Module 6.8 - Progress Reporting

Instructions :

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

The PPS success will be measured by our providers' understanding of their performance and how it is improved by our implementation of performance measurement. We will continually measure the level of engagement and involvement of providers in the performance reporting systems and processes that are established. In DY1 Q2, we will define metrics to measure providers' involvement in the PPS performance reporting structure (e.g. active users of performance reporting IT systems, involvement in feedback discussions with Clinical Quality & Finance Committee about performance dashboards). We will also set targets for performance against these metrics. The RPU Quality Committees and the RPU specific Performance Monitoring Leads will be held accountable for driving up these levels of involvement. Additionally, CBO contracts will be established leveraging a pay for performance model whereby contracted payments (excluding infrastructure build) will be based on achievement of results, rather than a grant based payment model.

Our front-lines will measure the outcomes that matter most to patients, and use our reporting and IT systems to monitor, evaluate, and identify the contributing processes and intermediate outcomes. They will be surveyed and interviewed to determine the level at which they find that the performance reporting system provides them with the right information, and the level at which they find that the information is clear and – most importantly – actionable.

On a monthly basis, our RPU, overseen by the RPU Quality Committee, using the standardized measurement and reporting framework, provide

their members with the relevant patient metrics, along with their deviation or improvement from the previous month. Our PPS Clinical Governance Committee and IT & Finance Governance Committee will then aggregate these reports and compile them into the Executive Report, which will be the top item during the monthly Governance meetings. The quarterly reports will show the variation in patient care outcomes between quarters, which will be easily accomplished using our monthly model. Tracking change in the metrics included on these dashboards over time will be the primary tool we use to evaluate the impact of our performance reporting systems and our efforts to embed a culture of continuous improvement.

IPQR Module 6.9 - IA Monitoring

Instructions :

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Section 07 – Practitioner Engagement

IPQR Module 7.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop Practitioners communication and engagement plan.	In Progress	Practitioner communication and engagement plan. This should include: -- Your plans for creating PPS-wide professional groups / communities and their role in the PPS structure -- The development of standard performance reports to professional groups --The identification of profession / peer-group representatives for relevant governing bodies, including (but not limited to) Clinical Quality Committee	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task Step 1 - At the PPS level, or within each Regional Performance Unit (RPU), appoint the following positions and responsibilities: (a) RPU Provider Relations professional who will coordinate provider relations, training, and touch point contact for key professional groups/ Participating Organizations. (b) RPU Quality Committees, comprised of RPU based physicians and professionals, each of which will report to the PPS Clinical Governance Committee. This group will be responsible for representing the interests and views of practitioners to the PPS Executive Body through the Clinical Governance Committee and representing the Executive Body's views to the various communities of practitioners. (c) RPU Leads / Project Manager(s) who, among	In Progress	See Narrative.	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
other things, is responsible for communication of cross-functional needs with the RPU Provider Relations professional. The RPU Lead will collaborate the RPU project, reporting, and governance needs with other RPU Leads/ Project Managers to allow strategies and methodologies to react uniformly and timely (when needed). (d) PPS Communications Coordinator, to promote development and distribution of internal and external PPS communications, and serve as a central connection for PPS related communications.									
Task Step 2 - Each RPU Quality Committee to develop draft communication and engagement plans, to be aligned where possible and approved by the Clinical Governance Committee. Key plans for development will include: i. Structures and processes for two-way communication between front-line practitioners and the Governance of the PPS; ii. Process for managing grievances rapidly and effectively; iii. High-level approach for the use of learning collaboratives; iv. Identification, creation, and communication of other forums for practitioners to discuss, collaborate, and shape how DSRIP will affect their practices.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3 - Perform an inquiry with professional networks, committees, groups, or stakeholders to develop a process on communication and engagement strategy. This will involve seeking input with the practitioners themselves on their role in the DSRIP transformative process	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4 - Build out practitioner support services designed to support the practitioner engagement plan. At each RPU this will include a	In Progress	See Narrative.	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
collaborative to build out leading practices and promote practitioners and providers improve the efficiency of their operations.									
Task Step 5 - Develop a communication plan to support the RPU structure and allow for connection between the RPU and Clinical Governance Committee by use of the Quality Committee.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6 - Finalize practitioner communication and engagement plans. Report as needed (e.g., quarterly).	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
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	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1 - Establish Regional Performing Unit (RPU) teams and RPU governance which allows for integration of training/education planning efforts with the Clinical Governance Committee.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2 - Create standardized DSRIP training programs for Provider Relations professionals which detail the following, as appropriate by participant (determined by results of 2.a.i Milestone 1, Step 1c. readiness assessment):	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2a. Core goals of DSRIP program, PPS projects, & the financial and operational impacts on providers	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2b. Cross-PPS work streams underpinning the delivery of the DSRIP projects, including value-based payment, case management, clinical	In Progress	See Narrative.	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
integration, and clinical improvement									
Task 2c. Financial risk seminars for concerned practitioners (involving MCOs), and PPS-wide plans for mitigating the impacts of revenue loss	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2d. The services and support available to providers / practices to help them improve the efficiency of their operations and thereby free up the time to allow for a shift to more collaborative models of care	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2e. Seminars on population health management	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2f. The role of different groups of practitioners in the delivery of the DSRIP projects	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2g. New lines of clinical accountability and the expectations around clinical integration	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2h. The various aspects of IT / data sharing infrastructure development and how this will impact on practitioners day-to-day	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3 - Leverage RPU Leads and Provider Relations professionals to develop and implement a training & education program delivery model which includes delivery at RPU level through in-person and electronic formats, tracking of participant level data, and training outcomes. The training targets will aim for reaching 65% of practitioners through live training.	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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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
Develop Practitioners communication and engagement plan.	In Progress - Milestone 1 includes six steps to implementation, each of which are scheduled for completion in DY1, Q3. Through the DY1, Q2 period foundational frameworks were built allowing the six steps to be achieved in DY1, Q3. Examples include the establishment of the Clinical Governance Quality Committee structure which will be fully seated and in place by DY1, Q3 (addressing Step 1 section a). Further, The RPU Leads have been seated, including the following individuals, Amy Gecan, North RPU Lead, Robin Kinslow-Evans & Wayne Mitteer (South RPU), Greg Rittenhouse (East RPU), and Laura Manning & Robin Stawasz (West RPU). To compliment these teams the PPS Provider Relations function is being filled and will at minimum include three full time staff as well as a secured partner contract for the provision of provider relation services in a targeted region by DY1, Q3. Additionally, the PPS staffing of Project Managers by region is largely complete with final positions accepted for start dates in DY1, Q3. These roles and supports serve as a key backbone through which the practitioner communication and engagement plan components will be executed through the DY1, Q3 period. Overall the PPS remains on track for completion of the remaining steps to implementation by the DY1, Q3 scheduled completion date.
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 – The CBO Engagement Council began meeting in May of 2015 to create structure and support around the Regional Performing Units (RPUs) and further increase the PPSs ability to engage beneficiaries in the respective local communities. In June, the RPUs began developing leadership teams and reporting to the CBO Engagement Council frequent updates regarding the development of strategies and plans at the local level, as well as education and communication of CCN DSRIP plans. These groups, facilitated by the Provider Relations team, will be critical to the creation and execution of standardized DSRIP training programs. In the DY1, Q2 period, initial training programs were initially developed to provide DSRIP general education and will be expanded in DY1, Q3 and DY1, Q4 to include the associated quality improvement items required for completion of this Milestone. Overall the PPS remains on track for completion of the remaining steps to implementation by the DY1, Q4 scheduled completion date.

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.

There is currently a moderate level of engagement of our practitioner community, facilitated through alternating bi-weekly Stakeholder/PAC Council, Executive PAC Council, and monthly Clinical Governance Committee meetings. Two major risks to the implementation of the plans for practitioner engagement, including the achievement of milestones listed above, includes:

(1) Practitioner Availability - There is an immediate need to develop the training and education plan, after which there will be a small window within which we will be able to execute and deliver training. Aligning these timeframes with physician availability will be a key risk to the completion of the training and educational requirements. Particular milestones impacted significantly includes Step 3 from both sections above "Perform an inquiry with professional networks" and "implement the training and education program." To mitigate these risks, we will incorporate key physician leadership into each RPU Quality Committee and solicit input during the development of physician incentive plans. Electronic training, for example, could be considered to accomodate physician schedules, making training flexible to account for scheduling conflicts. Strategies such as these can be deliberated in RPU Quality Committee meetings. We will also incorporate a feedback section into the training and education materials to allow physicians to have another platform through which feedback, critique, and suggestions can be communicated to the RPU & PPS.

(2) Workforce Transition - Another major risk to implementation of the Practitioner Engagement workstream will be the development, communication, and activation of the Workforce transition road map, which will have impacts across the entire nine county PPS. If not developed and communicated with appropriate strategy, the concept and realization of workforce transition could deter or eliminate overall Practitioner Engagement. To mitigate this risk we will coordinate and communicate workforce plans at the PPS level, first developing a road map which outlines the workforce transition at the PPS board level (which includes CBO representation), after which execution of the plan can be performed through the Workforce Transition Lead, PPS Communications Coordinator, and RPU leadership. Timing of these deliverables will be decided by leadership to align as close as possible with related efforts (e.g., bed reduction plan) to avoid pre-mature discussion on related topics. The PPS Workforce Transition lead will be responsible for continuity of communications across the RPUs, facilitated by the PPS Communications Coordinator, to ensure consistent messaging and proper communication. Further, prior to the communication plan, clear metrics and background knowledge will have been obtained to understand the overall workforce transition impact as related to any one particular RPU, CBO, or practitioner/provider.

IPQR Module 7.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

The Practitioner Engagement Workstream will in essence require a strong infrastructure and communication plan to promote activation and

engagement of PPS practitioners. To meet the needs of the Practitioner Engagement Workstream there are three related primary major dependencies on other work streams, which include:

(1) The inherent reliance on IT Infrastructure which will serve as a backbone with regards to overall practitioner engagement. As the Practitioner Engagement Workstream matures over time, the IT Infrastructure will also need to provide systems which inform the PPS about practitioner performance as related to DSRIP goals and related contracted terms.
(2) Similarly, communication tools which allow for adequate communication channels both up and down the PPS structure will need to be developed at the PPS Governance level, by means of the Clinical Governance Committee. Communication will also need to be linear and granule whereby RPU specific needs, such as participation of RPU hospitals is obtained to support physician awareness campaigns. Clear articulation of DSRIP benefits (e.g., reduced administrative burden), structure, and vision will also be critical to promote "practitioner buy-in". These relational and RPU specific communication needs will be developed cross-functionally by the Communications Workgroup and CBO Council and be led by the RPU Provider Relations professional and the PPS Communications Coordinator.
(3) A third major dependency includes the development of the funds flow and the related physician incentive models, which will help to engage providers outside of other incentive based models.

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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
RPU Project Managers	Dawn Sculley / Care Compass Network Rachael Mott / Care Compass Network Emily Pape / Care Compass Network	Responsible for functioning as the liaison between the Project Management Office (PMO) and the Regional Perfomance Unit (RPU).
CBO Engagement Council	Multiple	Responsible for the identification of PPS CBOs/providers and allocation by responsible RPU as well as the ongoing identification of practitioners. Responsible for development of education and awareness campaigns for each RPU.
RPU Clinical Quality Committees	Multiple	Responsible for clinical quality communicated and delivered at the RPU level and RPU results; reports to the PPS Clinical Governance Committee.
RPU Provider Relations	Julie Rumage, South RPU Provider Relations / Care Compass Network Jessica Grenier, Provider Relations Care Compass Network	Responsible for managing physician relations, performing education, training, and coordinating agreements at each RPU as well as pursuing contracts with CBOs/providers.
Clinical Governance Leads	Multiple	Responsible for the accuracy, completeness, and timeliness of clinical reporting.

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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		
Practictioners Network	Outreach and Engagement Activities	Responsible for attending training sessions, reporting to relevant Practitioner Champions, and the receipting/executing of practitioner agreement.
Workforce Group	Oversight of training, education, and identification of future needs	Responsible for input into practitioner education / training plan.
Clinical Governance Committee	Governance committee on which RPU Champions sit	Responsible for monitoring levels of practitioner engagement and forums for decision making about any changes to the practitioner engagement plan.
RPU Quality Committees	RPU specific quality committee, reporting to the PPS Clinical Governance Committee	Responsible for oversight of performance at the RPU level and quarterly reports for presentation at the Clinical Governance Committee.
FLPPS, Bassett & STRIPPS	Overlapping PPS's (FLPPS -Steuben & Schuyler Counties; Bassett - Delaware)	Responsible for the development of a patient engagement model which will leverage the benefits of dual PPS's without creating additional administrative burden (e.g., contracting, educational requirements, etc.).
External Stakeholders		
NYS Dept. of Health (DOH)	Key Stakeholder	Responsible for Quarterly Reports and Patient Outcomes.
Medicaid Enrollees	Beneficiaries	Care may be impacted by the nature and degree and approach of practitioner engagement and the related contracting efforts.
DSRIP Project Approval & Oversight Committee (PAOP)	Key Stakeholder	Responsible for Quarterly Reports and Patient Outcomes.

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.

'(1) For the Practitioner Engagement Workstream there is a significant need to have robust data transfer between CBOs and providers in a format that is relevant and usable. The PPS will also need to develop dashboards to help facilitate how information is provided to providers.

(2) A core function of DSRIP is the PPSs underlying requirement to develop implementation plans which will use clinical data to drive DSRIP outcomes. To achieve this there are two primary IT Infrastructure expectations to be achieve:
a. Facilitated/ IT developed communications throughout each of the four RPU's and more broadly across the nine county PPS;
b. The methodology and development of how clinical information can be used to drive decisions and DSRIP outcomes; &
c. Ongoing monitoring of progress through the RPU's to help drive provider/ CBO incentives and change, with primary focus on change towards achievement of the DSRIP goals.

IPQR Module 7.8 - Progress Reporting

Instructions :

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

The success of the Practitioner Engagement Workstream will be measured through the monitoring and ultimate achievement of the following core measures:
(1) Establishment of four Regional Performing Units (RPUs) which will allow for practitioner engagement and other DSRIP goals to be pursued and achieved at a localized level;
(2) The development of a training plan by the CBO Council to help educate providers and CBOs regarding the DSRIP program. This should include a variety of training programs or sessions based on the needs of the RPU, project modality, service type, etc.
(3) The development of a provider engagement contracting model and the subsequent monitoring activities. This will be measured through the number and type (e.g., Outreach or Engagement services, etc.) of provider agreements/contracts that are signed, versus the number of practitioners available.

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 Step 1 - Perform a review of existing PPS supporting infrastructure/capabilities, including at minimum Population Health Management System capabilities (e.g., Salient, RHIO, CBO Systems, etc.) as well as the associated Lead System Experts (e.g., knowledge experts) for each system who can be available to support the needs of the PPS, which can be leveraged in addition to the MAPP tool.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 2 - Identify frequent visitors to healthcare organizations using existing systems and algorithms to determine target populations and health disparities within PPS, borrowing Health Homes population health management strategies.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3 - Identify and/or develop standard reports	In Progress	See Narrative.	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
and one-off reports which will be utilized based on the needs of each RPU, project, or overall PPS needs. These reports will be leveraged to analyze the PPS data population to stratify risk and guide PPS implementation and performance achievement efforts. For example, this effort will include benchmarking reports to provide baseline data to the responsible PPS members or performing data analysis to identify where the governing body (e.g., RPU, PPS) is making progress against DSRIP goals.									
Task Step 4 - Create a dashboard to periodically update the program planning and individual care management database and registries, available for easy access by all participating providers in the PPS. Build out a public facing dashboard derived from the internal database to monitor outcomes and successes of the program.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5 - Complete workforce assessment for priority practice groups' care management capabilities, including staff skills and resources required to manage the diabetic and cardiovascular disease populations in each geographic area. Identify population health management strategies for overlapping PPS's.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6 - Develop the Population Health Management Road Map and PCMH level 3 overarching plans to be approved by the Board of Directors.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 7 - Leverage the IT Committee and RPU Clinical Quality Committees as the working groups responsible for assessing current state and identifying appropriate providers with regard to PCMH 2014 Level 3 certification, identifying	In Progress	See Narrative.	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
key gaps, and developing overarching plan to achieve Level 3 certification in all relevant providers.									
Task Step 8- Refine priority clinical issues from the Community Needs Assessment (at a whole-PPS level and also specific priorities for specific geographic areas) to ensure alignment between undertaken projects and clinical priorities, with particular focus on diabetes and cardiovascular health. Leverage communication channels established as part of the Practitioner Engagement plan to solicit participating provider feedback before finalization	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 9 - The Clinical Governance Committee will oversee the development of care guidelines for providers on priority clinical issues; establish metrics for each clinical area to monitor progress in managing population health. As these guidelines are established and modified throughout the DSRIP period the Population Health Management team can align and refine the Population Health Roadmap.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 10 - As needed, deploy staff support at provider level (as part of practitioner engagement training plan) to train providers to use and apply information learned from the registries, how to implement established care guidelines, develop disease pathways, determine effectiveness of interventions through team meetings, etc.	In Progress	See Narrative.	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	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task	In Progress	See Narrative.	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
Step 1 - Appoint a PPS representative group, including representatives from each acute care provider, chartered off the Board of Directors to perform a PPS-wide bed reduction planning analysis. Given results from the analysis, a detailed review will be performed on the data and assumptions with advisory 3rd party consultant, resulting in a draft Bed Reduction Plan.									
Task Step 2 - The PPS representative group will submit the draft Bed Reduction Plan to the Board of Directors for review. Upon review and consensus, the Board will finalize and sign the Bed Reduction Plan.	In Progress	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 3 - Using the Board approved Bed Reduction Plan, an ongoing monitoring process will be developed which will allow for monitoring and reporting activities (e.g., Quarterly Reports) related to the Bed Reduction Plan.	In Progress	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4 - Periodic content monitoring will be performed (e.g., quarterly) to summarize current state bed reduction impacts and be reported to the Project Management Office. Significant deviations from the Board approved Bed Reduction Plan will be submitted by the Director of Project Management to the Executive Director for formal review. If significant deviations are confirmed, the Bed Reduction Plan will be re-evaluated to confirm pertinence to the current operating environment, repeating Steps 1-3 above.	In Progress	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	

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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
Develop population health management roadmap.	In Progress - There are two Milestones for Performance Reporting including a total of 14 steps to implementation, none of which are due for completion in the DY1, Q2 report. Each Milestone and Step are in progress with no major issues or barriers which would hinder implementation efforts. Care Compass Network (CCN) is in the process of developing a Population Health Management Roadmap (Milestone 1). CCN's initial vision for Population Health Management is to be able to identify patient groups (superusers, low users, non-users, etc.), hot spots, provider groups, etc. to monitor PPS performance with a specific focus on reducing inpatient admissions and Emergency Department visits. CCN's Population Health Management system will deliver actionable data to healthcare providers, navigators, care coordinators, etc. in order to implement successful health management strategies to redirect care towards the most cost-effective setting or mode. The roadmap towards this goal will reflect current data and IT systems capabilities and the strategy to address the identified needs. A comprehensive IT assessment and gap analysis are underway through IT vendor WeiserMazars as part of their work on the IT Systems and Processes roadmap, expected for completion in DY1, Q4. CCN is also developing an internal analytics capacity, beginning with a team trained in Salient. This team is working with project and RPU leaders to develop dashboards to monitor performance by project and by RPU. The team is also developing a compendium of data needs. These data items may be available through Salient, the MAPP population health tool (future), or be collected by CCN from our partners either through systems like Phytel or manually, until a Population Health Management system is in place, in order to track performance and translate data into actionable information. CCN has also begun developing a Bed Reduction Plan (Milestone 2). In August 2015 the Executive Director presented to the Board of Directors a detailed overview of the CCN Bed Reduction implementation Milestone and steps. This presentation was revisited in September and included a deeper dive into the methodology and overall approach, leading towards components of Step 1. The Board is aware that the plan will require Board approval.
Finalize PPS-wide bed reduction plan.	In Progress - There are two Milestones for Performance Reporting including a total of 14 steps to implementation, none of which are due for completion in the DY1, Q2 report. Each Milestone and Step are in progress with no major issues or barriers which would hinder implementation efforts. Care Compass Network (CCN) is in the process of developing a Population Health Management Roadmap (Milestone 1). CCN's initial vision for Population Health Management is to be able to identify patient groups (superusers, low users, non-users, etc.), hot spots, provider groups, etc. to monitor PPS performance with a specific focus on reducing inpatient admissions and Emergency Department visits. CCN's Population Health Management system will deliver actionable data to healthcare providers, navigators, care coordinators, etc. in order to implement successful health management strategies to redirect care towards the most cost-effective setting or mode. The roadmap towards this goal will reflect current data and IT systems capabilities and the strategy to address the identified needs. A comprehensive IT assessment and gap analysis are underway through IT vendor WeiserMazars as part of their work on the IT Systems and Processes roadmap, expected for completion in DY1, Q4. CCN is also developing an internal analytics capacity, beginning with a team trained in Salient. This team is working with project and RPU leaders to develop dashboards to monitor performance by project and by RPU. The team is also developing a compendium of data needs.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	These data items may be available through Salient, the MAPP population health tool (future), or be collected by CCN from our partners either through systems like Phytel or manually, until a Population Health Management system is in place, in order to track performance and translate data into actionable information. CCN has also begun developing a Bed Reduction Plan (Milestone 2). In August 2015 the Executive Director presented to the Board of Directors a detailed overview of the CCN Bed Reduction implementation Milestone and steps. This presentation was revisited in September and included a deeper dive into the methodology and overall approach, leading towards components of Step 1. The Board is aware that the plan will require Board approval.

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.

1) IT Infrastructure - Overall IT Infrastructure challenges include items such as CBO connectivity throughout the PPS, availability of accessible and relevant data, care management infrastructure, and the PPS IT team capable of leveraging available data for Population Health Management purposes. To mitigate this IT risk, we have vendored the services of a healthcare IT management solutions firm to perform a robust IT needs assessment, which will provide reports on IT governance, analytics, as well as a status report on PPS connectivity, including Gap Assessment. We have dedicated PPS resources that will be working collaboratively with these consultants to drive results in a relatively short period of time, from which future action plans can be developed.

(2) CBO & Patient Engagement - Without the involvement of these members the ability for the PPS to perform outreach and/or engagement to the attributed patient population will be limited. To address and mitigate the risk the Coordinating Council has sponsored a sub-council, the CBO Council, which will be responsible for developing outreach efforts to CBO's, education programs, and serving as a single source contact to the CBOs, amongst other things. By properly educating the PPS CBO and provider members regarding DSRIP and what role they can play, and highlighting the benefits of the DSRIP program more members are expected to participate. In addition, the PPS is hiring Provider Relations and Patient Outreach professionals who will have significant focus on the CBO outreach as well as patient outreach efforts.

(3) Bed Reduction Plan - A third risk is the knowledge that as DSRIP evolves the associated plans will need to evolve as well. While a bed reduction plan can be prepared based on our market, DSRIP, and industry knowledge to date, a risk exists whereby currently unknown market forces may have significant impact on the bed reduction plan. As our PPS contains multiple health systems and other involved organizations, the need to revisit the bed reduction plan will likely promote contentious discussions. In addition, the PPSs authority over hospitals to complete a bed reduction, as well as the required community support for a bed reduction plan will be difficult to achieve. To mitigate this risk we will adopt within the beds reduction plan a frame work which includes dispute resolution and amendment process from which any future edits, revisions, or clarifications can operate from. We will also leverage existing communication channels, such as through the CBO Council, Outreach Coordinators, and Provider Relations, to promote transparency of DSRIP plans through education forums. Additionally, due to the conflcits of interest inherently present within the PPS representative group commissioned to dragft the Bed Reduction Plan, a 3rd party consultant is appropriate in order to minimize conflict and manage conflicts of interest.

(4) Community Engagement/Awareness - Another leading risk to the successful implementation of population health management plans is the potential disconnect between Population Health Management plans and how services are currently performed at the community level. To mitigate we will develop an Ambassador Team, including key stakeholders such as members of the Board of Directors, local Chamber of Commerce, etc.

(5) Overlapping PPSs - A final leading risk exists in two of our four RPUs (the West and the East RPUs), which overlap patient populations with other PPSs (FLPPS and Bassett PPS). To mitigate this risk, we have begun and will continue to collaborate with these PPS to develop RPU specific engagement plans which allow for collaboration with the multi-PPS region. This may include shared utilization of common consultants, alignment of policies, procedures, or consents, and sharing of data to promote overall NYS success with DSRIP goals.

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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.)

The Population Health Management Workstream is fairly complex and contains many interdependencies from across the PPS workstreams, including:

(1) Practitioner Engagement - A primary output of the Population Health Team will include analyzed data including providers of all types. The ability for the PPS to actively engage with providers through agreements/contracts, as achieved through the Governance Workstream, will be critical to making use of information populated by the Population Health Management Team.
(2) Clinical Integration - Similar to the above, a major dependency exists whereby the PPS will not be able to manage the health of a population through care coordination unless integration of the clinical information across the continuum has been achieved. An individual provider or CBO cannot expect to manage or leverage population health data unless they are integrated sufficiently with other providers or CBOs to the extent that they can work together/collaboratively to affect patient outcomes.
(3) IT Systems and Processes - Population Health management is highly dependent on the ability for various data systems and processes to communicate with each other in a way which data can be analyzed and plans be created to promote behavioral change and outcomes. The Population Health Management Workstream will heavily rely on the development of IT systems to collect data and present the data in a relevant and useable format. This baseline will equip the Population Health team to analyze that data to come up with plans and direct change.
(4) Workforce Transition - As workforce transition plans are executed over the DSRIP years, the expectation is that the transition will be commensurate with the achievement of specific pre-defined metrics (e.g., achievement of a number of patient outreaches, or patients with care coordinated models). The workforce transition plan will need to be communicated with the Population Health Management team so RPUs will better be able to track and monitor the effectiveness of the associated workforce transitions for CBO contract compliance (whereby CBO members are paid for performance).
(5) Cultural Competency / Health Literacy - Developments and education plans organized by the Cultural Competency Committee (CCC) will serve as inputs to the Population Health Management team so appropriate PPS groups, categories, or populations, can be adequately monitored for progress as related to the plan.

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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	Multiple	Responsible for monitoring impacts of DSRIP projects and progress related to changes/projects implemented.
Analytics	Multiple	Responsible for performance of bed reduction plan reivews and public outreach for bed reduction plan.
PPS IT Services	UHS IT Department (Vendor)	Responsible for data warehouse and interfaces.
Compliance Officer	Rebecca Kennis, Compliance Officer / Care Compass Network	Responsible for Compliance Plan cognizant of Data Sharing requirement(s), Audits for Compliance, and Reports to Associated Committee.
Coordinating Council	Multiple	Responsible for respective roles in overall project coordination.
Outreach Workers	Multiple	Responsible for outreach to patient population.
RPU PCMH Working Groups	Multiple	Responsible for reporting progress to the Clinical Governance Committee.
Care Compass Network Board of Directors	Matthew Salanger, UHS CEO, Care Compass Network Chair of the Board	Care Compass Network Board of Directors is responsible for approval of the Bed Reduction Plan overall plan and approach.

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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		
Partner CEOs	Multiple	Responsible for Board Member deliverables and providing hospital support for PPS events (e.g., forums, education/outreach).
Board of Directors	Governance	Responsible for overall PPS guidance.
RPU Leads	Leads RPU Operating Groups	Responsible for alignment of Pop Health results with DSRIP milestones and ongoing performance.
Care Coordination Teams	PPS Partner	Responsible for using Pop Health to develop and refine Care Coordination Strategies.
Primary Care Physicians	PPS Partner (See RPU Partner List)	Clinical group to be coordinated and contracted with at a PPS and RPU level.
Disease Management Teams	PPS Partner (See RPU Partner List)	Clinical group to be coordinated and contracted with at a PPS and RPU level.
Nursing Homes	PPS Partner (See RPU Partner List)	Clinical group to be coordinated and contracted with at a PPS and RPU level.
Non-Clinical CBOs	PPS Partner (See RPU Partner List)	Groups that may be engaged to help support DSRIP projects, such as support groups, charities, religious organizations, transportation services, housing services, etc.
External Stakeholders		
Managed Care Organizations (MCOs)	Key Stakeholder	Responsible for supporting patient health programs impacted by DSRIP.
Overlapping PPS - Finger Lakes PPS (Deb Blanchard, Janet King)	Adjacent or Overlapping PPSs with shared/similar patient populations	Responsible for coordination/customization of Population Health management approaches and the development of multi-PPS communication channels.
Overlapping PPS - Leatherstocking Collaborative Health Partners (Sue Van der Sommen)	Adjacent or Overlapping PPSs with shared/similar patient populations	Responsible for coordination/customization of Population Health management approaches and the development of multi-PPS communication channels.
Overlapping PPS - Central New York Care Collaborative (Kristen Heath)	Adjacent or Overlapping PPSs with shared/similar patient populations	Responsible for coordination/customization of Population Health management approaches and the development of multi-PPS communication channels.

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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.

The Population Health Management IT capabilities of the PPS are highlighted by a core team of trained professionals in the Salient system. Each of these five PPS Salient trained members has received Salient sponsored training and convene on a regular basis to determine baseline information and develop Salient specific skills which will be essential to future Population Health Management development and functionality. Additionally these members are from multiple PPS organizations and from a variety of backgrounds, which allows for diverse thought, perspective, and data gathering techniques to be leveraged. As the final IT needs assessment is completed by the IT consultants, additional IT developments will be identified and pursued. However, our initially expected IT resources for development include:

(1) Identification available/existing PPS IT resources and subsequent plan developments to allow for the leveraging and utilization of these resources.
(2) PPS Clinical Integration of IT Data - The pursuit of integrated clinical information across the continuum, to promote a providers ability to leverage population health data which is sufficiently integrated with other providers or CBOs to the extent that they can work together/collaboratively to affect patient outcomes.
(3) PPS IT Systems and Processes - The development of data systems and processes communication tools which promotes data analysis which can be used to promote behavioral change and outcomes.'

IPQR Module 8.8 - Progress Reporting

Instructions :

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

The success of this organizational workstream will be measured by progress towards achieving the following core Population Health Management milestones:

(1) Development and implementation of the Internal as well a public facing dashboard to monitor DSRIP progress and outcomes.
(2) Creation and implementation of a Population Health Roadmap with PCMH 2014 Level 3 certification strategy for all relevant providers.
(3) A PPS wide bed reduction plan completed and endorsed by the Board of Directors.
(4) Development and utilization of performance reports developed by the Population Health Management team across the applicable PPS members.

IPQR Module 8.9 - IA Monitoring

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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	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task Step 1 - Develop the design of a clinical integration needs assessment framework to identify the needs of the PPS, at the RPU level. These frameworks will outline a comprehensive vision inclusive of skillset, process, technology, and data requirements necessary for clinical integration as it pertains to each of the DSRIP target populations (including the technical requirements for data sharing and interoperability) and make considerations from the previously performed Community Needs Assessment (CNA).	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2 - Assess existing care transition programs.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task	In Progress	See Narrative.	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
Step 3 - Create a provider level map, incorporating the clinical integration framework with the community needs assessment and the DSRIP target populations using the Community Based Organization (CBO) Council and Provider Relations workers. This landscape per RPU will cover the entire continuum of the providers involved.									
Task Step 4 - Analyze results of CNA in order to inform Clinical Integration Strategy.	In Progress	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
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	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1 - For each RPU in the PPS, define what the target clinical integrated state should look like from a skillset, process, technology and data perspective (including assessment and care protocols and specific attention to care transitions). At a core, the Outreach and Engagement needs for each RPU should be identified, as well as any functional barriers to achieving this from the perspective of both provider organizations and individual clinicians.	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2 - Based on this target state and the gaps identified in the integrated care needs	In Progress	See Narrative.	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
assessment, define and prioritize the steps required to close the gaps between current state and desired end state at both the care management and clinical quality level (to include any needs for people, process, technology, or data).									
Task Step 3 - Identify synergies between the RPU needs across the PPS. For example: the need for supportive IT infrastructure to enable data sharing. Leverage the results from this review to standardize work flows where possible.	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4 - Conduct engagement exercise with practitioners and other stakeholders, focused on identifying the key clinical (and other) data that will be required to support effective information exchange at transitions of care with provider relations workers and RPU leads/managers operating as champions of this effort.	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5 - Define incentives to encourage the behaviors and practices that underpin the target state (e.g., multi-disciplinary care planning). These incentives might include financial / personnel support to providers looking to improve the efficiency of their operations in order to create more time for coordinated care practices; or the creation of shared back office service functions to improve the efficiency of provider organizations.	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6 - Carry out consultation process on draft strategy with internal and external stakeholders to the transformation (including patients when appropriate).	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 7 - Finalize PPS strategy and roadmap	In Progress	See Narrative.	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
document on clinical integration.									
Task Step 8 - Develop and implement a process to formally track and monitor progress of the clinical integration strategy/ roadmap. Leverage PPS' regional structure to integrate (Individual providers inform RPU strategy, RPU strategy feeds upward to inform overall PPS approach).	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	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
Perform a clinical integration 'needs assessment'.	There are two Milestones for Clinical Integration including a total of 12 steps to implementation, none of which are due for completion in the DY1, Q2 report. Each Milestone and Step are in progress with no major issues or barriers which would hinder implementation efforts. During DY1, Q2 the four Regional Performance Units have been working on assembling the quality subcommittees as part of the Care Compass Network Governance Structure. In Q3 these quality subcommittees begin meeting regularly and will begin development of a clinical integration needs assessment framework (Milestone 1). Care Compass Network has developed and is utilizing a Pre-Engagement Assessment in Q2 and pre-contracting checklist in Q3 to obtain baseline profiles for PPS partners. Therein, we have begun to identify particular providers, their services, IT components, and other pertinent organizational and clinical realities. The results of the data collection process, formation of the Regional Performance Units, coordination plans with overlapping PPSs, as well as the original community needs assessment, will be used as inputs to the generation of the Clinical Integration Strategy (Milestone 2).
Develop a Clinical Integration strategy.	There are two Milestones for Clinical Integration including a total of 12 steps to implementation, none of which are due for completion in the DY1, Q2 report. Each Milestone and Step are in progress with no major issues or barriers which would hinder implementation efforts. During DY1, Q2 the four Regional Performance Units have been working on assembling the quality subcommittees as part of the Care Compass Network Governance Structure. In Q3 these quality subcommittees begin meeting regularly and will begin development of a clinical integration needs assessment framework (Milestone 1). Care Compass Network has developed and is utilizing a Pre-Engagement Assessment in Q2 and pre-contracting checklist in Q3 to obtain baseline profiles for PPS partners. Therein, we

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	have begun to identify particular providers, their services, IT components, and other pertinent organizational and clinical realities. The results of the data collection process, formation of the Regional Performance Units, coordination plans with overlapping PPSs, as well as the original community needs assessment, will be used as inputs to the generation of the Clinical Integration Strategy (Milestone 2).

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.

1) A leading major risk includes the patient consent process, which is a pivotal action item and potential bottleneck to the successful implementation of not just 2.a.i. but each of the 11 projects selected by our PPS. The successful receipt of patient consents will ultimately drive our PPS's ability to provide those essential Care Coordination services which have been selected as a result of the Community Needs Assessment to align PPS actions (e.g., projects, toolkits, interventions) with DSRIP goals. Without patient consents, we will have no patients for whom we can access data for purposes of care coordination. We will leverage multiple risk mitigation strategies to alleviate and reduce the overall risk exposure, however we understand it is ultimately each patients personal decision to choose whether or not to sign a consent. First, we will develop a PPS infrastructure which promotes engagement with patients to consent and share data. This will include the creation of Regional Performing Unit's (RPU's) which will allow for patient contacts to be made at a regional/local level. We will also leverage our knowledge from existing Health Homes within the PPS to develop our approach to implementing the 11 projects. For example, we have seen positive results with 'warm handoffs' with patients, which we've identified can be executed at a PPS level through our Navigators and Project 11 (2.d.i.) In addition, patients will be engaged through the Care Coordinators using existing services, new projects implemented as a result of DSRIP, and a Performance Management Team which will oversee work metrics at the RPU level.

2) A second major risk includes overall Provider Readiness & Awareness. Successful engagement of the providers is required for the success of DSRIP. To mitigate the provider readiness and awareness, we will place Provider Relations professionals within each RPU, assigned to build and manage the physician relations. Key actions will include providing education to providers regarding DSRIP goals and what potential impacts may be, overviewing benefits of leveraging the PPS for care coordination purposes (e.g., expected reduced 'no shows'), as well as monetary inputs for contracted services such as outreach and engagement. We also have developed an equitable governance structure which promotes transparency and allows for physician leaders from throughout the PPS to provide guidance and strategies for PPS provider readiness & awareness plan developments and to also serve as regional provider champions to promote DSRIP related activities.

3) A third major risk is the successful implementation of the IT connectivity strategy. Our PPS includes five health systems, a federally qualified health center, and multiple physician practices and community based organizations that span a nine county region. There exists a risk that some partners don't have any EMR connectivity while many others have not yet developed mature EMR practices which would allow for seamless integration with PPS needs. Failure to not connect providers to the network will seriously impede the PPS' ability to leverage required data to make patient related decisions. The integration and leveraging of existing platforms, complimented by upgrading existing systems and integration of systems throughout the network (as appropriate) is our primary risk mitigation strategy. This will be achieved by identifying the different stages of readiness for each partner and develop customized plans to successfully bring them into the network. The upgrading of existing systems and integration of systems throughout the network will greatly facilitate the risk mitigation efforts. Lastly, initial and ongoing education requirements will be determined, for which training will be made available to responsible persons.

IPQR Module 9.4 - 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.)

We have identified three leading major dependencies on other workstreams, including:
1) IT Systems and Processes - The core aspect of clinical integration will be reliant on the PPSs ability to create standardized platforms that allow for relational information to be shared when needed/appropriate centrally to the PPS for clinical integration related purposes.
2) Engagement of Practitioners - A secondary core dependency will be whether the PPS practitioners opt to participate with the PPS or not. In addition to making tools, educational or professional services available we will also leverage an empathetic approach whereby our understanding of the providers and the market they serve to communicate the benefits of DSRIP. For example, as a result of participating with the PPS the providers may experience less administrative burden and may also receive various benefits by further integrating with the PPS.
3) Governance - The overarching governance model is a prerequisite for how communications flow between the PPS and CBOs.

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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	Dr. David Evelyn, CMO, Cayuga Medical Center, Care Compass Network Clinical Governance Committee Chair	Responsible for the development of PPS Clinical Quality Standards, RPU oversight, and reporting to the Board of Directors.
RPU Quality Committees	11 Total SubCommittees, Inclusive of more than 70 members.	Responsible for individual RPU clinical governance oversight, application of standards at the RPU level, reporting to the Clinical Governance Committee, and remediation strategies for Non-Performance.
Provider Relations	Julie Rumage, Provider Relations / Care Compass Network Jessica Grenier, Provider Relations / Care Compass Network	Responsible for managing physician relations, performing education, training, and coordinating agreements.
South RPU Lead	Robin Kinslow-Evans, Interim Executive Director (Care Compass Network)	Alignment of RPU needs at the Governance Level, including clinical integration.
North RPU Lead	Amy Gecan, Director System Integration and Operations (Cayuga Medical Center)	Alignment of RPU needs at the Governance Level, including clinical integration.
East RPU Lead	Greg Rittenhouse, VP, COO, Home Care (UHS)	Alignment of RPU needs at the Governance Level, including clinical integration.
West RPU Leads	Laura Manning (Guthrie) & Robin Stawasz (CareFirst)	Alignment of RPU needs at the Governance Level, including clinical integration.

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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		
PPS Family Practitioners	Provider	Responsible for knowledge and integration of PPS Clinical Standards.
PPS Clinical Staff	Provider	Responsible for knowledge and integration of PPS Clinical Standards.
PPS Behavioral Health Providers	Provider	Responsible for knowledge and integration of PPS Clinical Standards along with the integration of PPS Clinical Standards and/or interventions.
PPS Project Management Office (Mark Ropiecki, Care Compass Network PMO Director)	PPS Reporting Agent	Responsible for monitoring and reporting results from clinical integration efforts.
Substance Abuse Professionals	Provider	Responsible for knowledge & integration of PPS Clinical Standards and/or interventions.
Providers of Services for People with Developmental Disabilities	Provider	Responsible for knowledge & integration of PPS Clinical Standards and/or interventions.
External Stakeholders		
Care Compass Network Patients	Key Stakeholder	Recipient of DSRIP care model.
Care Compass Network Family Members	Key Stakeholder	Recipient of DSRIP care model.
RMS Panel Participants	Medicaid Beneficiary Representation with recurring target audience of 400 beneficiaries	Recipients of DSRIP care model.
RHIOs - HealthLinkNY (Christina Galanis)	Vendor of information services	Participation in IT structure and sustainability
RHIOs - HealtheConnections (Robert Hack)	Vendor of information services	Participation in IT structure and sustainability
RHIOs - Rochester (Ted Kremer)	Vendor of information services	Participation in IT structure and sustainability

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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.

Below we have identified three of the primary IT developments that will promote the Clinical Integration Workstream's ability to achieve DSRIP goals, including:
(1) The early performance of a detailed IT Needs Assessment which will provide PPS-wide CBO and provider baseline IT information, among other things. The IT Needs Assessment will serve as an input to the development of the Connectivity Roadmap and for who to integrate CBOs and providers over the next five years.
(2) Availability and/or development of relevant information from across the PPS CBO and Provider members. The ability for accurate data to be populated to common fields at the PPS level from across a range of stakeholders will be critical to the maturation of the Clinical Integration Workstream. As needed, reminders may need to be provided to promote consistent use of EMR fields or training made available to overview how to utilize new or upgraded systems.
(3) Buy in from "downstream providers' to participate with our PPS/DSRIP. Participation will be promoted through various educational and outreach efforts coordinated through the CBO Council and executed by the RPU Provider Relations professionals.

IPQR Module 9.8 - Progress Reporting

Instructions :

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

Progress reporting to measure the success of the Clinical Integration Workstream in the STRIPPS will be measured against several factors and milestones including:

(1) Utilization of Provider Surveys - Provider Surveys will be performed at the direction of the CBO Council and executed through the dedicated RPU leads in accordance with timeframes and frequencies as determined by the CBO Council.
(2) Patient Surveys - The PPS has engaged the vendor RMS to develop panel surveys to allow for adoption/consideration of patient and community input to the DSRIP plans. Patient Surveys, as part of the RMS panel population, are ongoing and can be modified as needed based on the needs and requests of the PPS. The PPS relationship with RMS is currently scheduled to continue through the end of the DSRIP five year program.
(3) The successful development of the Clinical Integration Needs Assessment.
(4) The successful development of Clinical Integration Strategy, as approved by the Clinical Governance Committee.

IPQR Module 9.9 - IA Monitoring:

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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.

Our PPS approach is to push down the functionality of the PPS to the Regional Performing Unit (RPU) level. Multiple leaders will be assigned to each RPU to promote consistency and effectiveness of project implementation, including an RPU Project Manager, an RPU Provider Relations Professional, Behavioral Health, and Disease Management professionals. In addition, we will have PPS staff such as the PPS Communications Coordinator, PPS Workforce Transition Lead, and PPS Project Management Coordinator to oversee application and consistency of projects at a cross-RPU basis. The approach for project specific implementation is based around five core modalities, as follows:
A) Engagement, communication, and education of providers and patients is considered to be the area of highest priority for project implementation focus, as all other project components could fail if not addressed sufficiently. Care Compass Network (CCN) will implement a Provider Relations functionality to ensure that communication, engagement, and education is streamlined across all projects and providers throughout the PPS network. STRIPPS will host a public website to ensure that the community also has the opportunity to participate, stay abreast of network changes, and have PPS related information readily available. As the CCN network evolves into an IDS, our CBO Engagement Council will help develop education on how individual CBO performance relates to overall PPS outcomes, define what support CBO's can receive from the PPS (e.g., in relation to their role as a participating provider), and filter and facilitate CBO communications throughout the PPS. Further, patients will be engaged and educated through projects 2di and 2ci, where a team of outreach workers and community health advocates will ensure that the maximum number of beneficiaries are engaged and connected to network resources.
B) Development of standardized treatment protocols and interventions across the PPS. Our approach will include pursuit of provider buy-in, applying resources to change existing work flows within the practice setting, a dedicated Care Coordination Team, and participation from a diverse group of providers in developing and championing the protocols for each project.
1) Utilize the Clinical Governance Committee to oversee the development of clinical protocols, relying on the RPU infrastructure (e.g., RPU Clinical Quality Committee, Provider Relations professionals, Outreach Coordinators, RPU Project Manager, etc.) to communication and deploy the tools as appropriate.
2) Implement Care Coordination efforts at the local RPU level to promote the successful deployment of protocols and interventions, following guidelines adopted by the Clinical Governance Committee.
3) Incorporate standardization of care needs into the IT strategy and vision, to ensure that the data elements needed to track progress, results, and reporting requirements exist at a PPS and RPU level. As needed, this model will be adapted based on the needs of the RPU (e.g., PPS overlap areas, patient service areas, etc.).
C) Leverage existing infrastructure and resources.
1) Identify, track and coordinate existing efforts for care coordination / care management and population health management with the 5 hospital systems and the 2 Medicaid Health Homes within the STRIPPS.
2) Build on the existing framework of clinical integration such as with Tompkins County through the Cayuga Area Physicians group ("CAP" - a Physician Hospital Organization) at the local RPU level.
3) Leverage the PPS resources such as the Rural Health Networks and other CBO's within STRIPPS to augment patient outreach and engagement for projects (in this example: 2ci and 2di).

D) Development of a coordinated IT strategy and vision.
E) The delegated leadership model that places project execution tasks at local RPUs.

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

Instructions :

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

Our approach is to push down functioning of PPS to the lowest RPU level. (Add structure of PMO that is RPU specific) Potential to contract with FLPPS to manage the implementation of the 7 overlapping projects in Chemung and Steuben counties, as FLPPS controls the majority of outpatient providers in those counties and has the majority of covered lives. (Forming a collaboration committee to address the overlap with FLPPS and other bordering PPS's).
1) The cross over functionality is in PCMH accreditation for participating PCP's (3ai, 2ai, 3bi, 3gi);
2) IT committee will be coordinating efforts to implement EHR's, connecting providers to the RHIO's and ensuring that safety net providers meet Meaningful Use requirements by the end of DY3; Ensure everyone's efforts are coordinated and prioritizing those providers who are critical.
3) Outreach and navigation coordination for projects 2ci and 2di;
4) Communication Assess current state and identify a plan to get providers up to PCMH certification) need to mention workforce

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IPQR Module 10.3 - Project Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Project Management Office (PMO)	Mark Ropiecki, Care Compass Network Project Management Director	The PMO will be responsible for consolidating results from the RPU quarterly reports and delivering results to the DOH. The PMO will be responsible for oversight and management of the Project Manager leads at each RPU, addressing issues/risks as raised or identified by the RPU leadership teams. Further, the PMO will be responsible for identifying, prioritizing, and driving DSRIP efforts at the PPS level as well as at the RPU level. The PMO will monitor the implementation of cross-PPS organizational development initiatives (e.g., cross-over counties), such as IT infrastructure development and workforce transformation. The PMO will serve as a governance link between the RPU leadership teams and the PPS governance structure including the Board of Directors and the associated Committees (IT & Data Governance, Financial Governance, Clinical Governance, and Audit & Compliance Committees).
RPU Clinical Quality Committee	Dr. David Evelyn, Chair, Clinical Governance Committee (expected)	The RPU Quality Committees will ensure PPS Clinical Quality Standards, approaches, and methodologies, established by the PPS Clinical Governance Committee are implemented, monitored, and are effectively driving improvements in clinical outcomes and improved clinical integration. RPU Clinical Quality Committees will escalate any major quality issues / risks to the PPS Clinical Governance Committee. FCQC will ensure any overlap between project-specific clinical quality committees is managed (for example, where there is considerable overlap between two of our projects, we may consider merging the two clinical quality committees). The RPU Quality Committees will oversee and report on the performance metrics specific to their assigned RPU. The RPU Quality Committee will also ensure the associated RPU network providers have received adequate education and awareness regarding DSRIP goals, clinical requirements, and when necessary implementation

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		plans/broader PPS agendas.
Regional Performance Unit (RPU) Performance Management	Multiple	Responsible for stratification of population health data to determine the patient profiles, categorization, and strategy for patient outreach and engagement approach by RPU. The RPU Performance Management team will also work closely with the PMO to monitor progress against DSRIP requirements, milestones, and associated vision/strategy plans. Will also work to perform data analysis on results each DSRIP quarter and determine if approaches are adequately achieving DSRIP goals or if approaches need to be modified based on results of analysis. These efforts can help to either align standard approaches across each RPU and when necessary customize approaches based on the specific needs of a particular RPU.
Regional Performance Unit (RPU) Leadership	RPU Leads (* Amy Gecan (Cayuga Medical Ctr)- North RPU * Greg Rittenhouse (UHS) - East RPU * Robin Kinslow-Evans (UHS) - South RPU * Robin Stawaz (Care First) - West RPU	RPU Performance Leadership teams will include member(s) of the PMO, including at minimum one Lead Project Manager per RPU, the lead RPU Provider Relations professional, RPU specific Disease Management and Behavioral Health professionals, the RPU Outreach Coordinator, as well as PPS positions which will support multiple RPU's, such as the Workforce Transition Leader, IT Coordinator, PMO Coordinator, and Communications Coordinator. Together, these members will communicate RPU needs to the associated committee/council (e.g., CBO Council, Coordinating Council, Finance Committee, etc.) and drive implementation efforts as related to their functions. The RPU Leadership team members will work closely with CBO members and PPS support teams (e.g., IT, etc.) to oversee the implementation of the phased DSRIP plans for progress, identification and remediation of issues, and report development for periodic PPS meetings as well as quarterly DOH submissions.
Project Leads	Multiple	PPS Project Leads, along with their team, are members of the Coordinating Council and serve as the technical leaders for individual DSRIP projects and organizational sections. The Project Leads provide insight as to the development of integration, staffing, obtainment of consulting services, and otherwise to drive the planning, development, and execution of DSRIP related projects. This includes bringing the right people to the table, including identification of technical leaders from across the PPS, interviewing PPS candidates, or generating Requests for service Proposals for PPS services to be achieved through hired vendors/consultants. The Project Leads are also responsible for understanding the

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		layout of the PPS RPUs and aligning available resources with technical planning for RPU development and functionality. The Project Leads work closely with the organizational level teams (ie. PMO, Finance, etc.) to ensure project-specific needs are understood cross-functionally by RPU team.
Workforce Transition Consultant	AHEC Workforce Consultant	Responsible for providing workforce development services.
Behavioral Works Consultant	TBD Vendor	Responsible for providing behavioral works related services.

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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		
Finance Governance Committee	Determine funds flow; Monitor financial impact	Responsible for identifying flow of funds to providers based on project operating costs and monitoring the impact of the DSRIP projects.
Board of Directors	Overall PPS Guidance	Responsible for monthly Board Meetings and approval of key documents (Bylaws, policies, plans).
Clinical Governance Committee	Develops and manages PPS-wide clinical standards	Responsible for development of PPS Clinical Standards and monitoring of the quality of Clinical Standards Application.
Regional Performing Units (RPUs)	Primary Operating Unit of the PPS	Responsible for reporting to the Clinical Governance Committee and identifying local RPU needs as related to DSRIP timelines (e.g., PPS overlap, regional clinical needs, etc.).
Workforce Team	Develops and manages the delivery of the workforce transformation strategy for each of the PPS RPUs.	Responsible for consolidating and managing the (re)training, redeployment, and new hire needs at the RPU level, preparing quarterly reports of workforce transformation numbers for the Project Management Office (PMO), and the alignment of the overall Workforce program to indentify staffing needs, reassigning existing staff, and training.
IT & Data Governance Committee	Manages the overall PPS IT needs, as well as the needs of each RPU.	The IT & Data Gov. Com. will be responsible for managing the various PPS-wide IT & data transformation initiatives. The IT & Data Gov. Com will include member(s) of the PMO in appropriate working sub-committees, and seat the Director of Project Management as a non-voting Committee member to ensure IT related initiatives are appropriately integrated and communicated throughout the overall PPS implementation approach.
Provider Relations Team	Ensures professional groups are engaged (e.g., aware, educated, contracted) with the RPU/PPS needs.	Alongside the local RPU Clinical Quality Committees, the Provider Relations Professionals will be responsible for working closely with RPU identified CBOs/groups (e.g. Pediatrician community of practice, Community health worker community of practice etc.), as well as the CBO Council to develop and implement plans to promote provider/ CBO engagement.
Compliance and Audit Committee	Ensures PPS compliance on all applicable fronts (e.g., state,	Responsible for developing a PPS Compliance Plan, implementing

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
	federal, RPU, PPS, Board, etc.).	the PPS Compliance Plan, and reviewing PPS's conduct in terms of adherence to Compliance Plan and DSRIP guidelines, laws, and associated regulations.
CBO Engagement Council	Develops the PPS approach for relationship development with RPU CBOs.	Responsible for the development of provider outreach, education, and communication program, select provider contracting terms, and the allocation of providers/CBOs within responsible RPUs.
Coordinating Council	Coordinates, Plans, and Oversees the Project Plan Development and Allocation at the RPUs.	Responsible for leading each of the 11 PPS projects and domains/organizational sections. The Coordinating Council is initially responsible for the development of implementation plans and speed & scale documents and will later transition into oversight/advisors for each plan to connect the correct professionals to the development of the RPUs as DSRIP plans are executed and help promote overall IDS development.
Cultural Competence Committee	Manages the cultural competency and health literacy transformation process.	Responsible for developing, distributing, and operating the cultural competency educational program as well as the health literacy patient program.
External Stakeholders		
RMS Patient Panel	Patient / User group	We have engaged a patient panel with RMS to engage a patient population on a scheduled (e.g., monthly) basis to obtain key input, which will vary based on the needs of the PPS over time as the DSRIP model matures.
PPS Labor Unions (CSEA, NYSNA, SEIU and PEF)	Labor representation	We have held seats and membership to key councils and committees for Union representation to allow for Union participation. We will continue to engage with them on the specific changes to the workforce or otherwise as the DSRIP model matures.
Finger lakes PPS	Overlapping PPS	Some projects as related to the West RPU will have a direct impact to the Finger lakes PPS. Efforts to communicate and coordinate overlapping plans are being pursued for mutual agreement and approach.
Bassett PPS	Overlapping PPS	Some projects as related to the East RPU will have a direct impact to the Bassett PPS. Efforts to communicate and coordinate overlapping plans are being pursued for mutual agreement and approach.
Central NY PPS	Overlapping PPS	Some projects as related to multiple RPUs may have a direct impact to the Central NY PPS. Efforts to communicate and coordinate overlapping plans are being pursued for mutual agreement and approach.
NYS Office of Mental Health (OMH)	State Agency	Issues guidance, protocols for NYS (by default the PPS). Members

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
		are a part of the PPS demographic.
NYS Office for People with Developmental Disabilities (OPWDD)	State Agency	Issues guidance, protocols for NYS (by default the PPS). Members are a part of the PPS demographic.
NYS Office of Alcoholism and Substance Abuse Services (OASAS)	State Agency	Issues guidance, protocols for NYS (by default the PPS). Members are a part of the PPS demographic.

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.

Information Technology is a major backbone and theme behind the development, implementation, and achievement of DSRIP goals. One key element of the IT infrastructure development which will serve as a common theme over multiple projects, RPUs, and PPS 'system level' functions includes the development, active participation, and effective usage of EMR system functionality and patient registries for providers in the system by DY3. Major sub-components of this include Meeting Meaningful Use and PCMH standards achieved by the end of DY3, connecting to the local RHIO's to ensure the availability of clinical data as well as the ability to share it amongst the appropriate PPS providers, the development of web-based surveys and functionality (i.e. PAM and eMOLST), and the ability to aggregate all relevant PHI into a centralized data warehouse that will be used for population health management functionality. To promote the achievement of the IT plan and requirements mentioned above, there will be multiple IT sub-committees, or workgroups, developed to focus on particular IT needs which will report to the PPS IT & Data Governance Committee. The IT & Data Governance Committee will be comprised of technical experts who provide the governing committee a requisite spread of experience and knowledge. The PPS has filed multiple CRFP applications to enhance core capital IT infrastructure investment needs.

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.

The PPS performance monitoring will be measured at a granular level using our providers' understanding of their performance and how it is improved by our implementation of performance measurement. We will continually measure the progress against plan, for example the level of engagement and involvement of providers in the performance reporting systems and processes that are established. To this effect, in DY1 Q2, we will define metrics to measure providers' involvement in the PPS performance reporting structure (e.g. active users of performance reporting IT systems, involvement in feedback discussions with Clinical Quality & Finance Committee about performance dashboards). We will also set targets for performance against these required metrics. The RPU Quality Committees and the RPU specific Performance Monitoring Leads will be held accountable for driving up these levels of involvement. Additionally, CBO contracts will be established leveraging a pay for performance model whereby contracted payments (excluding infrastructure build) will be based on achievement of results, rather than a grant based payment model.

Our front-lines will measure the outcomes that matter most to patients, and use our reporting and IT systems to monitor, evaluate, and identify the contributing processes and intermediate outcomes. They will be surveyed and interviewed to determine the level at which they find that the performance reporting system provides them with the right information, and the level at which they find that the information is clear and – most importantly – actionable.

On a monthly basis, our RPU, overseen by the RPU Quality Committee, using the standardized measurement and reporting framework, provide

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their members with the relevant patient metrics, along with their deviation or improvement from the previous month. Our PPS Clinical Governance Committee and IT & Finance Governance Committee will then aggregate these reports and compile them into the Executive Report, which will be the top item during the monthly Governance meetings. The quarterly reports will show the variation in patient care outcomes between quarters, which will be easily accomplished using our monthly model. Tracking change in the metrics included on these dashboards over time will be the primary tool we use to evaluate the impact of our performance reporting systems and our efforts to embed a culture of continuous improvement.

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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.

Our PPS will approach community engagement through several avenues leveraging different specialties to develop the associated communications content. The PPS will hire a Communications Coordinator through which all PPS public communications will be routed to ensure overall consistency. Incorporation of existing services, skillsets, and knowledge from the PPS community will be vital to the PPS as the existing infrastructure is an invaluable asset to the achievement of DSRIP related projects and the movement towards an integrated delivery system.
Overall risks with requiring the community involvement is the possibility and likelihood that some CBOs will not actively engage in the short term, while some may defer DSRIP involvement entirely. To mitigate this risk and to create strong working relationships across the PPS with CBO members we plan on engagement through the following activities:
(1) The PPS has established the CBO Engagement Council to promote CBO involvement and education at an RPU level to each of the CBOs and providers. The RPU Provider Relations professional will serve as a single point contact for each RPU to better facilitate CBO involvement at a localized level.
(2) Following initial outreach and education programs the PPS will contract with participating CBOs on an as needed basis either for specific projects, such as 2ci and 2di, or for services (e.g., outreach, engagement, etc.) associated with the achievement of DSRIP goals. Other than identified infrastructure enhancements, CBO contracts will be established based on pre-defined achievement of performance metrics.
(3) To further promote community engagement and input during the five year DSRIP period, the PPS will also retain the services of the RMS Panel to engage pulse of the patient and provider population. Information obtained through the monthly panels will be used as direct inputs to how PPS approaches and/or communication plans are developed and implemented.
(4) Also, the PPS will continue to host recurring Stakeholders/PAC meetings to allow for an open forum where PPS members can openly communicate and receive PPS information. Additionally, these meetings help to educate the PPS members regarding DSRIP news, PPS progress, and serve as an input for Stakeholder/PAC feedback.
(5) Lastly, the PPS will create additional communication channels such as the community/public facing website, PPS newsletters, etc. through which PPS information can be shared with the broader community, and through which PPS contact information for upcoming items (e.g., training seminar) or RPU Provider Relations Leads can be made available.

IPQR Module 10.8 - IA Monitoring

Instructions :

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Section 11 – Workforce

IPQR Module 11.1 - Workforce Strategy Spending

Instructions :

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

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

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IPQR Module 11.2 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Define target workforce state (in line with DSRIP program's goals).	In Progress	Finalized PPS target workforce state, signed off by PPS workforce governance body.			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1: The Project lead and Workforce Development and Transition Team (WDTT) will continue to convene and recruit new members to the Workforce Development and Transition Team (WDTT) which currently includes: HR representatives, union representatives, subject matter experts and key stakeholders.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2: The workforce consultant, under the guidance of the WDTT, will identify methods and tools for tracking and reporting Domain 1 Process Measures.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: The workforce consultant will work with project leads and the WDTT to identify specific number and type of occupations required to carry out our workforce needs, by DSRIP project.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4: The workforce consultant will work with project leads and the WDTT to identify competencies (skills, training needs) for DSRIP-created positions, by DSRIP project.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5: The workforce consultant will compile a Project-by-Project Analysis (from information	In Progress	In Process			07/01/2015	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
garnered during steps 3 & 4) to be reviewed by WDTT, project leads, project managers, and other key stakeholders.									
Task Step 6: Based on the reviewer input of the Project-by-Project Analysis, a Future State Staffing Assessment will be conducted by the workforce consultant, under the guidance of the WDTT and including inputs from the compensation and benefits analysis, to develop a comprehensive view of the areas within the PPS that will require more, less, or different staffing resources to support DSRIP projects and ultimately assist in identifying DSRIP-staffing location.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 7: The workforce consultant and WDTT will conduct an Organizational Impact Assessment, informed by a face-to-face session with key stakeholders, that will determine the degree and magnitude of impacts by role/provider organization, key roles and responsibility changes, impact to staffing patterns, etc.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 8: The WDTT and workforce consultant will create a detailed target state workforce model to include: number of staff by skill, location, shift, pay category, etc.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
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.			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1: Solidify governance model and decision-making structure with the ability to approve workforce decisions.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2: The WDTT will define the workforce transition roadmap utilizing inputs from the	In Progress	In Process			07/01/2015	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
Target State Workforce Assessment to determine workforce needed, the Gap Analysis to illustrate affects on current positions, the Compensation and Benefits Analysis to show impacts on current positions and salaries and a Communication plan to map out staff involvement.									
Task Step 3: Consolidate all specific workforce changes within the PPS; incorporating speed and scale projections by position, a recruitment plan for new hires (see Detailed Gap Analysis), retraining/re-deployment strategies (see Compensation and Benefit Analysis), training timelines (see Training Strategy) and the creation of a Communication and Engagement Plan.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4: Generate a workforce transition roadmap, based on inputs from Milestone 2, Step 2 and Step 3, the Target Workforce State and the Detailed Gap Analysis.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5: Workforce transition roadmap is approved by governing body.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	In Progress	Current state assessment report & gap analysis, signed off by PPS workforce governance body.			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1: Identify which positions may involve direct re-deployment vs. retraining with input from HR representatives and consideration for HR policies and Labor agreements.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2: Compare job skill requirements of Target Workforce State versus skills of jobs to be reduced/eliminated.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task	In Progress	In Process			07/01/2015	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
Step 3: Utilizing the results from Milestone 3, Step 1 and Step 2, identify eligible staff for re-deployment/retraining through an HR-implemented skill assessment.									
Task Step 4: Confirm impact analysis of existing workers (current state assessment) by identifying staff availability and competency levels, project-specific implementation needs, by member organization, in order to assess: 1) Staff able to fill target state positions through retraining and 2) Staff who could be redeployed directly into target state roles.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5: Make appropriate considerations for the PPS-wide healthcare environment by identifying barriers and affected subgroups.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6: Create a recruitment plan for new hire positions that cannot be filled through re-deployment/retraining, to include a recruitment timeline, strategies by position and solutions for positions difficult to fill (i.e. long-term pipeline approach).	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 7: Refine original budget projections based on analysis results.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 8: Create a Gap Analysis Matrix, to include: 1) Workers impacted by job category; 2) Percent of overall workforce impacted that can be retrained or redeployed; 3) Of impacted workers, project number of workers that are expected to achieve full or partial placement.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 9: Reflect gap analysis results as they inform the workforce transition roadmap.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task	In Progress	In Process			07/01/2015	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
Step 10: Gap analysis will be reported PPS-wide (RPU's, project leads, clinical performance units) and approved by governing body.									
Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	In Progress	Compensation and benefit analysis report, signed off by PPS workforce governance body.			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task Step 1: Contract Iroquois Healthcare Alliance (IHA) to produce a compensation and benefits analysis to include the healthcare systems and community-based healthcare organizations.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2: Conduct a comprehensive PPS-wide analysis, in collaboration with IHA. Examine findings by: 1) job category; 2) variations on a regional level; and 3) variations on a facility-type level.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Based on current state analysis results, solidify origin and destination of staff vulnerable to re-deployment.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4: Work with HR to gather compensation and benefits, to be confidentially provided to a third party vendor, information for vulnerable staff and assess potential changes to compensation.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5: With HR, third party vendor, and Union input, determine specific impacts to partial placement staff and potential contingencies.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6: With HR, third party vendor, and Union input, develop and incorporate policies for staff impacted by partial placement or who refuse retraining or re-deployment.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 7: Workforce governing body approves compensation and benefits analysis.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #5 Develop training strategy.	In Progress	Finalized training strategy, signed off by PPS workforce governance body.			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1: The sub-committee will examine target state training/retraining needs to support DSRIP goals by project and position, training need types (skill building, performance metrics, vbp, etc.) and identification of all positions who will require training through surveys, project summaries and project lead interviews.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2: Include stakeholders, from positions in the workforce who will require training, in planning efforts.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Examine PPS-training/retraining capacity to support DSRIP goals by conducting a survey of existing training programs available and identify gaps in current training capacity versus target state training needs (skill building, training for performance metrics, VBP, etc.).	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4: Explore opportunities to coordinate efforts with existing state-wide education programs.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5: Solicit input from the Regional Performance Units (RPUs), finance committee and all other aspects of the organization (governance, IT physician engagement, clinical integration, cultural competency and health literacy, performance reporting) to inform the development of the training strategy. All workforce strategies will be available to other projects and workstreams via the PPS sharepoint	In Progress	In Process			07/01/2015	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
site.									
Task Step 6: Develop a training strategy to guide the training plan, to include: goals, objectives and guiding principles for the detailed training plan; employee skill assessment; confirm process and approach to training (e.g. voluntary vs. mandatory, etc.).	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 7: Review accuracy of initial assessments, potential shortage of qualified workers, clearly defined position titles, predictions of benefits and compensation, refusal of employees to be retrained or redeployed and incorporate findings into training strategy.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 8: Provide training strategy to the clinical domain of the governing body for review, feedback and approval.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 9: Identify methods and tools (IT system) for measuring training effectiveness and tracking and reporting DSRIP-related training.	In Progress	In Process			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 10: Generate training plan for approval by governing body.	In Progress	In Process			07/01/2015	03/31/2016	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

NYS Confidentiality – High

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Define target workforce state (in line with DSRIP program's goals).	
Create a workforce transition roadmap for achieving defined target workforce state.	
Perform detailed gap analysis between current state assessment of workforce and projected future state.	
Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	
Develop training strategy.	

Milestone Review Status

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

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IPQR Module 11.3 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

There are several challenges and risks, that have been identified by the Workforce Committee, associated in achieving the workforce milestones. The first of these risks is relying on the completeness and accuracy of the numbers and projections provided by each project and having the capability to alter workforce projections based on ability to meet projected numbers. In order to mitigate this risk, a direct and regular line of communication with project leads will be necessary to determine the accuracy of information in the implementation plan and any alterations to employment projections as they move forward with project implementation. There will also be a need to obtain objective statistical analysis to justify conclusions.
A second risk that has been identified is the potential shortage of qualified workers to fill DSRIP-created positions. Specifically, new hires may not be available, employees may resist redeployment, redeployment options may not align geographically for workers, and the potential for poor communication of new openings and opportunities. Strategies to mitigate these risks include: 1) Establish a working relationship with community agencies, training programs and policy-makers in higher education to establish long-term recruitment strategies; and 2) work closely with STRIPPS Communication Committee to ensure best communication practices are utilized to reach the workforce.
A third risk, is the need for clearly-defined position titles across the PPS (case manager versus care manager). Mitigation strategies include convening all appropriate parties to review and approve a recommended set of position titles by the Workforce Committee.
A fourth risk, regarding benefits and compensation, include the inability to predict market forces that drive compensation, continually increasing benefit costs, and reimburses determining the amount paid to employers, which impacts cash flow, FTE counts and compensation packages. To mitigate these risks, the PPS will examine the feasibility of PPS-wide contract negotiations with payors to enhance revenues. The PPS will also continually monitor market forces that will indicate adjustments needed.
A fifth risk, is the potential for employees to refuse retraining or redeployment. To mitigate this risk, each healthcare system, community-based organization, and other partners, will develop clear and transparent policies and ramifications for refusals and provide guidance to transitional services as applicable.
A sixth risk is the need to develop an effective IT interface to transfer knowledge for managing and reporting workforce information. The mitigation strategy will be to build upon structures currently in place to manage and collect data.
A final risk is the need for an accurate understanding of training needs and required certifications and licenses, cost of training, identifying where DSRIP-related positions will be housed, and credibility of training offerings. The mitigation strategy, again, relies on an effective communication relationship with the project leads, who serve as the PPS experts for employment projections and training needs within their specific project areas. Additionally, the PPS will need open communications with potential providers of training in order for current best practices to be incorporated into training offerings.

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.)

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All other DSRIP project workstreams are, both, affected by and essential to workforce. The speed and scale with which each project is implemented will affect plans to recruit and train the corresponding staff.
One of the key workstreams that Workforce will be interdependent upon is the Governance workstream. Workforce has an obligation to provide timely and accurate information to Governance for approval and in turn the Communications Team, housed within Governance, will be critical in regards to timely outreach for workforce recruitment and training efforts. Having a well-defined relationship with Communications will also be critical for Workforce to garner support for PPS projects from all healthcare workers, particularly providers.
Budget, Funds Flow and Financial Stability workstreams all impact the Workforce workstream. Budget allocations to workforce will drive recruitment, re-deployment and training abilities; Funds flow conclusions will potentially determine hiring ability of potential DSRIP-position employers and the availability of funds for training, and; the results of the financial health assessment may impact the placement location of DSRIP-created positions.
The Physician Engagement workstream's ability to garner physician involvement will impact the potential need to on-board new physician hires for project implementation if the project's needs cannot be met through the current physician population.
One of the roles of Population Health Management workstream will be to provide a PPS-wide bed reduction plan. The number of bed reductions will have an affect on the number of worker reductions and placement of DSRIP-related positions.
The dependency on the IT workstream will be illustrated and discussed further in the "IT Expectations" section.
Five of the workstreams, including: Cultural Competency & Health Literacy, IT Systems and Processes, Performance Reporting, Physician Engagement and Clinical Integration, are all responsible for creating a training strategy as part of their Implementation Planning. All of these training strategies will need to be considered and incorporated into the PPS-wide Workforce Training Strategy.

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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 Lead	Lenore Boris / SUNY Upstate Binghamton Clinical Campus	Responsible for development of IP and execution of all workforce-related activities.
Workforce Development Manager (PPS Staff person)	TBD	Responsible for executing or supporting the execution of the Implementation Plan activities. Staff liason with workforce committee.
PPS Staff	Robin Kinslow-Evans, Interim Executive Director Roseanna Stasik, Executive Assistant Mark Ropiecki, Director, Project Management	Responsible for reviewing and providing timely feedback/input on various aspects of the PPS Workforce Strategy including the hiring and sub-contracting of vendors. Also, interface with leads for funds, communications, governance, coordinating workforcoce issues into MAPP portal.
IT Project Lead & Consultants	Srikanth Poranki, IT Project Lead Bill Ahrens, Senior Manager Jenna Barsky, Senior Consultant Kathleen Grueter, Consultant	Responsible for understanding workforce data, tracking & reporting needs and providing recommendations for solutions.
Workforce Development and Transition Team (Workforce Committee)	Cori Belles, Donna Chapman, Anne English, Janet Hertzog, Martha Hubbard, Mary Hughs, Bonita Lindberg, Dawn Morello, Sage Peak, Sue Preset, Sue Ellen Stuart, Elizabeth Zicari	Responsible for overall direction, guidance and decisions related to the workforce strategy plan.
Workforce Strategy Vendor	Central & Northern AHEC	Responsible for the coordination and execution of workforce activities and analyses, reporting directly to the WF Project Lead
Labor Representation	SEIU 1099, CSEA, NYSNA	Provide insights and expertise into likely workforce impacts, staffing models and key job categories that will require retraining, re-deployment or hiring.

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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		
Robin Kinslow-Evans, Interim Executive Director Roseanna Stasik, Executive Assistant Mark Ropiecki, Director, Project Management	PPS Staff	Provide approval at various stages of workforce implementation including the hiring/payments to PPS subcontractors.
TBD	Affected healthcare disciplines	Input will be needed in defining the strategy. Key stakeholders will continually be evaluated throughout DSRIP.
Anne English, Mary Hughs, Cori Belles, Donna Chapman, Bonita Lindbery, Sage Peak	Participating Partner HR Representatives	Workforce data & reporting Direct communication link to front-line workers Current state workforce information Potential hiring needs
Multiple	Participating Partner Learning Department Representatives	Training data & reporting Direct link to employee training resources
Janet Hertzog, Martha Hubbard	Local Educational Institution Representatives	Provide insights and information related to the development of the training needs assessment, strategy and plan
Greg Rittenhouse, Shelley Eggleton, Kathy Swezey, Victoria Mirabito, Sue Ellen Stuart, Amy Gecan, Alan Wilmarth, Sue Romanczuk, Nancy Frank, Pam Guth, Deborah Blakeney	Project Leads	Provide information related to sources and destinations of redeployed staff by project
Multiple	Leads at larger PPS member organizations	Employing DSRIP-created positions, providing DSRIP-related training, Project implementation Potential employer, potential training resource, project participant
External Stakeholders		
Educational Institutions	Potential Training Developer	Provide DRSIP-related training needs
Other training providers	Potential training provider/developer	Provide DRSIP-related training needs
SUNY RP2 (squared)	Facilitate creation of SUNY-wide post-secondary training programs	Provide long-term DRSIP-related training needs
SEIU 1099, CSEA, NYSNA	Labor representative	Provide advising around labor issues
AHEC	Workforce Vendor	Coordination and execution of workforce activities and analyses
Department of Health (DOH)	Provide guidance on DSRIP workforce-related issues PPS reports to DOH	Clear expectations around reporting requirements (when, type of documentation they require, etc.) Resource for providing information on DSRIP Workforce Best

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
		Practices
Providers	Employers	Keep PPS informed of their workforce needs including: need for new hires, competencies needed and training needs
Community Based Organizations	Employers	Keep PPS informed of their workforce needs including: need for new hires, competencies needed and training needs
Patients	Provide feedback on quality of care	Patient feedback is an indicator of workforce training needs
Compensation & Benefits Analysis Vendor	Iroquis Healthcare Alliance (IHA)	Compensation and benefit analysis

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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.

The interdependency between IT and Workforce is paramount to DSRIP success. A shared IT infrastructure has the potential to support the Workforce workstream by supporting training initiatives such as: 1) leveraging available resources to capture PPS-wide training availability; and 2) link each project/workstream-specific training strategy into one overarching training strategy; 3) track training progress for quarterly reporting (e.g. who's been trained, subject matter of training, etc.). Second, as the workforce transition roadmap is executed, it will serve as a platform to house resources for staff that are looking for DSRIP-related jobs, career counseling resources and to track staff movement across the PPS (e.g. redeployed staff, new hires). Finally, the IT system will need to gather the information needed for quarterly reporting of domain 1 process measures with the potential of utilizing a third-party to aggregate details for the PPS.

The WDTT will work with the IT committee and IT consultants to identify the components needed for tracking and ultimately identify a product (such as HWapps, the Health Workforce NY platform) to perform the following functions:
- Connect partners within in the PPS to standardize workforce Data Collection and Reporting
- Connect partners within and across PPS territories to access existing best-practices and available trainings through a Learning Collaborative
- Connect with IT to assess partner capability for Tracking Training progress
- Connect partner within and across PPS territories to promote job openings through a PPS-wide Job Board
- Provide resources for impacted workers to access career counseling and skills assessment tools

IPQR Module 11.9 - Progress Reporting

Instructions :

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

The success of the Workforce workstream will be measured by its ability to meet milestone target completion dates and develop an effective means of gathering quarterly data. In order to successfully coordinate quarterly data collection, the Workforce workstream will operationalize the progress reporting process through the identification and use of an electronic survey mechanism to collect and report this data (referenced in Milestone 1, Step 2).

The Workforce workstream will work with IT and Clinical Governance committees to identify an online tool for workforce data collection and assessment of worker performance. It will also be important for the identified tool to measure the success of the components of the workforce strategy (for example: the training strategy). Establishing mechanisms to capture employee feedback through training completion reports and subsequently sharing with appropriate PPS-partners and HR reps will be incorporated. Once a tool is identified, a reporting structure will be developed that will funnel the information to the workforce team, who will report progress on a quarterly basis to the New York State Department of Health with respect to domain 1 process measures. The Workforce workstream will ensure training is provided for staff (within PPS and partner HR

representatives) on use of the reporting platform in addition to emphasizing the importance of workforce data collection/reporting.
As part of an internal process, the Workforce workstream will measure success based on a detailed workforce action plan that provides specific dates for anticipated implementation, regular meetings and work plan review.

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.

Three major risks have been identified by a PPS representative group. These major risks, as well as the associated mitigation plans are listed as follows:
1) A leading major risk includes the patient consent process, which is a pivotal action item and potential bottleneck to the successful implementation of not just 2.a.i. but each of the 11 projects selected by our PPS. The successful receipt of patient consents will ultimately drive our PPS's ability to provide those essential Care Coordination services which have been selected as a result of the Community Needs Assessment to align PPS actions (e.g., projects, toolkits, interventions) with DSRIP goals. Without patient consents, we will have no patients for whom we can access data for purposes of care coordination. We will leverage multiple risk mitigation strategies to alleviate and reduce the overall risk exposure. First, we will develop a PPS infrastructure which promotes engagement with patients to consent and share data. This will include the creation of Regional Performing Units (RPU's) which will allow for patient contacts to be made at a regional/local level. We will also leverage our knowledge from existing Health Homes within the PPS to develop our approach to implementing the 11 projects. For example, we have seen positive results with 'warm handoffs' with patients. In addition, patients will be engaged through the Care Coordinators using existing services, new projects implemented as a result of DSRIP, and a Performance Management Team which will oversee work metrics at the RPU level.

2) A second major risk includes overall Provider Readiness & Awareness. To mitigate the provider readiness and awareness, we will place Provider Relations professionals within each RPU, assigned to build and manage the physician relations. Key actions will include providing education to providers regarding DSRIP goals and what potential impacts may be, overviewing benefits of leveraging the PPS for care coordination purposes (e.g., expected reduced 'no shows'), as well as monetary inputs for contracted services such as outreach and engagement. We also have developed an equitable governance structure which promotes transparency and allows for physician leaders from throughout the PPS to provide guidance and strategies for PPS provider readiness & awareness plan developments and to also serve as regional provider champions to promote DSRIP related activities.

3) A third major risk is the successful implementation of the IT connectivity strategy. Our PPS includes a diverse spectrum of organizations that span a nine county region. There exists a risk that some partners don't have any EMR connectivity while many others have not yet developed mature EMR practices which would allow for seamless integration with PPS needs. Failure to connect providers to the network will seriously impede the PPS' ability to leverage required data to make patient related decisions. The integration and leveraging of existing platforms, complimented by upgrading existing systems and integration of systems throughout the network (as appropriate) is our primary risk mitigation strategy. This will be achieved by identifying the different stages of readiness for each partner and develop customized plans to successfully bring them into the network. Towards this effort we have completed a PPS CRFP application which includes upgrading of the PPS wide IT infrastructure, including RHIO connectivity, Data Analytics & Performance management functions, EMR for Safety Net Providers, Care Management/ Population Health Management, Telehealth/Telemonitoring needs, and Web-based surveys. Lastly, initial and ongoing education requirements will be determined, for which training will be made available to responsible persons.

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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	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 1a. - Develop a Participating Organization (e.g., provider) Network List for the PPS to outline the Partner Organization (e.g., providers, Community Based Organization (CBO), social service organizations, etc.) demographics for the PPS Integrated Delivery System.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 1b. - Establish operating units for the PPS called Regional Performing Units (RPUs) within which the PPS Participating Organizations from across the nine county region can be identified and engaged at a localized level.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 1c. Conduct a provider readiness survey and awareness campaign to position the PPS to contract with participating organizations and engage with safety net providers	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 1d. Initiate contracts with safety net providers.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 1e. Establish Participation Agreements for Participating Organizations within each RPU which contract PPS services	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
required to achieve DSRIP goals, such as patient outreach and patient engagement. Manage ongoing process as needed.									
Task Step 1f. - When appropriate, engage payers at a PPS leadership level roundtable, to be completed at minimum annually and supported by meeting minutes.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 1g. - The Provider Relations professionals will perform periodic (e.g., quarterly) assessments of PPS Partner Organizations to confirm relationships exist, are active, and overall participation and results are aligned with the contractual terms or overall needs of the PPS (e.g., updated CNA assessment, etc.) As a result of the quarterly reviews, any changes to the Provider Network List will be made and communicated, and the need for priority status may assigned to further engage PPS Participating Organizations where needed.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	Project	N/A	Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task PPS produces a list of participating HHs and ACOs.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2d. - Identify PPS HH and ACOs and create a Network Provider List. Integrate the Health Home representatives to recurring Stakeholder/ PAC meetings to ensure appropriate Health Home representation exists.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2e. - Review existing Health Home systems and capabilities, particularly the Health Home system architecture and how information is disseminated, and integrate leading practices/service models to the PPS Operating Model at the RPU level. On an ongoing basis, the RPU Project Managers will	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
monitor results and progress to centrally communicate how to further refine the PPS approach or customize the service model at the RPU level.									
Task Step 2f. To the extent possible, identify and leverage Health Home-specific IT elements including case management information sharing, care coordination templates, connectivity/relation to the RHIO, etc.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2g. - To integrate the PPS and further promote the development of the integrated delivery system, assign an RPU Lead who will communicate and reinforce updates to and from the Clinical Governance Committee.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2h. - Note: There are currently no ACO's in place, nor in development, within the STRIPPS Partnering Organizations. This project requirement will be periodically reviewed for ongoing ACO pertinence.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Clinically Interoperable System is in place for all participating providers.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS trains staff on IDS protocols and processes.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3f. - Development of a Standard PPS Care Coordination Plan which will be informed by the Care Coordination needs assessment and developed based on guidance provided by the RPU Quality Committee as well as the Clinical Governance	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Committee. Upon finalization, the Standard PPS Care Coordination Plan will be shared appropriately with the Partnering Organizations and made available on the Care Compass Network SharePoint site. To promote consistency of IDS protocols, education or tutorials may also be provided.									
Task Step 3g. - Implement a process to track performance within the Care Coordination Plan through periodic reporting, including services provided outside of hospitals in order to assist with service integration. RPU adherence to standards established by the Clinical Governance Committee, including Care Coordination Plans, will be monitored by the RPU Quality Committee.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Hospital	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Nursing Home	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 4g. - Perform a current state assessment of safety net connectivity to region-specific RHIOs. Expand on the efforts in	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
project 2.a.i. Project Requirement 1a. development of a Participating Organization (e.g., provider) Network List for the PPS which outlines the Partner Organization (e.g., providers, Community Based Organization (CBO), payers, social service organizations, etc.) demographics for the PPS Integrated Delivery System by including EHR system and connectivity demographic overviews for the safety net providers in the PPS.									
Task Step 4h. - Maintain ongoing communication with RHIO to identify potential capabilities relevant to PPS activities.	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task Step 4i. - Upon provider completion of project 2.a.i. Project Requirement 5, which includes leveraging a consulting service to assist with a PCMH & Meaningful Use readiness assessment, creation & implementation of the associated implementation plan(s), provide assistance with the application process, and formally document/retain certification related documentation; the PPS IT Coordinator will review and monitor the IT environment to confirm EHR system capabilities are in place are used and functioning as designed ensuring access to real-time data to improve interoperability. Periodic reviews will be performed and include evidence of alerts/secure messaging, availability of training materials, training(s) completed, and percentage of staff trained. The status of these reviews will be reported at minimally quarterly to the IT & Data Governance Committee and/or Clinical Governance Committee as appropriate.	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task Step 4j. - The PPS will support partners (e.g., CBOs, providers, etc.) in actively sharing by promoting infrastructure build and/or other requirements as identified by the current state assessment above. As appropriate, partners will be contracted with the PPS for achievement of specific tasks, which will be monitored for completion as reported to the RPU Clinical Quality Committees for review.	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
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	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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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.	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 5c. - In conjunction with project 2.a.i. Project Requirement 4, utilize the PPS IT and Data Governance team to identify Safety Net Providers preparation requirements for activation with the RHIO. When needed, utilize the PPS IT Coordinator to coordinate resources needed for Safety Net Provider(s) activation with the appropriate RHIO.	Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 5d. - Using the readiness assessment (See 2.a.i Milestone 1, Step 1c), determine PPS providers' status on achievement of PCMH and Meaningful Use requirements.	Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 5e. - Identify and contract with a Consulting service to assist with a PCMH readiness assessment and implementation and collaborate with adjacent PPS' (as appropriate).	Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 5f. - Leverage the PCMH Readiness Assessment as a baseline to create a Meaningful Use and PCMH implementation plan for PPS providers. The plan will include a current state assessment for each safety net provider and detail key milestones which will allow for a phased implementation approach towards PCMH and Meaningful Use DY3, Q4 requirements.	Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 5g. - The RPU Provider Relations professionals will assist safety net providers with the associated application(s) throughout each phase of the PCMH Level 3 implementation plan.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 5h. - Obtain and retain certification documentation substantiating safety net providers within the PPS have achieved Meaningful Use and PCMH Level 3 standards.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #6	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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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.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 6b. - Identify those person(s) responsible for review of population health data and provide requisite HIPAA, PHI, and regulatory training to ensure overall PPS compliance. As applicable, obtain DEAA, BAA, or other required arrangement.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6c. - Identify data elements specified in DSRIP requirements.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6d. - Initiate population health management with available patient data, such as Salient and participating provider clinical systems.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6e. - Identify available patient health registries and population health software.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6f. - Develop a population health stratification approach to confirm EHR completeness and validity.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 6g. - Develop a population health stratification approach to identify patient groups for targeting.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 6h. - Develop a defined population health registry for individual patients for enhanced care management and each RPU.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6i. - Develop a dictionary of registry elements to ensure ease of implementation and standardization of use PPS-wide.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6j. - Develop a monitoring process which allows for the RPU Leads to actively track patients for metrics such as status (engaged/not engaged) and performance against project milestones, to be included in reporting at the PPS level.	Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 6k. - Perform periodic reviews of user access and system requirements to perform population health management.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 7d. - In conjunction with project 2.a.i. Project Requirement 4, utilize the PPS IT and Data Governance team to identify all participating PCPs for activation with the RHIO. When needed, utilize the PPS IT Coordinator to coordinate resources needed for Primary Care Providers (PCPs) activation with the appropriate RHIO.	Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 7e. - Identify and contract with a Consulting service to assist with a PCMH readiness assessment and implementation and collaborate with adjacent PPS' (as appropriate).	Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 7f. - Leverage the PCMH Readiness Assessment as a baseline to create a Meaningful Use and PCMH implementation plan for PPS providers. The plan will include a current state assessment for each PCP and detail key milestones which will allow for a phased implementation approach towards PCMH and Meaningful Use DY3, Q4 requirements.	Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 7g. - Monitor primary care access/capacity by performing a PPS survey through existing RMS panel resources and using	Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
available provider surveys, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Action plans will be developed, as needed, to address primary care access needs of the PPS.									
Task Step 7h. - The RPU Provider Relations professional will assist the PCPs with the associated application(s) throughout each phase of the PCMH Level 3 implementation plan.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 7i. - Obtain and retain certification documentation substantiating safety net providers within the PPS have achieved Meaningful Use and PCMH Level 3 standards.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 7j. - Provider Relations professionals will record, monitor, and communicate identified primary care physician needs by their assigned RPU.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Medicaid Managed Care contract(s) are in place that include value-based payments.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 8b. - Analyze the NYSDOH data related to the risk-adjusted cost of care as well as the potential (shared) savings, at both the total population level as per care bundle and subpopulation per the Value Based Purchasing (VBP) Roadmap, in order to identify best possible opportunities for PPS providers in their move towards VBP.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 8c. - Expand upon Baseline Assessment of VBP readiness creating a matrix of existing mechanisms both helping and hindering the implementation of the VBP model, including NYS VBP Roadmap, existing ACO and MCO models (as applicable), and other VBP models in the current marketplace.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 8d. - Analyze matrix of existing mechanisms both helping and hindering the implementation of VBP at the provider level of our PPS in order to identify which providers are best equipped to	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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lead the movement towards VBP based on their current level of VBP engagement.									
Task Step 8e. - Identify within the PPS providers who fall into one of three tiers: 1) Established - Providers currently utilizing VBP models 2) Enthusiastic and/or Equipped - Providers who are eager to pursue the movement towards VBP models and/or equipped to do so based on the helping/hindering matrix 3) Everyone else.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 8f. - Coordinate regional payor forums with PPS providers.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 8g. - Re-assess current landscape of VBP adoption throughout PPS by updating VBP Baseline Assessment, reviewing new information if available from the state and feedback from PPS Providers and MCOs regarding the payor forums as well as lessons learned from early adopters.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 8h. - Perform Gap Analysis based on updated matrix of PPS landscape.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 8i. - Coordinate additional regional payor forums with PPS providers based on Gap Analysis.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 8j. - Collectively review the level of VBP engagement and continue to encourage open dialogue among the PPS providers regarding VBP models and adoption.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 8k. - Update, modify and finalize VBP Adoption Plan	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	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	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 9b. - Establish VBP committee comprised of members from PPS constituency with representation from all provider types. VBP Committee will seek to follow & leverage industry wide VBP Prepatory Strategies via HANYS. (Step corresponds with Financial Sustainability Implementation Plan)	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 9c. - Cultivate pathways between VBP Committee and the rest of the system in order to survey and educate current landscape of existing VBP arrangements amongst PPS providers in PPS. (Step corresponds with Financial Sustainability Implementation Plan)	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 9d. - Create education and communication plan, including the myriad components intrinsic to VBP, particularly the different strata of risk. (Step corresponds with Financial Sustainability Implementation Plan)	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 9e. - Secure educational resources for outreach endeavors. (Step corresponds with Financial Sustainability Implementation Plan)	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 9f. - Carry out education and outreach endeavors for PPS providers ensuring a thorough understanding of the various VBP models and methods. Coordinate regional payor forums with providers in the region. (Step corresponds with Financial Sustainability Implementation Plan)	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 9g. - Create a readiness self-assessment survey (High, Moderate, Low) for individual providers within the PPS to assess the varying levels of evolution as movement towards fully implemented VBP occurs. The self-assessment survey will include the following (per the state): 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	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
network funds flow monitoring. Provider ability (financial stability) and willingness to take downside risk in a risk sharing arrangement. Level of assistance needed to negotiate plan options with Medicaid Managed Care (High, Moderate, Low). (Step corresponds with Financial Sustainability Implementation Plan)									
Task Step 9h. - Distribute the readiness self-assessment survey to all providers to establish accurate baseline. (Step corresponds with Financial Sustainability Implementation Plan)	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 9i. - Collect, assemble, and analyze readiness self-assessment survey results. (Step corresponds with Financial Sustainability Implementation Plan)	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 9j - Prepare Initial VBP Baseline Assessment based on readiness self-assessment survey results and dialogue from providers. (Step corresponds with Financial Sustainability Implementation Plan)	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 9k. - Disseminate preliminary results of readiness self-assessment survey analysis for review by PPS Providers. (Step corresponds with Financial Sustainability Implementation Plan)	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 9l. - Update, revise and finalize VBP Baseline Assessment based on Providers & Boards review. (Step corresponds with Financial Sustainability Implementation Plan)	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 9m. - PPS Board to sign off on preference for PPS providers to contract with MCO's at their own discretion. (Step corresponds with Financial Sustainability Implementation Plan)	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 9n. - Established VBP Committee will coordinate with Medicaid MCOs to schedule monthly meetings to discuss utilization trends, performance issues and payment reform based on VBP Adoption Plan.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	Project	N/A	In Progress	04/01/2015	06/30/2019	04/01/2015	06/30/2019	06/30/2019	DY5 Q1
Task	Project		In Progress	04/01/2015	06/30/2019	04/01/2015	06/30/2019	06/30/2019	DY5 Q1

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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.	Project		In Progress	04/01/2015	06/30/2019	04/01/2015	06/30/2019	06/30/2019	DY5 Q1
Task Step 10c. - Identify patient subgroups and populations and stratify by assigning risk values.	Project		In Progress	04/01/2015	06/30/2018	04/01/2015	06/30/2018	06/30/2018	DY4 Q1
Task Step 10d. - Conduct a provider analysis exercise to determine if the provider is better categorized as a "Large Organized Group Practice Provider" or an "Independent Provider."	Project		In Progress	04/01/2015	06/30/2018	04/01/2015	06/30/2018	06/30/2018	DY4 Q1
Task Step 10e. - Develop a contracting strategy which correlates DSRIP goals, timelines, patient risk stratification, and physician metrics and results with monetary incentive payments. As part of this process, a compensation model and implementation plan will be developed based on provider categorization. For "Large Organized Group Practice Providers" the PPS will integrate a value based system which focus' on an RVU and quality base. As noted in Step 1 above, Partnering Organizations will be contracted at the RPU level through Provider Relations professionals.	Project		In Progress	04/01/2015	12/31/2018	04/01/2015	12/31/2018	12/31/2018	DY4 Q3
Task Step 10f. - For physicians identified as "Independent Providers" the PPS will pursue value based contracts with their associated Medicaid MCO which includes the elements noted in Step 10b. section of the 2.a.i Implementation Plan.	Project		In Progress	04/01/2015	06/30/2019	04/01/2015	06/30/2019	06/30/2019	DY5 Q1
Task Step 10g. - The Provider Relations professionals, assigned at each RPU, will monitor contract compliance and pertinence of contractual terms to meet DSRIP goals as DSRIP implementation matures and develops. This may be achieved through leveraging the integrated delivery system model, including Population Health professionals as well as the PPS PMO. Results will be reviewed through the PPS PMO performance management process.	Project		In Progress	04/01/2015	06/30/2019	04/01/2015	06/30/2019	06/30/2019	DY5 Q1
Milestone #11 Engage patients in the integrated delivery system through	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	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
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	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 11b. - As noted above in Project 2.a.i Step 1f. and in line with the plan for project 2.d.i., the targeted patient population will be identified and consents subsequently obtained through the use of a robust contracted patient activation outreach worker team, as well as close collaboration with the community-based health navigation team (refer to Project 2.c.i.). These combined efforts, along with the training efforts that will occur through the patient activation training team for safety-net providers in the network, will ensure that the maximum number of individuals complete the PAM. Additionally, the PPS plans to embed the PAM survey in all safety-net practices at a minimum and will implement a process whereby all patients without insurance and all patients with Medicaid coverage will be given the PAM if it is determined they have not yet completed the survey. The PPS plans to leverage the RPU structure to achieve this efficiently and effectively (see attached for RPU structure).	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 11c. - A comprehensive incentive plan will be developed, which will compensate providers for their participation and will assign a value to each PAM survey that is collected. Additionally, the patient activation training team will work with the provider relations component of the PPS to inform providers about the overall DSRIP initiative and PPS objectives, in addition to patient activation and the PAM.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 11d. - A broad range of responsible individuals will receive training in the PAM, and the efforts will initially start out in the 9 hospitals within the PPS network, so that lessons learned can be applied as the project is expanded to other providers. To this effect, Project 2.a.i will work closely with Project 2.d.i. as well as with the Workforce Department group to ensure that the right skillset is matched up with each of the two position types.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 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 1a. - Develop a Participating Organization (e.g., provider) Network List for the PPS to outline the Partner Organization (e.g., providers, Community Based Organization (CBO), social service organizations, etc.) demographics for the PPS Integrated Delivery System.										
Task Step 1b. - Establish operating units for the PPS called Regional Performing Units (RPUs) within which the PPS Participating Organizations from across the nine county region can be identified and engaged at a localized level.										
Task Step 1c. Conduct a provider readiness survey and awareness campaign to position the PPS to contract with participating organizations and engage with safety net providers										
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Task Step 1e. Establish Participation Agreements for Participating Organizations within each RPU which contract PPS services required to achieve DSRIP goals, such as patient outreach and patient engagement. Manage ongoing process as needed.										
Task Step 1f. - When appropriate, engage payers at a PPS leadership level roundtable, to be completed at minimum annually and supported by meeting minutes.										
Task Step 1g. - The Provider Relations professionals will perform periodic (e.g., quarterly) assessments of PPS Partner Organizations to confirm relationships exist, are active, and overall participation and results are aligned with the contractual terms or overall needs of the PPS (e.g., updated CNA assessment, etc.) As a result of the quarterly reviews, any changes to the Provider Network List will be made and communicated, and the need for priority status may assigned to										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
further engage PPS Participating Organizations where needed.										
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.										
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Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.										
Task Step 2d. - Identify PPS HH and ACOs and create a Network Provider List. Integrate the Health Home representatives to recurring Stakeholder/ PAC meetings to ensure appropriate Health Home representation exists.										
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Task Step 2f. To the extent possible, identify and leverage Health Home-specific IT elements including case management information sharing, care coordination templates, connectivity/relation to the RHIO, etc.										
Task Step 2g. - To integrate the PPS and further promote the development of the integrated delivery system, assign an RPU Lead who will communicate and reinforce updates to and from the Clinical Governance Committee.										
Task Step 2h. - Note: There are currently no ACO's in place, nor in development, within the STRIPPS Partnering Organizations. This project requirement will be periodically reviewed for ongoing ACO pertinence.										
Milestone #3 Ensure patients receive appropriate health care and community										

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Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
support, including medical and behavioral health, post-acute care, long term care and public health services.										
Task Clinically Interoperable System is in place for all participating providers.										
Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.										
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Task Step 3f. - Development of a Standard PPS Care Coordination Plan which will be informed by the Care Coordination needs assessment and developed based on guidance provided by the RPU Quality Committee as well as the Clinical Governance Committee. Upon finalization, the Standard PPS Care Coordination Plan will be shared appropriately with the Partnering Organizations and made available on the Care Compass Network SharePoint site. To promote consistency of IDS protocols, education or tutorials may also be provided.										
Task Step 3g. - Implement a process to track performance within the Care Coordination Plan through periodic reporting, including services provided outside of hospitals in order to assist with service integration. RPU adherence to standards established by the Clinical Governance Committee, including Care Coordination Plans, will be monitored by the RPU Quality Committee.										
Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR 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.										
Task Step 4g. - Perform a current state assessment of safety net connectivity to region-specific RHIOs. Expand on the efforts in project 2.a.i. Project Requirement 1a. development of a Participating Organization (e.g., provider) Network List for the PPS which outlines the Partner Organization (e.g., providers, Community Based Organization (CBO), payers, social service organizations, etc.) demographics for the PPS Integrated Delivery System by including EHR system and connectivity demographic overviews for the safety net providers in the PPS.										
Task Step 4h. - Maintain ongoing communication with RHIO to identify potential capabilities relevant to PPS activities.										
Task Step 4i. - Upon provider completion of project 2.a.i. Project Requirement 5, which includes leveraging a consulting service to assist with a PCMH & Meaningful Use readiness assessment, creation & implementation of the associated implementation plan(s), provide assistance with the application process, and formally document/retain certification related documentation; the PPS IT Coordinator will review and monitor the IT environment to confirm EHR system capabilities are in place are used and functioning as designed ensuring access to real-time data to improve interoperability. Periodic reviews will be performed and include evidence of alerts/secure messaging, availability of training materials, training(s) completed, and percentage of staff trained. The status of these reviews will be reported at minimally quarterly to the IT & Data Governance Committee and/or Clinical Governance Committee as appropriate.										
Task Step 4j. - The PPS will support partners (e.g., CBOs, providers, etc.) in actively sharing by promoting infrastructure build and/or other requirements as identified by the current state assessment above. As appropriate, partners will be contracted with the PPS for achievement of specific tasks, which will be monitored for										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
completion as reported to the RPU Clinical Quality Committees for review.										
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	0	0	0	0	0	0	0	0	0
Task Step 5c. - In conjunction with project 2.a.i. Project Requirement 4, utilize the PPS IT and Data Governance team to identify Safety Net Providers preparation requirements for activation with the RHIO. When needed, utilize the PPS IT Coordinator to coordinate resources needed for Safety Net Provider(s) activation with the appropriate RHIO.										
Task Step 5d. - Using the readiness assessment (See 2.a.i Milestone 1, Step 1c), determine PPS providers' status on achievement of PCMH and Meaningful Use requirements.										
Task Step 5e. - Identify and contract with a Consulting service to assist with a PCMH readiness assessment and implementation and collaborate with adjacent PPS' (as appropriate).										
Task Step 5f. - Leverage the PCMH Readiness Assessment as a baseline to create a Meaningful Use and PCMH implementation plan for PPS providers. The plan will include a current state assessment for each safety net provider and detail key milestones which will allow for a phased implementation approach towards PCMH and Meaningful Use DY3, Q4 requirements.										
Task Step 5g. - The RPU Provider Relations professionals will assist safety net providers with the associated application(s) throughout each phase of the PCMH Level 3 implementation plan.										
Task Step 5h. - Obtain and retain certification documentation substantiating safety net providers within the PPS have achieved Meaningful Use and PCMH Level 3 standards.										
Milestone #6 Perform population health management by actively using EHRs										

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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 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 6b. - Identify those person(s) responsible for review of population health data and provide requisite HIPAA, PHI, and regulatory training to ensure overall PPS compliance. As applicable, obtain DEAA, BAA, or other required arrangement.										
Task Step 6c. - Identify data elements specified in DSRIP requirements.										
Task Step 6d. - Initiate population health management with available patient data, such as Salient and participating provider clinical systems.										
Task Step 6e. - Identify available patient health registries and population health software.										
Task Step 6f. - Develop a population health stratification approach to confirm EHR completeness and validity.										
Task Step 6g. - Develop a population health stratification approach to identify patient groups for targeting.										
Task Step 6h. - Develop a defined population health registry for individual patients for enhanced care management and each RPU.										
Task Step 6i. - Develop a dictionary of registry elements to ensure ease of implementation and standardization of use PPS-wide.										
Task Step 6j. - Develop a monitoring process which allows for the RPU Leads to actively track patients for metrics such as status (engaged/not engaged) and performance against project milestones, to be included in reporting at the PPS level.										
Task Step 6k. - Perform periodic reviews of user access and system requirements to perform population health management.										
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										

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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, and meet EHR Meaningful Use standards by the end of DY 3.										
Task Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.										
Task All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.	0	0	0	0	0	0	0	0	75	151
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 7d. - In conjunction with project 2.a.i. Project Requirement 4, utilize the PPS IT and Data Governance team to identify all participating PCPs for activation with the RHIO. When needed, utilize the PPS IT Coordinator to coordinate resources needed for Primary Care Providers (PCPs) activation with the appropriate RHIO.										
Task Step 7e. - Identify and contract with a Consulting service to assist with a PCMH readiness assessment and implementation and collaborate with adjacent PPS' (as appropriate).										
Task Step 7f. - Leverage the PCMH Readiness Assessment as a baseline to create a Meaningful Use and PCMH implementation plan for PPS providers. The plan will include a current state assessment for each PCP and detail key milestones which will allow for a phased implementation approach towards PCMH and Meaningful Use DY3, Q4 requirements.										
Task Step 7g. - Monitor primary care access/capacity by performing a PPS survey through existing RMS panel resources and using available provider surveys, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Action plans will be developed, as needed, to address primary care access needs of the PPS.										
Task Step 7h. - The RPU Provider Relations professional will assist the PCPs with the associated application(s) throughout each phase of the PCMH Level 3 implementation plan.										
Task Step 7i. - Obtain and retain certification documentation substantiating safety net providers within the PPS have achieved Meaningful Use and PCMH Level 3 standards.										

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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 7j. - Provider Relations professionals will record, monitor, and communicate identified primary care physician needs by their assigned RPU.										
Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.										
Task Medicaid Managed Care contract(s) are in place that include value-based payments.										
Task Step 8b. - Analyze the NYSDOH data related to the risk-adjusted cost of care as well as the potential (shared) savings, at both the total population level as per care bundle and subpopulation per the Value Based Purchasing (VBP) Roadmap, in order to identify best possible opportunities for PPS providers in their move towards VBP.										
Task Step 8c. - Expand upon Baseline Assessment of VBP readiness creating a matrix of existing mechanisms both helping and hindering the implementation of the VBP model, including NYS VBP Roadmap, existing ACO and MCO models (as applicable), and other VBP models in the current marketplace.										
Task Step 8d. - Analyze matrix of existing mechanisms both helping and hindering the implementation of VBP at the provider level of our PPS in order to identify which providers are best equipped to lead the movement towards VBP based on their current level of VBP engagement.										
Task Step 8e. - Identify within the PPS providers who fall into one of three tiers: 1) Established - Providers currently utilizing VBP models 2) Enthusiastic and/or Equipped - Providers who are eager to pursue the movement towards VBP models and/or equipped to do so based on the helping/hindering matrix 3) Everyone else.										
Task Step 8f. - Coordinate regional payor forums with PPS providers.										
Task Step 8g. - Re-assess current landscape of VBP adoption throughout PPS by updating VBP Baseline 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
reviewing new information if available from the state and feedback from PPS Providers and MCOs regarding the payor forums as well as lessons learned from early adopters.										
Task Step 8h. - Perform Gap Analysis based on updated matrix of PPS landscape.										
Task Step 8i. - Coordinate additional regional payor forums with PPS providers based on Gap Analysis.										
Task Step 8j. - Collectively review the level of VBP engagement and continue to encourage open dialogue among the PPS providers regarding VBP models and adoption.										
Task Step 8k. - Update, modify and finalize VBP Adoption Plan										
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 9b. - Establish VBP committee comprised of members from PPS constituency with representation from all provider types. VBP Committee will seek to follow & leverage industry wide VBP Prepatory Strategies via HANYS. (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9c. - Cultivate pathways between VBP Committee and the rest of the system in order to survey and educate current landscape of existing VBP arrangements amongst PPS providers in PPS. (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9d. - Create education and communication plan, including the myriad components intrinsic to VBP, particularly the different strata of risk. (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9e. - Secure educational resources for outreach endeavors. (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9f. - Carry out education and outreach endeavors for PPS providers ensuring a thorough understanding of the various VBP										

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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
models and methods. Coordinate regional payor forums with providers in the region. (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9g. - Create a readiness self-assessment survey (High, Moderate, Low) for individual providers within the PPS to assess the varying levels of evolution as movement towards fully implemented VBP occurs. The self-assessment survey will include the following (per the state): 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. Level of assistance needed to negotiate plan options with Medicaid Managed Care (High, Moderate, Low). (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9h. - Distribute the readiness self-assessment survey to all providers to establish accurate baseline. (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9i. - Collect, assemble, and analyze readiness self-assessment survey results. (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9j - Prepare Initial VBP Baseline Assessment based on readiness self-assessment survey results and dialogue from providers. (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9k. - Disseminate preliminary results of readiness self-assessment survey analysis for review by PPS Providers. (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9l. - Update, revise and finalize VBP Baseline Assessment based on Providers & Boards review. (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9m. - PPS Board to sign off on preference for PPS providers to contract with MCO's at their own discretion. (Step corresponds with Financial Sustainability Implementation Plan)										

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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 9n. - Established VBP Committee will coordinate with Medicaid MCOs to schedule monthly meetings to discuss utilization trends, performance issues and payment reform based on VBP Adoption Plan.										
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 10c. - Identify patient subgroups and populations and stratify by assigning risk values.										
Task Step 10d. - Conduct a provider analysis exercise to determine if the provider is better categorized as a "Large Organized Group Practice Provider" or an "Independent Provider."										
Task Step 10e. - Develop a contracting strategy which correlates DSRIP goals, timelines, patient risk stratification, and physician metrics and results with monetary incentive payments. As part of this process, a compensation model and implementation plan will be developed based on provider categorization. For "Large Organized Group Practice Providers" the PPS will integrate a value based system which focus' on an RVU and quality base. As noted in Step 1 above, Partnering Organizations will be contracted at the RPU level through Provider Relations professionals.										
Task Step 10f. - For physicians identified as "Independent Providers" the PPS will pursue value based contracts with their associated Medicaid MCO which includes the elements noted in Step 10b. section of the 2.a.i Implementation Plan.										
Task Step 10g. - The Provider Relations professionals, assigned at each RPU, will monitor contract compliance and pertinence of contractual terms to meet DSRIP goals as DSRIP implementation matures and develops. This may be achieved through leveraging the integrated delivery system model, including Population Health professionals as well as the PPS PMO. Results will be reviewed through the PPS PMO performance management 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
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 11b. - As noted above in Project 2.a.i Step 1f. and in line with the plan for project 2.d.i., the targeted patient population will be identified and consents subsequently obtained through the use of a robust contracted patient activation outreach worker team, as well as close collaboration with the community-based health navigation team (refer to Project 2.c.i.). These combined efforts, along with the training efforts that will occur through the patient activation training team for safety-net providers in the network, will ensure that the maximum number of individuals complete the PAM. Additionally, the PPS plans to embed the PAM survey in all safety-net practices at a minimum and will implement a process whereby all patients without insurance and all patients with Medicaid coverage will be given the PAM if it is determined they have not yet completed the survey. The PPS plans to leverage the RPU structure to achieve this efficiently and effectively (see attached for RPU structure).										
Task Step 11c. - A comprehensive incentive plan will be developed, which will compensate providers for their participation and will assign a value to each PAM survey that is collected. Additionally, the patient activation training team will work with the provider relations component of the PPS to inform providers about the overall DSRIP initiative and PPS objectives, in addition to patient activation and the PAM.										
Task Step 11d. - A broad range of responsible individuals will receive training in the PAM, and the efforts will initially start out in the 9 hospitals within the PPS network, so that lessons learned can be applied as the project is expanded to other providers. To this effect, Project 2.a.i will work closely with Project 2.d.i. as well as with the Workforce Department group to ensure that the right skillset is matched up with each of the two position types.										

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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 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.										
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Task Step 1b. - Establish operating units for the PPS called Regional Performing Units (RPUs) within which the PPS Participating Organizations from across the nine county region can be identified and engaged at a localized level.										
Task Step 1c. Conduct a provider readiness survey and awareness campaign to position the PPS to contract with participating organizations and engage with safety net providers										
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Task Step 1e. Establish Participation Agreements for Participating Organizations within each RPU which contract PPS services required to achieve DSRIP goals, such as patient outreach and patient engagement. Manage ongoing process as needed.										
Task Step 1f. - When appropriate, engage payers at a PPS leadership level roundtable, to be completed at minimum annually and supported by meeting minutes.										
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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
further engage PPS Participating Organizations where needed.										
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 2d. - Identify PPS HH and ACOs and create a Network Provider List. Integrate the Health Home representatives to recurring Stakeholder/ PAC meetings to ensure appropriate Health Home representation exists.										
Task Step 2e. - Review existing Health Home systems and capabilities, particularly the Health Home system architecture and how information is disseminated, and integrate leading practices/service models to the PPS Operating Model at the RPU level. On an ongoing basis, the RPU Project Managers will monitor results and progress to centrally communicate how to further refine the PPS approach or customize the service model at the RPU level.										
Task Step 2f. To the extent possible, identify and leverage Health Home-specific IT elements including case management information sharing, care coordination templates, connectivity/relation to the RHIO, etc.										
Task Step 2g. - To integrate the PPS and further promote the development of the integrated delivery system, assign an RPU Lead who will communicate and reinforce updates to and from the Clinical Governance Committee.										
Task Step 2h. - Note: There are currently no ACO's in place, nor in development, within the STRIPPS Partnering Organizations. This project requirement will be periodically reviewed for ongoing ACO pertinence.										
Milestone #3 Ensure patients receive appropriate health care and community										

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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
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 3f. - Development of a Standard PPS Care Coordination Plan which will be informed by the Care Coordination needs assessment and developed based on guidance provided by the RPU Quality Committee as well as the Clinical Governance Committee. Upon finalization, the Standard PPS Care Coordination Plan will be shared appropriately with the Partnering Organizations and made available on the Care Compass Network SharePoint site. To promote consistency of IDS protocols, education or tutorials may also be provided.										
Task Step 3g. - Implement a process to track performance within the Care Coordination Plan through periodic reporting, including services provided outside of hospitals in order to assist with service integration. RPU adherence to standards established by the Clinical Governance Committee, including Care Coordination Plans, will be monitored by the RPU Quality Committee.										
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	62	62	62	62	62	62	62	62	62
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	81	81	81	81	81	81	81	81	81

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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 connectivity to RHIO's HIE and SHIN-NY requirements.	0	9	9	9	9	9	9	9	9	9
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	44	44	44	44	44	44	44	44	44
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	22	22	22	22	22	22	22	22	22
Task PPS uses alerts and secure messaging functionality.										
Task Step 4g. - Perform a current state assessment of safety net connectivity to region-specific RHIOs. Expand on the efforts in project 2.a.i. Project Requirement 1a. development of a Participating Organization (e.g., provider) Network List for the PPS which outlines the Partner Organization (e.g., providers, Community Based Organization (CBO), payers, social service organizations, etc.) demographics for the PPS Integrated Delivery System by including EHR system and connectivity demographic overviews for the safety net providers in the PPS.										
Task Step 4h. - Maintain ongoing communication with RHIO to identify potential capabilities relevant to PPS activities.										
Task Step 4i. - Upon provider completion of project 2.a.i. Project Requirement 5, which includes leveraging a consulting service to assist with a PCMH & Meaningful Use readiness assessment, creation & implementation of the associated implementation plan(s), provide assistance with the application process, and formally document/retain certification related documentation; the PPS IT Coordinator will review and monitor the IT environment to confirm EHR system capabilities are in place are used and functioning as designed ensuring access to real-time data to improve interoperability. Periodic reviews will be performed and include evidence of alerts/secure messaging, availability of training materials, training(s) completed, and percentage of staff trained. The status of these reviews will be reported at minimally quarterly to the IT & Data Governance Committee and/or Clinical Governance Committee as appropriate.										
Task Step 4j. - The PPS will support partners (e.g., CBOs, providers, etc.) in actively sharing by promoting infrastructure build and/or other requirements as identified by the current state assessment above. As appropriate, partners will be contracted with the PPS for achievement of specific tasks, which will be monitored for										

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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
completion as reported to the RPU Clinical Quality Committees for review.										
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	62	62	62	62	62	62	62	62	62
Task Step 5c. - In conjunction with project 2.a.i. Project Requirement 4, utilize the PPS IT and Data Governance team to identify Safety Net Providers preparation requirements for activation with the RHIO. When needed, utilize the PPS IT Coordinator to coordinate resources needed for Safety Net Provider(s) activation with the appropriate RHIO.										
Task Step 5d. - Using the readiness assessment (See 2.a.i Milestone 1, Step 1c), determine PPS providers' status on achievement of PCMH and Meaningful Use requirements.										
Task Step 5e. - Identify and contract with a Consulting service to assist with a PCMH readiness assessment and implementation and collaborate with adjacent PPS' (as appropriate).										
Task Step 5f. - Leverage the PCMH Readiness Assessment as a baseline to create a Meaningful Use and PCMH implementation plan for PPS providers. The plan will include a current state assessment for each safety net provider and detail key milestones which will allow for a phased implementation approach towards PCMH and Meaningful Use DY3, Q4 requirements.										
Task Step 5g. - The RPU Provider Relations professionals will assist safety net providers with the associated application(s) throughout each phase of the PCMH Level 3 implementation plan.										
Task Step 5h. - Obtain and retain certification documentation substantiating safety net providers within the PPS have achieved Meaningful Use and PCMH Level 3 standards.										
Milestone #6 Perform population health management by actively using EHRs										

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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 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 6b. - Identify those person(s) responsible for review of population health data and provide requisite HIPAA, PHI, and regulatory training to ensure overall PPS compliance. As applicable, obtain DEAA, BAA, or other required arrangement.										
Task Step 6c. - Identify data elements specified in DSRIP requirements.										
Task Step 6d. - Initiate population health management with available patient data, such as Salient and participating provider clinical systems.										
Task Step 6e. - Identify available patient health registries and population health software.										
Task Step 6f. - Develop a population health stratification approach to confirm EHR completeness and validity.										
Task Step 6g. - Develop a population health stratification approach to identify patient groups for targeting.										
Task Step 6h. - Develop a defined population health registry for individual patients for enhanced care management and each RPU.										
Task Step 6i. - Develop a dictionary of registry elements to ensure ease of implementation and standardization of use PPS-wide.										
Task Step 6j. - Develop a monitoring process which allows for the RPU Leads to actively track patients for metrics such as status (engaged/not engaged) and performance against project milestones, to be included in reporting at the PPS level.										
Task Step 6k. - Perform periodic reviews of user access and system requirements to perform population health management.										
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										

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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
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.	225	301	301	301	301	301	301	301	301	301
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 7d. - In conjunction with project 2.a.i. Project Requirement 4, utilize the PPS IT and Data Governance team to identify all participating PCPs for activation with the RHIO. When needed, utilize the PPS IT Coordinator to coordinate resources needed for Primary Care Providers (PCPs) activation with the appropriate RHIO.										
Task Step 7e. - Identify and contract with a Consulting service to assist with a PCMH readiness assessment and implementation and collaborate with adjacent PPS' (as appropriate).										
Task Step 7f. - Leverage the PCMH Readiness Assessment as a baseline to create a Meaningful Use and PCMH implementation plan for PPS providers. The plan will include a current state assessment for each PCP and detail key milestones which will allow for a phased implementation approach towards PCMH and Meaningful Use DY3, Q4 requirements.										
Task Step 7g. - Monitor primary care access/capacity by performing a PPS survey through existing RMS panel resources and using available provider surveys, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Action plans will be developed, as needed, to address primary care access needs of the PPS.										
Task Step 7h. - The RPU Provider Relations professional will assist the PCPs with the associated application(s) throughout each phase of the PCMH Level 3 implementation plan.										
Task Step 7i. - Obtain and retain certification documentation substantiating safety net providers within the PPS have achieved Meaningful Use and PCMH Level 3 standards.										

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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 7j. - Provider Relations professionals will record, monitor, and communicate identified primary care physician needs by their assigned RPU.										
Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.										
Task Medicaid Managed Care contract(s) are in place that include value-based payments.										
Task Step 8b. - Analyze the NYSDOH data related to the risk-adjusted cost of care as well as the potential (shared) savings, at both the total population level as per care bundle and subpopulation per the Value Based Purchasing (VBP) Roadmap, in order to identify best possible opportunities for PPS providers in their move towards VBP.										
Task Step 8c. - Expand upon Baseline Assessment of VBP readiness creating a matrix of existing mechanisms both helping and hindering the implementation of the VBP model, including NYS VBP Roadmap, existing ACO and MCO models (as applicable), and other VBP models in the current marketplace.										
Task Step 8d. - Analyze matrix of existing mechanisms both helping and hindering the implementation of VBP at the provider level of our PPS in order to identify which providers are best equipped to lead the movement towards VBP based on their current level of VBP engagement.										
Task Step 8e. - Identify within the PPS providers who fall into one of three tiers: 1) Established - Providers currently utilizing VBP models 2) Enthusiastic and/or Equipped - Providers who are eager to pursue the movement towards VBP models and/or equipped to do so based on the helping/hindering matrix 3) Everyone else.										
Task Step 8f. - Coordinate regional payor forums with PPS providers.										
Task Step 8g. - Re-assess current landscape of VBP adoption throughout PPS by updating VBP Baseline Assessment,										

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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
reviewing new information if available from the state and feedback from PPS Providers and MCOs regarding the payor forums as well as lessons learned from early adopters.										
Task Step 8h. - Perform Gap Analysis based on updated matrix of PPS landscape.										
Task Step 8i. - Coordinate additional regional payor forums with PPS providers based on Gap Analysis.										
Task Step 8j. - Collectively review the level of VBP engagement and continue to encourage open dialogue among the PPS providers regarding VBP models and adoption.										
Task Step 8k. - Update, modify and finalize VBP Adoption Plan										
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 9b. - Establish VBP committee comprised of members from PPS constituency with representation from all provider types. VBP Committee will seek to follow & leverage industry wide VBP Prepatory Strategies via HANYS. (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9c. - Cultivate pathways between VBP Committee and the rest of the system in order to survey and educate current landscape of existing VBP arrangements amongst PPS providers in PPS. (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9d. - Create education and communication plan, including the myriad components intrinsic to VBP, particularly the different strata of risk. (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9e. - Secure educational resources for outreach endeavors. (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9f. - Carry out education and outreach endeavors for PPS providers ensuring a thorough understanding of the various VBP										

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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
models and methods. Coordinate regional payor forums with providers in the region. (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9g. - Create a readiness self-assessment survey (High, Moderate, Low) for individual providers within the PPS to assess the varying levels of evolution as movement towards fully implemented VBP occurs. The self-assessment survey will include the following (per the state): 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. Level of assistance needed to negotiate plan options with Medicaid Managed Care (High, Moderate, Low). (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9h. - Distribute the readiness self-assessment survey to all providers to establish accurate baseline. (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9i. - Collect, assemble, and analyze readiness self-assessment survey results. (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9j - Prepare Initial VBP Baseline Assessment based on readiness self-assessment survey results and dialogue from providers. (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9k. - Disseminate preliminary results of readiness self-assessment survey analysis for review by PPS Providers. (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9l. - Update, revise and finalize VBP Baseline Assessment based on Providers & Boards review. (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9m. - PPS Board to sign off on preference for PPS providers to contract with MCO's at their own discretion. (Step corresponds with Financial Sustainability Implementation Plan)										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Step 9n. - Established VBP Committee will coordinate with Medicaid MCOs to schedule monthly meetings to discuss utilization trends, performance issues and payment reform based on VBP Adoption Plan.										
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 10c. - Identify patient subgroups and populations and stratify by assigning risk values.										
Task Step 10d. - Conduct a provider analysis exercise to determine if the provider is better categorized as a "Large Organized Group Practice Provider" or an "Independent Provider."										
Task Step 10e. - Develop a contracting strategy which correlates DSRIP goals, timelines, patient risk stratification, and physician metrics and results with monetary incentive payments. As part of this process, a compensation model and implementation plan will be developed based on provider categorization. For "Large Organized Group Practice Providers" the PPS will integrate a value based system which focus' on an RVU and quality base. As noted in Step 1 above, Partnering Organizations will be contracted at the RPU level through Provider Relations professionals.										
Task Step 10f. - For physicians identified as "Independent Providers" the PPS will pursue value based contracts with their associated Medicaid MCO which includes the elements noted in Step 10b. section of the 2.a.i Implementation Plan.										
Task Step 10g. - The Provider Relations professionals, assigned at each RPU, will monitor contract compliance and pertinence of contractual terms to meet DSRIP goals as DSRIP implementation matures and develops. This may be achieved through leveraging the integrated delivery system model, including Population Health professionals as well as the PPS PMO. Results will be reviewed through the PPS PMO performance management process.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #11 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 11b. - As noted above in Project 2.a.i Step 1f. and in line with the plan for project 2.d.i., the targeted patient population will be identified and consents subsequently obtained through the use of a robust contracted patient activation outreach worker team, as well as close collaboration with the community-based health navigation team (refer to Project 2.c.i.). These combined efforts, along with the training efforts that will occur through the patient activation training team for safety-net providers in the network, will ensure that the maximum number of individuals complete the PAM. Additionally, the PPS plans to embed the PAM survey in all safety-net practices at a minimum and will implement a process whereby all patients without insurance and all patients with Medicaid coverage will be given the PAM if it is determined they have not yet completed the survey. The PPS plans to leverage the RPU structure to achieve this efficiently and effectively (see attached for RPU structure).										
Task Step 11c. - A comprehensive incentive plan will be developed, which will compensate providers for their participation and will assign a value to each PAM survey that is collected. Additionally, the patient activation training team will work with the provider relations component of the PPS to inform providers about the overall DSRIP initiative and PPS objectives, in addition to patient activation and the PAM.										
Task Step 11d. - A broad range of responsible individuals will receive training in the PAM, and the efforts will initially start out in the 9 hospitals within the PPS network, so that lessons learned can be applied as the project is expanded to other providers. To this effect, Project 2.a.i will work closely with Project 2.d.i. as well as with the Workforce Department group to ensure that the right skillset is matched up with each of the two position types.										

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	rachaelm	Meeting Materials	44_PMDL2003_1_2_20151030131748_Contact List + Meetings - Highlight HH.pdf	As per requirement for Milestone 2, evidence of meetings to develop collaborative care practices and IDS - Health Home representation highlighted for reference.	10/30/2015 01:17 PM
	rachaelm	Communication Documentation	44_PMDL2003_1_2_20151030122310_STRIPPS PAC Meeting 06122015_MR_RKE.pptx	As per requirements for Milestone 2, evidence of interaction and HH-IDS progress. Additional Note: No contracts in place as of DY1, Q2. Written agreements to follow.	10/30/2015 12:23 PM
	rachaelm	Other	44_PMDL2003_1_2_20151029170446_CCN Participating Health Homes.xlsx	As per requirement for Milestone 2, an updated list of participating Health Homes.	10/29/2015 05:04 PM

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.	In Progress - The Participating Organization Network List for Care Compass Network has been updated on a regular basis by Provider Relations / Outreach Coordinator staff over the course of DY1, Q2. This list has been reviewed at multiple meetings including the CBO Engagement Council as well as Regional Performing Unit (RPU) Operating Groups to ensure that integral providers are included in the PPS network, positioning Care Compass Network for successful performance (Step 1a - Complete). This list is central to the PPS operations and will continue to be modified and built on throughout the five year DSRIP period. Furthermore, Regional Performing Units (RPUs) have been established and operations meetings have begun for all four regions (North, South, East, and West) in the Q2 timeframe (Step 1b - Complete). Each week, the RPU Leaders gather in a central meeting, the CBO Engagement Council, to promote the alignment and continued integration of the RPUs to ensure consistent messaging and communications at each of the four RPUs. The provider readiness assessment was also distributed as early as the end of DY1, Q1 and continued to be distributed to partners and potential partners throughout DY1, Q2 with over 90 organizations participating (Step 1c). This assessment was developed by the CBO Engagement Council and distributed with the aid of its members as well as the localized RPUs in addition to their efforts to identify any missing organizations that might be interested in participating. It is anticipated that awareness efforts will commence in DY1, Q3 as contracting discussions begin with Care Compass Network partners including Safety Net Providers (Step 1d). Progress towards the remaining steps and milestone remain on target for Completion by the associated due date.
Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	Complete - The Health Home model has proven to be valuable in informing the Care Compass Network approach to DSRIP, with many overlapping elements including, but not limited to, the integrated delivery approach and case management/care coordination and the opt-out process. As such CCN has engaged with the largest health home in the PPS to provide representation (Annie Bishop, Administrative Manager, UHS Medicaid Health Home) in various committees and councils, where she serves several roles including member of the South RPU Onboarding Quality Committee, Care Compass Network Clinical Governance Committee, and Coordinating Council, and Chairperson for the Cultural Competency and Health Literacy Committee (Step 2c). Through this integration of Health Home representation, Health Home models, systems, and techniques utilized can be disseminated by other project teams (Step 2d). To summarize a few topics, Health Home experiences have led multiple discussions overviewing their leadership in the fields of real service integration and population management strategies (Step 2b) including the utilization of acuity scores in the care coordination setting, utilization of state populated systems versus home grown systems, approaches and successes regarding patient consenting and outreach efforts, and communication strategies for how to otherwise engage with beneficiaries (Step 2f). Overall, the Health Homes from across the CCN nine county regions include ten total Health Home locations, representing five different organizations. Of these five organizations there is overlap with adjacent PPSs, including FLPPS and the Bassett PPS for two

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	Health Homes. Each of the three Health Homes attributed to CCN have attested with CCN and are included in the MAPP Partner List (Step 2a). To promote the Health Home experiences in service integration towards building the Integrated Delivery System (IDS) the PAC Executive Council coordinated a presentation from Julie Smith (Division Director of Mental Health Services, Catholic Charities of Broome County), one of the three CCN Health Homes during a PPS-wide stakeholders meeting on June 12, 2015. Health Home representatives consistently attend Stakeholder / PAC meetings. Additionally, Health Home organizations have attested with Care Compass Network and are included on the Network Provider list. The pre-engagement assessment conducted PPS-wide allowed for the CBO Engagement Council and RPU Leads to review Health Home systems and capabilities (Step 2f). Each week, the RPU Leads provider updates to the CBO Engagement Council regarding outreach and engagement efforts at the local level (Step 2e). Each respective RPU has been assigned an RPU Lead, or in some cases 'co-leads' to facilitate communication between their region and the Clinical Governance Committee (Step 2g) in order to establish and reinforce an integrated delivery system structure which is as follows: North RPU – Amy Gecan (Director System Integration, Operations, & Access, Cayuga Medical Center) South RPU – Robin Kinslow-Evans (VP Strategy & Market Development, UHS) & Wayne Mitteer (Executive Advisor, Our Lady of Lourdes) East – Greg Rittenhouse (VP, COO, UHS Home Care) West – Laura Manning (Administration, The Guthrie Clinic) & Robin Stawasz (Access Director, CareFirst) In Q2 the primary function of the leads has been to oversee the development of the Clinical Governance Committee quality sub-committees at the respective regional locations. Under the direction of the Clinical Governance Committee chair, each has completed the development of the framework, identified qualified candidates to represent the region & skillsets on the Clinical Governance Committee and prepared slates for each of the regional quality committees. There continues to be no ACOs within Care Compass Network territory as of DY1, Q2 (Step 2h).
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	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	In Progress - This Milestone is due for completion at DY1, Q4 and has 12 associated steps for implementation targeted for completion between DY1, Q2 and DY1, Q4. The Finance Committee discussed the Value-Based Payment (VBP) planning efforts, including summary of items prepared by HANYS as well as CCN commitment as outlined in the DSRIP application during the August 3 meeting. The Finance Committee agreed on August 3 to coordinate the establishment of the VBP subcommittee chaired by John Collett, CFO, Cayuga Medical Center which was seated and met on August 10. The VBP subcommittee is comprised of membership representing hospitals, homecare agencies, skilled nursing homes, outpatient services, and CBOs (Step 9b.). Throughout Q2 the VBP subcommittee completed three meetings, the outcomes and minutes from which were subsequently presented at the following Finance Committee meeting. As part of the DY1Q2 deliverables, the VBP Committee has cultivated pathways (Step 9c.) between the committee and the rest of the system in order to survey and educate the current landscape of existing VBP arrangements amongst providers within the PPS. An education and communication plan was created and reviewed at the VBP committee meeting on 09/14/2015 (Step 9d.) and approved by the VBP subcommittee on 09/14/2015, being based on the VBP roadmap as released on July 22nd, 2015 by New York State Department of Health. On September 30th, 2015 a contract was executed with a vendor who has a high level of expertise and experience in Value-Based Payment arrangements, securing educational resources for the outreach endeavors with the anticipation of completing those endeavors by December 31st, 2015 (Step 9e.). Successful completion of the endeavors is defined as a VBP presentation at each of the RPUs (North/South/East/West) as well as the PAC (Total 5 times). The PAC presentation will be a recorded webinar and made available on the Care Compass Network website for those who were unable to attend an in-person presentation. Future steps to implementation are on target for completion. The readiness self-assessment survey is scheduled for review by the Value-Based Payment Committee on October 19th, 2015 and will be open for a comment period through October 30th, 2015, after which the survey will be sent to partner organizations in November for returns to be collected, assembled, and analyzed by the DY1, Q3 requirement. Additional steps will follow as identified in the implementation plan for this milestone. Overall progress of the steps and Milestone are on track with no barriers identified which would prevent completion by the respective due dates.
Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	
Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	

Milestone Review Status

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

1. The first risk facing our project is a potential difficulty in engaging providers. This is especially true considering the variety of providers inherent to our project – we have a total of 261 providers across the spectrum of healthcare. It is obvious to us that we will have to deal with the risk of how to engage such a widely cast net. Nuance and particularity will be needed as we seek out the participation of these various providers.
This has a direct impact on our project in that non-engaged providers equates to not being able to achieve the requirements set forth by the State for our project. Participation and collaboration are needed not only for the sake of the DSRIP project itself, but its larger endeavor of patient health and cost savings.
A mitigation strategy will be the development of a comprehensive communications strategy by the PPS Provider Relations and Communications staff. These teams will be responsible to carry a unified message across their Regional Performance Units (RPU). Provider engagement and readiness will take place at the RPU level utilizing standardized education materials to guide providers as well as to facilitate patient engagement.
2. Our second risk focuses on an insufficient capacity for providers to expand access or add complexity to existing workflows. This will impact our project in that continued fragmentation of services, delays in post-acute care follow-up and readmissions within 30 days will be consequences of an unaltered work flow. To mitigate this risk we plan on implementing care management/coordination work flow system including standardized protocols. Utilization of care coordination software and an integrated electronic health record with connectivity to the RHIO are essential to creating capacity within the provider network. This will be a task done in conjunction with the IT Committee.
3. Our third identified risk centers on the consistent deployment of targeted interventions/solutions across the PPS. It is recognized there will be a degree of variability at the RPU level given availability of services and resources. This will impact the project by creating a varying level of participation by providers. The level of ability to accept and employ targeted inventions and solutions will affect the level to which the project is successful. To mitigate this risk, we propose a six-step approach to ensure consistent deployment of targeted interventions across the PPS and accomplish overall project goals: 1. ensure clinical partners are fully aware and appropriately engaged in the CTP program, 2. routine case identification of Medicaid participants is necessary for program enrollment, 3. engage Hospice as appropriate, 4. home visits by a CTP RN will be scheduled prior to patient discharge, 5. timely follow up with Care Providers, 6. utilize Remote Patient Monitoring (RPM).

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Care Compass Network (PPS ID:44)

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	11,331

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
0	0	0.00%	1,700	0.00%

Warning: Please note that your patients engaged to date does not meet your committed amount (1,700)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

While there were no executed contracts in the Q2 timeframe, two of the PPSs nine attested partners self-reported completed care transitions eligible for current speed and scale metrics which totaled 1,182 for the period April 1, 2015 through September 30, 2015. During the Q2 timeframe the PPS speed and scale commitments for project 2biv totaled 1,700. Also, CCN is investigating how speed and scale calculations and requirements are setup in the Salient system for the 2biv project. Currently, the Salient bookmark/collections for the 2biv project exclude discharges for natural birth or cesareans section maternity visits. The CCN project team has concerns with excluding discharged mothers and babies from the project as these represent vulnerable populations who would benefit from the services made available from a post discharge 30 day care plan, applicable related home visits, etc. developed by the 2biv project. Without proper guidance the CCN team has reported the conservative number of self-reported care transitions above. If the IA were to deem the entire Medicaid population which were discharged with no restrictions as acceptable to this project, regardless of how Salient data mining features are established, CCN would be in a position to report roughly double for the same time period, well above the Q2 speed and scale requirement of 1,700.

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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 DY1,Q2.

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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 1b. The 2biv Project Team, through the Clinical Governance Committee and Board of Directors will identify and adopt evidence-based Care Transition Intervention Models appropriate for implementation and adoption by the Performing Provider System (PPS).	Project		Completed	04/01/2015	12/31/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 1c. Using the approved Care Transition Protocols, the 2biv Project Team and Project Champion from each of the nine PPS hospitals will perform a facility gap analysis to identify differences between the hospital care transition operating model versus the PPS Care Transition Plan. Following the assessment, the PPS will engage with hospitals who meet the criteria of the PPS Care Transition Protocol for Care Transitions Work. Organizations who do not meet the criteria, if any, would have training provided on use of the standardized protocol.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1d. The PPS will leverage the Regional Performing Unit (RPU) model to ensure consistency as well as customizability throughout PPS. RPU-specific Clinical Governance subcommittees (e.g., quality committees) will be used to determine strategies at the RPU level as well as perform oversight of adherence to established Care Transition Protocols.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
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	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
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	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
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	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 2d. The 2biv Project Team and PMO will collaborate with the Medicaid Managed Care organizations and Health Homes, with focus on strategy development with MCOs and Health Homes to: i) improve care coordination, access, and delivery, ii) strengthen the community and safety-net infrastructure, and iii) prevent illness and reduce disparities. Risk assessment will begin at admission. Within 24 hours of admission, the Care Transition RN will identify what each beneficiary requires for a smooth and safe transition from the acute care hospital. As part of this assessment, the team will leverage tools (e.g., screening tool) to identify whether the patient is i) Not Eligible for Health Home (HH) Services, ii) Eligible for HH and connected to a HH, or iii) Eligible for HH and not connected to a HH. The use of a standardized Care Transition Protocol (CTP) will identify the root cause for admission, assess/address clinical, functional, behavioral, available/lack of available resources and social determinants for each beneficiary. Data analytic and population health technologies will provide a foundation for quality improvement and enable beneficiaries to be effectively risk stratified. A longitudinal plan of care will be developed in concert with	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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appropriate service and community based organizations including Health Homes. In an attempt to break down the barriers between systems (e.g., with MCOs) of mental health and long term care, and in recognition of the complex psycho-social needs of Medicaid beneficiaries as identified in the Care Compass Network community needs assessment, the CTP program will work to facilitate linkages with programs across systems. With the beneficiary's consent, the CTP program will refer to Health Homes within the PPS for ongoing care management services. A Health Home care manager will assist in coordinating the ongoing medical, mental health, substance abuse and social service needs of qualifying beneficiaries. Wherever appropriate, beneficiaries will be referred for additional long term care services such as home delivered meals and personal emergency response services. Beneficiaries will also be referred to outpatient services offered through CBOs where appropriate.									
Task 2e. Collaboratively use claims data to identify gaps in care.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2f. Seek community input in designing interventions through quarterly meetings either in-person or telephonically.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2g. Commit resources to transitional care development including, but not limited to fiscal, human, and training resources.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2h. Create a Cross Continuum Team (CCT) made up of representatives from hospitals, discharge planning staff, Emergency Department (ED) staff, behavioral health staff, home care services, and medical directors and administrators from skilled nursing facilities. Members of the Cross Continuum Team can be selected to engage 2-3 beneficiaries in meetings to solicit feedback.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2i. Payer agreements will be reviewed for Managed Care Organizations (MCOs) with patients in the PPS region.	Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 2j. Leverage telehealth strategies. (Beneficiaries suffering from	Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
chronic disease and are at an increased risk of re-hospitalization are candidates for the use of telehealth. Telemonitoring services have proven to be effective among Medicaid beneficiaries for managing such conditions as hypertension, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and diabetes, with improved health outcomes and reductions in hospital admissions and emergency department usage. Telemonitoring promotes self-care behaviors and a sense of control for beneficiaries.)									
Milestone #3 Ensure required social services participate in the project.	Project	N/A	In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Required network social services, including medically tailored home food services, are provided in care transitions.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3b. Identify required social service agencies using feedback from the CBO Engagement Council.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3c. Identify required social service agencies using responses to the PPS' readiness assessment.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3d. Collaborate with the local social services department as well as other CBOs to identify beneficiaries. Community based organizations have been actively engaged since PPS inception. To further identify and cultivate the breadth of services required to deliver project interventions, a CBO Council has been established and meets weekly. The nine county PPS has been divided into four Regional Performance Units (RPUs) to better understand the resources at the community level, foster the relationships among CBOs, and target providers to support outreach, patient activation and care coordination. An Academic Detailing approach will be used to educate and engage providers on Care Transitions as well as other PPS DSRIP projects. Goals of academic modeling include, but are not limited to: improving clinician knowledge of new clinical guidelines or health threats, selecting treatments to increase effectiveness and safety or to decrease overuse, improving patient education by helping clinicians communicate vital information to patients, increasing diagnosis or screening for overlooked conditions, and increasing	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
utilization of complimentary resources such as community-based public health programs.									
Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Hospital	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4e. Through the Clinical Governance Committee and the IT Committee as needed, identify methods of early notification of planned discharges and case manager patient visits.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4f. Establish protocols regarding early notification of planned discharges and case manager patient visits through the Clinical Governance Committee.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4g. Leverage RPU model to ensure consistency as well as customizability throughout PPS. RPU-specific Clinical Governance subcommittees will be used to determine strategies and effectiveness of implementation at the RPU level.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	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
updated in interoperable EHR or updated in primary care provider record.									
Task 5b. Create a Cross Continuum Team made up of representatives from hospitals, discharge planning staff, ED staff, behavioral health staff, home care services, and medical directors and administrators from skilled nursing facilities. Members of the Cross Continuum Team can be selected to engage 2-3 beneficiaries in meetings to solicit feedback. Physician recommendation is key to patients' acceptance as well as the initial presentation of the programs to beneficiaries and caregivers.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5c. Establish protocols for care record transition with Cross Continuum Team (CCT). Using the Eric Coleman model as a platform (an evidence based nationally recognized) protocol will be implemented inclusive of but not limited to the following four core pillars: 1. Medication reconciliation and teaching - using Medication tools from VNAA, 2. Ensuring follow up appointment with PCP after hospital discharge, 3. Disease/condition-specific teaching as well as recognition of signs and symptoms of worsening disease and how to appropriately respond, and 4. Personal Health Record is created with the patient to improve communication with providers-using document from VNAA.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #6 Ensure that a 30-day transition of care period is established.	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6c. Through the Clinical Governance Committee, identify appropriate policies and procedures to ensure a 30-day transition of care period with consideration of the following nine elements: 1. Outreach and Engagement - Prior to discharge the Care Transition nurse will identify what each beneficiary requires for a smooth and safe transition from the acute care hospital. This includes but is not limited to: gain knowledge of social and physical factors that affect functional status at discharge	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
(transportation, medication, specialized medical equipment, financial ability to sustain independent living and their feasibility to acquire what is needed). 2. Health Literacy - Assessment of the beneficiary's and caregiver's level of engagement and empowerment is key to developing a safe discharge to home. Assessment of the beneficiary and caregiver's knowledge of the disease process must take place during the hospital stay as limited health literacy has been shown to undermine beneficiary follow up with primary care provider, decreased adherence to treatment protocols, and their own engagement in their care. 3. Meet Patients Physically Where They Are - The Care Transition nurse or appropriate healthcare representative (e.g. Community Health Advocate, Home Care agencies, etc.) will visit beneficiary while in inpatient setting and then visit the patient at home. Home visit(s) will emphasize best practices in care transitions including: medication reconciliation, follow-up with primary care physician and/or mental health clinician, awareness of worsening symptoms of a person's health condition, home safety, and connections to home and community-based supports. 4. Family/Caregiver Involvement - Family caregivers play a significant role in keeping loved ones living at home and in the community. The Care Transition nurse will engage with caregivers wherever possible and appropriate. Following the wishes of the beneficiary, family caregivers will be included in education about symptom management and medication management. Caregivers will be informed about support services and respite care to enable them to care for themselves while providing care. 5. Create Warm Hand Offs/ Minimize Hand Offs - Wherever possible, beneficiaries will be connected with CBOs where they have a preexisting relationship. 6. Community Navigation - Identified as a vital component of an effective 30 day transition of care plan, all beneficiaries will be introduced to the array of Community Navigation services within the PPS tailored to each beneficiary's unique profile. 7. Provide Incentives - Care Compass Network will develop guidelines and policy to incentivize beneficiaries for engagement and achievement of personal milestones. The Care Transition nurse will work within this framework. 8. Create Virtual Support Groups/ RMS Panel - Beneficiaries will be offered the option to									

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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
participate with their peers in diagnosis specific, social support groups, or as a member on the CHNA Panel. 9. Maximize Physician Support - Physician recommendation is a key contributor to patient's acceptance as well as the initial presentation of the programs to beneficiaries and caregivers. Discuss all standards of care being utilized to insure understanding.									
Task 6d. Leverage RPU model to ensure consistency as well as customizability throughout PPS. RPU-specific Clinical Governance subcommittees will be used to determine strategies at the RPU level.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6e. Cross continuum team to meet (e.g., monthly or as needed) to monitor performance of participating organizations. QA Plan reviewed by the cross continuum team would include PPS use claims and lab reporting and related data fields and be reported to the associated RPU Quality Committee as required.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6f. Adjust procedures and protocols accordingly, informed by provider performance.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	04/01/2015	03/31/2017	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 7b. Leverage telehealth platforms. (Beneficiaries suffering from chronic disease and are at an increased risk of re-hospitalization are candidates for the use of telehealth. Telemonitoring services have proven to be effective among Medicaid beneficiaries for managing such conditions as hypertension, CHF, COPD, and diabetes, with improved health outcomes and reductions in hospital admissions and emergency department usage. Telemonitoring promotes self-care behaviors and a sense of control for beneficiaries.)	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7c. Care Transitions will utilize existing and new referral	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
management technologies to enhance the patient referral process. A care management system will support the development of patient care plans across various care settings with alerts and automated follow-up reminders and Telehealth will be used to monitor patients in the community through a required and developing robust broadband/Wi-Fi network. The Care Management System will connect to the RHIOs to provide a foundation in support of the PPS Integrated Delivery System. Investment in IT is a baseline requirement for successful care coordination. Utilization of care coordination software and an integrated electronic health record with connectivity to the RHIO are essential to creating capacity within the provider network. Utilization of Office Based Case Managers, RNs and Allied Health Professionals will also be an important factor. Technology such as Telehealth and telemedicine will connect patients to providers and allow for intervention and efficient access to patient information which will simplify providers work and simplifying processes will create capacity. To move toward a high reliability PPS, creating and imbedding disease management protocols in EHRs is a building block toward standardization and process optimization. CTI RN and PCP providers will be engaged to encourage beneficiaries to consent to the RHIOS's where providers can gain access to historical medical data; current treatments and medications, medical and surgical history, and community based organization involvement.									

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.										
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.										
Task 1b. The 2biv Project Team, through the Clinical Governance Committee and Board of Directors will identify and adopt evidence-based Care Transition Intervention Models appropriate for implementation and adoption by the Performing 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
System (PPS).										
Task 1c. Using the approved Care Transition Protocols, the 2biv Project Team and Project Champion from each of the nine PPS hospitals will perform a facility gap analysis to identify differences between the hospital care transition operating model versus the PPS Care Transition Plan. Following the assessment, the PPS will engage with hospitals who meet the criteria of the PPS Care Transition Protocol for Care Transitions Work. Organizations who do not meet the criteria, if any, would have training provided on use of the standardized protocol.										
Task 1d. The PPS will leverage the Regional Performing Unit (RPU) model to ensure consistency as well as customizability throughout PPS. RPU-specific Clinical Governance subcommittees (e.g., quality committees) will be used to determine strategies at the RPU level as well as perform oversight of adherence to established Care Transition Protocols.										
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 2d. The 2biv Project Team and PMO will collaborate with the Medicaid Managed Care organizations and Health Homes, with focus on strategy development with MCOs and Health Homes to: i) improve care coordination, access, and delivery, ii) strengthen the community and safety-net infrastructure, and iii) prevent illness and reduce disparities. Risk assessment will begin at admission. Within 24 hours of admission, the Care Transition RN will identify what each beneficiary requires for a smooth and safe transition from the acute care hospital. As part of this assessment, 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
team will leverage tools (e.g., screening tool) to identify whether the patient is i) Not Eligible for Health Home (HH) Services, ii) Eligible for HH and connected to a HH, or iii) Eligible for HH and not connected to a HH. The use of a standardized Care Transition Protocol (CTP) will identify the root cause for admission, assess/address clinical, functional, behavioral, available/lack of available resources and social determinants for each beneficiary. Data analytic and population health technologies will provide a foundation for quality improvement and enable beneficiaries to be effectively risk stratified. A longitudinal plan of care will be developed in concert with appropriate service and community based organizations including Health Homes. In an attempt to break down the barriers between systems (e.g., with MCOs) of mental health and long term care, and in recognition of the complex psycho-social needs of Medicaid beneficiaries as identified in the Care Compass Network community needs assessment, the CTP program will work to facilitate linkages with programs across systems. With the beneficiary's consent, the CTP program will refer to Health Homes within the PPS for ongoing care management services. A Health Home care manager will assist in coordinating the ongoing medical, mental health, substance abuse and social service needs of qualifying beneficiaries. Wherever appropriate, beneficiaries will be referred for additional long term care services such as home delivered meals and personal emergency response services. Beneficiaries will also be referred to outpatient services offered through CBOs where appropriate.										
Task 2e. Collaboratively use claims data to identify gaps in care.										
Task 2f. Seek community input in designing interventions through quarterly meetings either in-person or telephonically.										
Task 2g. Commit resources to transitional care development including, but not limited to fiscal, human, and training resources.										
Task 2h. Create a Cross Continuum Team (CCT) made up of representatives from hospitals, discharge planning staff, Emergency Department (ED) staff, behavioral health staff, home care services, and medical directors and administrators from skilled nursing facilities. Members of the Cross Continuum Team can be selected to engage 2-3 beneficiaries in meetings to solicit feedback.										

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project 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 2i. Payer agreements will be reviewed for Managed Care Organizations (MCOs) with patients in the PPS region.										
Task 2j. Leverage telehealth strategies. (Beneficiaries suffering from chronic disease and are at an increased risk of re-hospitalization are candidates for the use of telehealth. Telemonitoring services have proven to be effective among Medicaid beneficiaries for managing such conditions as hypertension, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and diabetes, with improved health outcomes and reductions in hospital admissions and emergency department usage. Telemonitoring promotes self-care behaviors and a sense of control for beneficiaries.)										
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 3b. Identify required social service agencies using feedback from the CBO Engagement Council.										
Task 3c. Identify required social service agencies using responses to the PPS' readiness assessment.										
Task 3d. Collaborate with the local social services department as well as other CBOs to identify beneficiaries. Community based organizations have been actively engaged since PPS inception. To further identify and cultivate the breadth of services required to deliver project interventions, a CBO Council has been established and meets weekly. The nine county PPS has been divided into four Regional Performance Units (RPUs) to better understand the resources at the community level, foster the relationships among CBOs, and target providers to support outreach, patient activation and care coordination. An Academic Detailing approach will be used to educate and engage providers on Care Transitions as well as other PPS DSRIP projects. Goals of academic modeling include, but are not limited to: improving clinician knowledge of new clinical guidelines or health threats, selecting treatments to increase effectiveness and safety or to decrease overuse, improving patient education by helping clinicians communicate vital information to patients, increasing diagnosis or screening for overlooked conditions, and increasing utilization of complimentary resources such as community-based public health programs.										

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project 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 #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.										
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	0	0	62	62	62	62	62
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	0	0	81	81	81	81	81
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	0	0	9	9	9	9	9
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 4e. Through the Clinical Governance Committee and the IT Committee as needed, identify methods of early notification of planned discharges and case manager patient visits.										
Task 4f. Establish protocols regarding early notification of planned discharges and case manager patient visits through the Clinical Governance Committee.										
Task 4g. Leverage RPU model to ensure consistency as well as customizability throughout PPS. RPU-specific Clinical Governance subcommittees will be used to determine strategies and effectiveness of implementation at the RPU level.										
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 5b. Create a Cross Continuum Team made up of representatives from hospitals, discharge planning staff, ED staff, behavioral health staff, home care services, and medical directors and administrators from skilled nursing facilities. Members of the Cross Continuum Team can be selected to engage 2-3										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
beneficiaries in meetings to solicit feedback. Physician recommendation is key to patients' acceptance as well as the initial presentation of the programs to beneficiaries and caregivers.										
Task 5c. Establish protocols for care record transition with Cross Continuum Team (CCT). Using the Eric Coleman model as a platform (an evidence based nationally recognized) protocol will be implemented inclusive of but not limited to the following four core pillars: 1. Medication reconciliation and teaching - using Medication tools from VNAA, 2. Ensuring follow up appointment with PCP after hospital discharge, 3. Disease/condition-specific teaching as well as recognition of signs and symptoms of worsening disease and how to appropriately respond, and 4. Personal Health Record is created with the patient to improve communication with providers-using document from VNAA.										
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 6c. Through the Clinical Governance Committee, identify appropriate policies and procedures to ensure a 30-day transition of care period with consideration of the following nine elements: 1. Outreach and Engagement - Prior to discharge the Care Transition nurse will identify what each beneficiary requires for a smooth and safe transition from the acute care hospital. This includes but is not limited to: gain knowledge of social and physical factors that affect functional status at discharge (transportation, medication, specialized medical equipment, financial ability to sustain independent living and their feasibility to acquire what is needed). 2. Health Literacy - Assessment of the beneficiary's and caregiver's level of engagement and empowerment is key to developing a safe discharge to home. Assessment of the beneficiary and caregiver's knowledge of the disease process must take place during the hospital stay as limited health literacy has been shown to undermine beneficiary follow up with primary care provider, decreased adherence to treatment protocols, and their own engagement in their care. 3. Meet Patients Physically Where They Are - The Care Transition nurse or appropriate healthcare representative (e.g. Community Health Advocate, Home Care agencies, etc.) will visit beneficiary while in inpatient setting and then visit the patient at home. Home visit(s) will emphasize best practices in care transitions										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
including: medication reconciliation, follow-up with primary care physician and/or mental health clinician, awareness of worsening symptoms of a person's health condition, home safety, and connections to home and community-based supports. 4. Family/Caregiver Involvement - Family caregivers play a significant role in keeping loved ones living at home and in the community. The Care Transition nurse will engage with caregivers wherever possible and appropriate. Following the wishes of the beneficiary, family caregivers will be included in education about symptom management and medication management. Caregivers will be informed about support services and respite care to enable them to care for themselves while providing care. 5. Create Warm Hand Offs/ Minimize Hand Offs - Wherever possible, beneficiaries will be connected with CBOs where they have a preexisting relationship. 6. Community Navigation - Identified as a vital component of an effective 30 day transition of care plan, all beneficiaries will be introduced to the array of Community Navigation services within the PPS tailored to each beneficiary's unique profile. 7. Provide Incentives - Care Compass Network will develop guidelines and policy to incentivize beneficiaries for engagement and achievement of personal milestones. The Care Transition nurse will work within this framework. 8. Create Virtual Support Groups/ RMS Panel - Beneficiaries will be offered the option to participate with their peers in diagnosis specific, social support groups, or as a member on the CHNA Panel. 9. Maximize Physician Support - Physician recommendation is a key contributor to patient's acceptance as well as the initial presentation of the programs to beneficiaries and caregivers. Discuss all standards of care being utilized to insure understanding.										
Task 6d. Leverage RPU model to ensure consistency as well as customizability throughout PPS. RPU-specific Clinical Governance subcommittees will be used to determine strategies at the RPU level.										
Task 6e. Cross continuum team to meet (e.g., monthly or as needed) to monitor performance of participating organizations. QA Plan reviewed by the cross continuum team would include PPS use claims and lab reporting and related data fields and be reported to the associated RPU Quality Committee as required.										
Task 6f. Adjust procedures and protocols accordingly, informed by provider performance.										

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #7 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 7b. Leverage telehealth platforms. (Beneficiaries suffering from chronic disease and are at an increased risk of re-hospitalization are candidates for the use of telehealth. Telemonitoring services have proven to be effective among Medicaid beneficiaries for managing such conditions as hypertension, CHF, COPD, and diabetes, with improved health outcomes and reductions in hospital admissions and emergency department usage. Telemonitoring promotes self-care behaviors and a sense of control for beneficiaries.)										
Task 7c. Care Transitions will utilize existing and new referral management technologies to enhance the patient referral process. A care management system will support the development of patient care plans across various care settings with alerts and automated follow-up reminders and Telehealth will be used to monitor patients in the community through a required and developing robust broadband/Wi-Fi network. The Care Management System will connect to the RHIOs to provide a foundation in support of the PPS Integrated Delivery System. Investment in IT is a baseline requirement for successful care coordination. Utilization of care coordination software and an integrated electronic health record with connectivity to the RHIO are essential to creating capacity within the provider network. Utilization of Office Based Case Managers, RNs and Allied Health Professionals will also be an important factor. Technology such as Telehealth and telemedicine will connect patients to providers and allow for intervention and efficient access to patient information which will simplify providers work and simplifying processes will create capacity. To move toward a high reliability PPS, creating and imbedding disease management protocols in EHRs is a building block toward standardization and process optimization. CTI RN and PCP providers will be engaged to encourage beneficiaries to consent to the RHIOS's where providers can gain access to historical medical data; current treatments and medications, medical and surgical history, and community based organization involvement.										

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project 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 1b. The 2biv Project Team, through the Clinical Governance Committee and Board of Directors will identify and adopt evidence-based Care Transition Intervention Models appropriate for implementation and adoption by the Performing Provider System (PPS).										
Task 1c. Using the approved Care Transition Protocols, the 2biv Project Team and Project Champion from each of the nine PPS hospitals will perform a facility gap analysis to identify differences between the hospital care transition operating model versus the PPS Care Transition Plan. Following the assessment, the PPS will engage with hospitals who meet the criteria of the PPS Care Transition Protocol for Care Transitions Work. Organizations who do not meet the criteria, if any, would have training provided on use of the standardized protocol.										
Task 1d. The PPS will leverage the Regional Performing Unit (RPU) model to ensure consistency as well as customizability throughout PPS. RPU-specific Clinical Governance subcommittees (e.g., quality committees) will be used to determine strategies at the RPU level as well as perform oversight of adherence to established Care Transition Protocols.										
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.										

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

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Care Compass Network (PPS ID:44)

Project 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 2d. The 2biv Project Team and PMO will collaborate with the Medicaid Managed Care organizations and Health Homes, with focus on strategy development with MCOs and Health Homes to: i) improve care coordination, access, and delivery, ii) strengthen the community and safety-net infrastructure, and iii) prevent illness and reduce disparities. Risk assessment will begin at admission. Within 24 hours of admission, the Care Transition RN will identify what each beneficiary requires for a smooth and safe transition from the acute care hospital. As part of this assessment, the team will leverage tools (e.g., screening tool) to identify whether the patient is i) Not Eligible for Health Home (HH) Services, ii) Eligible for HH and connected to a HH, or iii) Eligible for HH and not connected to a HH. The use of a standardized Care Transition Protocol (CTP) will identify the root cause for admission, assess/address clinical, functional, behavioral, available/lack of available resources and social determinants for each beneficiary. Data analytic and population health technologies will provide a foundation for quality improvement and enable beneficiaries to be effectively risk stratified. A longitudinal plan of care will be developed in concert with appropriate service and community based organizations including Health Homes. In an attempt to break down the barriers between systems (e.g., with MCOs) of mental health and long term care, and in recognition of the complex psycho-social needs of Medicaid beneficiaries as identified in the Care Compass Network community needs assessment, the CTP program will work to facilitate linkages with programs across systems. With the beneficiary's consent, the CTP program will refer to Health Homes within the PPS for ongoing care management services. A Health Home care manager will assist in coordinating the ongoing medical, mental health, substance abuse and social service needs of qualifying beneficiaries. Wherever appropriate, beneficiaries will be referred for additional long term care services such as home delivered meals and personal emergency response services. Beneficiaries will also be referred to outpatient services offered through CBOs where appropriate.										
Task 2e. Collaboratively use claims data to identify gaps in care.										
Task 2f. Seek community input in designing interventions through quarterly meetings either in-person or telephonically.										

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

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Care Compass Network (PPS ID:44)

Project 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 2g. Commit resources to transitional care development including, but not limited to fiscal, human, and training resources.										
Task 2h. Create a Cross Continuum Team (CCT) made up of representatives from hospitals, discharge planning staff, Emergency Department (ED) staff, behavioral health staff, home care services, and medical directors and administrators from skilled nursing facilities. Members of the Cross Continuum Team can be selected to engage 2-3 beneficiaries in meetings to solicit feedback.										
Task 2i. Payer agreements will be reviewed for Managed Care Organizations (MCOs) with patients in the PPS region.										
Task 2j. Leverage telehealth strategies. (Beneficiaries suffering from chronic disease and are at an increased risk of re-hospitalization are candidates for the use of telehealth. Telemonitoring services have proven to be effective among Medicaid beneficiaries for managing such conditions as hypertension, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and diabetes, with improved health outcomes and reductions in hospital admissions and emergency department usage. Telemonitoring promotes self-care behaviors and a sense of control for beneficiaries.)										
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 3b. Identify required social service agencies using feedback from the CBO Engagement Council.										
Task 3c. Identify required social service agencies using responses to the PPS' readiness assessment.										
Task 3d. Collaborate with the local social services department as well as other CBOs to identify beneficiaries. Community based organizations have been actively engaged since PPS inception. To further identify and cultivate the breadth of services required to deliver project interventions, a CBO Council has been established and meets weekly. The nine county PPS has been divided into four Regional Performance Units (RPUs) to better understand the resources at the community level, foster the relationships among CBOs, and target providers to support										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
outreach, patient activation and care coordination. An Academic Detailing approach will be used to educate and engage providers on Care Transitions as well as other PPS DSRIP projects. Goals of academic modeling include, but are not limited to: improving clinician knowledge of new clinical guidelines or health threats, selecting treatments to increase effectiveness and safety or to decrease overuse, improving patient education by helping clinicians communicate vital information to patients, increasing diagnosis or screening for overlooked conditions, and increasing utilization of complimentary resources such as community-based public health programs.										
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.	62	62	62	62	62	62	62	62	62	62
Task Policies and procedures are in place for early notification of planned discharges.	81	81	81	81	81	81	81	81	81	81
Task Policies and procedures are in place for early notification of planned discharges.	9	9	9	9	9	9	9	9	9	9
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 4e. Through the Clinical Governance Committee and the IT Committee as needed, identify methods of early notification of planned discharges and case manager patient visits.										
Task 4f. Establish protocols regarding early notification of planned discharges and case manager patient visits through the Clinical Governance Committee.										
Task 4g. Leverage RPU model to ensure consistency as well as customizability throughout PPS. RPU-specific Clinical Governance subcommittees will be used to determine strategies and effectiveness of implementation at the RPU level.										
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.										

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Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.										
Task 5b. Create a Cross Continuum Team made up of representatives from hospitals, discharge planning staff, ED staff, behavioral health staff, home care services, and medical directors and administrators from skilled nursing facilities. Members of the Cross Continuum Team can be selected to engage 2-3 beneficiaries in meetings to solicit feedback. Physician recommendation is key to patients' acceptance as well as the initial presentation of the programs to beneficiaries and caregivers.										
Task 5c. Establish protocols for care record transition with Cross Continuum Team (CCT). Using the Eric Coleman model as a platform (an evidence based nationally recognized) protocol will be implemented inclusive of but not limited to the following four core pillars: 1. Medication reconciliation and teaching - using Medication tools from VNAA, 2. Ensuring follow up appointment with PCP after hospital discharge, 3. Disease/condition-specific teaching as well as recognition of signs and symptoms of worsening disease and how to appropriately respond, and 4. Personal Health Record is created with the patient to improve communication with providers-using document from VNAA.										
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 6c. Through the Clinical Governance Committee, identify appropriate policies and procedures to ensure a 30-day transition of care period with consideration of the following nine elements: 1. Outreach and Engagement - Prior to discharge the Care Transition nurse will identify what each beneficiary requires for a smooth and safe transition from the acute care hospital. This includes but is not limited to: gain knowledge of social and physical factors that affect functional status at discharge (transportation, medication, specialized medical equipment, financial ability to sustain independent living and their feasibility to acquire what is needed). 2. Health Literacy - Assessment of the beneficiary's and caregiver's level of engagement and										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
empowerment is key to developing a safe discharge to home. Assessment of the beneficiary and caregiver's knowledge of the disease process must take place during the hospital stay as limited health literacy has been shown to undermine beneficiary follow up with primary care provider, decreased adherence to treatment protocols, and their own engagement in their care. 3. Meet Patients Physically Where They Are - The Care Transition nurse or appropriate healthcare representative (e.g. Community Health Advocate, Home Care agencies, etc.) will visit beneficiary while in inpatient setting and then visit the patient at home. Home visit(s) will emphasize best practices in care transitions including: medication reconciliation, follow-up with primary care physician and/or mental health clinician, awareness of worsening symptoms of a person's health condition, home safety, and connections to home and community-based supports. 4. Family/Caregiver Involvement - Family caregivers play a significant role in keeping loved ones living at home and in the community. The Care Transition nurse will engage with caregivers wherever possible and appropriate. Following the wishes of the beneficiary, family caregivers will be included in education about symptom management and medication management. Caregivers will be informed about support services and respite care to enable them to care for themselves while providing care. 5. Create Warm Hand Offs/ Minimize Hand Offs - Wherever possible, beneficiaries will be connected with CBOs where they have a preexisting relationship. 6. Community Navigation - Identified as a vital component of an effective 30 day transition of care plan, all beneficiaries will be introduced to the array of Community Navigation services within the PPS tailored to each beneficiary's unique profile. 7. Provide Incentives - Care Compass Network will develop guidelines and policy to incentivize beneficiaries for engagement and achievement of personal milestones. The Care Transition nurse will work within this framework. 8. Create Virtual Support Groups/ RMS Panel - Beneficiaries will be offered the option to participate with their peers in diagnosis specific, social support groups, or as a member on the CHNA Panel. 9. Maximize Physician Support - Physician recommendation is a key contributor to patient's acceptance as well as the initial presentation of the programs to beneficiaries and caregivers. Discuss all standards of care being utilized to insure understanding.										
Task 6d. Leverage RPU model to ensure consistency as well as customizability throughout PPS. RPU-specific Clinical Governance subcommittees will be used to determine strategies										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
at the RPU level.										
Task 6e. Cross continuum team to meet (e.g., monthly or as needed) to monitor performance of participating organizations. QA Plan reviewed by the cross continuum team would include PPS use claims and lab reporting and related data fields and be reported to the associated RPU Quality Committee as required.										
Task 6f. Adjust procedures and protocols accordingly, informed by provider performance.										
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 7b. Leverage telehealth platforms. (Beneficiaries suffering from chronic disease and are at an increased risk of re-hospitalization are candidates for the use of telehealth. Telemonitoring services have proven to be effective among Medicaid beneficiaries for managing such conditions as hypertension, CHF, COPD, and diabetes, with improved health outcomes and reductions in hospital admissions and emergency department usage. Telemonitoring promotes self-care behaviors and a sense of control for beneficiaries.)										
Task 7c. Care Transitions will utilize existing and new referral management technologies to enhance the patient referral process. A care management system will support the development of patient care plans across various care settings with alerts and automated follow-up reminders and Telehealth will be used to monitor patients in the community through a required and developing robust broadband/Wi-Fi network. The Care Management System will connect to the RHIOs to provide a foundation in support of the PPS Integrated Delivery System. Investment in IT is a baseline requirement for successful care coordination. Utilization of care coordination software and an integrated electronic health record with connectivity to the RHIO are essential to creating capacity within the provider network. Utilization of Office Based Case Managers, RNs and Allied Health Professionals will also be an important factor. Technology such as Telehealth and telemedicine will connect patients to providers and allow for intervention and efficient access to patient information which will simplify providers work										

Care Compass Network (PPS ID:44)

Project 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 simplifying processes will create capacity. To move toward a high reliability PPS, creating and imbedding disease management protocols in EHRs is a building block toward standardization and process optimization. CTI RN and PCP providers will be engaged to encourage beneficiaries to consent to the RHIOS's where providers can gain access to historical medical data; current treatments and medications, medical and surgical history, and community based organization involvement.										

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.	There were no milestones or tasks due for the Q2 report, however we are reporting Step 1b as Complete one quarter early. At the September 10, 2015 Clinical Governance Committee meeting the project 2biv leader (Greg Rittenhouse, VP & COO UHS Home Care) presented the 2biv plan which includes four pillars for coordinated care, which reference an Eric Coleman based model for an evidenced based process for Care Transitions. The four components or pillars of coordinated care have been endorsed by CMS and are as follows: 1. Medication reconciliation and teaching using tools from the Eric Coleman model, 2. Ensuring follow up appointment with PCP after hospital discharge, 3. Disease/condition-specific teaching as well as recognition of signs and symptoms of worsening disease and how to appropriately respond, and 4. Personal Health Record is created with the patient to improve communication with providers. The Clinical Governance Committee adopted the Care Transitions Intervention Model during the September meeting which in turn were presented and approved by the Board of Directors at the October 13, 2015 meeting. The Care Transition framework will serve as the basis for PPS contracting for project 2biv partners which is commencing in the Q3 timeframe. The remaining tasks and milestone remain on target for completion by the assigned due dates. While there were no executed contracts in the Q2 timeframe, two of the PPSs nine attested partners self-reported completed care transitions eligible for current speed and scale metrics which totaled 1,182 for the period April 1, 2015 through September 30, 2015. During the Q2 timeframe the PPS speed and scale commitments for project 2biv totaled 1,700. Also, CCN is investigating how speed and scale calculations and requirements are setup in the Salient system for the 2biv project. Currently, the Salient bookmark/collections for the 2biv project exclude discharges for natural birth or cesareans section maternity visits. The CCN project team has concerns with excluding discharged mothers and babies from the project as these represent vulnerable populations who would benefit from the services made available from a post discharge 30 day care plan, applicable related home visits, etc. developed by the 2biv project. Without proper guidance the CCN team has reported the conservative number of self-reported care transitions above. If the IA were to deem the entire Medicaid population which were discharged with no restrictions as acceptable to this project, regardless of how Salient data mining features are established, CCN would be in a position to report roughly double for the same time period, well above the Q2 speed and scale requirement of 1,700.
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.	Care Compass Network (CCN) has invested several resources to the Care Transition project transitional care development throughout Q2 (Step 2g.) The 2biv project team is led by Greg Rittenhouse (VP & COO, UHS Home Care) and Shelley Eggleton (Service Line Administrator, Our Lady of Lourdes), who are supported by CCN staff including Dawn Sculley (CCN Project Manager) as well as Scott Emery (M.S. Hall Associate and Consultant). CCN hosted Greg Rittenhouse's attendance at the DSRIP Learning Symposium September 17/18th for participation in the Care Transitions presentation as well as general DOH

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	updates. We have cross PPS Care Transition collaboration primarily with the Finger Lakes PPS (FLPPS) as we have a provider located within our PPS with experienced resources actively using the Care Transition Intervention model. CareFirst, (formerly known as Southern Tier Hospice & Palliative Care) is engaged with FLPPS in the Care Transition project and met their Speed & Scale goal for FLPPS in Q2. They are located in the West RPU of Care Compass Network and serve Chemung, Schuyler and Steuben counties. CareFirst has two of their staff members trained in the Eric Coleman Care Transitions Intervention model and will be training a few more. The CareFirst resources will be used to help train others in CTI throughout the CCN network. The remaining tasks for this milestone remain in progress and are on target for completion by the associated due date. Additionally, the Care Transition project team (approximately 20 members from across the PPS) met on August 27, 2015 to discuss and develop a Standardized Care Transition Protocol for Project 2.b.iv. Care Transition protocols were presented to the Clinical Governance Committee on September 10, 2015 and approved by the Board of directors at the October 13, 2015 meeting. Additionally, during Q3 the Care Transition project leads in collaboration with the Facility Champion at each of the PPS partner hospitals will assess the existing Care Transition protocols and begin contracting for 2biv related work.
Ensure required social services participate in the project.	Milestone 3 and the associated tasks are due for reporting in Q3, each remains on target for completion by this deadline. In Q3 the Regional Performing Units have begun to discuss social services departments located within the region to collaborate with on the Care Transitions project. Additionally the CBO Engagement Council will be included in discussions for required social services to participate with the goals of: improving clinician knowledge of new clinical guidelines or health threats, selecting treatments to increase effectiveness and safety or to decrease overuse, improving patient education by helping clinicians communicate vital information to patients, increasing diagnosis or screening for overlooked conditions, and increasing utilization of complimentary resources such as community-based public health programs.
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.	Neither Milestone 4 nor the associated tasks are due for reporting in Q2, however each remains on target for completion by their respective due dates. Overall the Care Transition project team is in the process of identifying methods of early notification of planned discharges and case manager patient visits in October and will be presenting them to the Clinical Governance Committee for their adoption as well as Care Compass Network Board of Directors approval in Q3.
Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Neither Milestones 5 or 7, nor the respective tasks are due for reporting in Q2, however each remains on target for completion by their associated due dates. At the September 10, 2015 Clinical Governance Committee meeting the project 2biv leader (Greg Rittenhouse, VP & COO UHS Home Care) presented the 2biv plan which includes four pillars for coordinated care, which reference an Eric Coleman based model for an evidenced based process for Care Transitions. The four components or pillars of coordinated care have been endorsed by CMS and are as follows: 1. Medication reconciliation and teaching using tools from the Eric Coleman model, 2. Ensuring follow up appointment with PCP after hospital discharge, 3. Disease/condition-specific teaching as well as recognition of signs and symptoms of worsening disease and how to appropriately respond, and 4. Personal Health Record is created with the patient to improve communication with providers. The Clinical Governance Committee adopted the Care Transitions Intervention Model which in turn were presented and approved by the Board of Directors at the October 13, 2015 meeting. The Care Transition framework will serve as the basis for PPS contracting for project 2biv partners which is commencing in the Q3 timeframe.
Ensure that a 30-day transition of care period is established.	Neither Milestone 6 nor the associated tasks are due for reporting in Q2, however each remains on target for completion by their respective due dates, including several which are due in Q3. At a high level, the Care Transition project team is in the process of identifying appropriate policies and procedures to ensure a 30-day transition of care period and will be presenting them to the Clinical Governance Committee for their adoption as well as Care Compass Network Board of Directors approval in Q3.
Use EHRs and other technical platforms to track all patients engaged in the project.	Neither Milestones 5 or 7, nor the respective tasks are due for reporting in Q2, however each remains on target for completion by their associated due dates. At the September 10, 2015 Clinical Governance Committee meeting the project 2biv leader (Greg Rittenhouse, VP & COO UHS Home Care) presented the 2biv plan which includes four pillars for coordinated care, which reference an Eric Coleman based model for an evidenced based process for Care Transitions. The four components or pillars of coordinated care have been endorsed by CMS and are as follows: 1. Medication reconciliation and teaching using tools from the Eric Coleman model, 2. Ensuring follow up appointment with PCP after hospital discharge, 3. Disease/condition-specific teaching as well

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	as recognition of signs and symptoms of worsening disease and how to appropriately respond, and 4. Personal Health Record is created with the patient to improve communication with providers. The Clinical Governance Committee adopted the Care Transitions Intervention Model which in turn were presented and approved by the Board of Directors at the October 13, 2015 meeting. The Care Transition framework will serve as the basis for PPS contracting for project 2biv partners which is commencing in the Q3 timeframe.

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

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

Instructions :

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

The three main risks to implementation are:
1. Concerns over level of commitment and participation of the 24 different facilities in 7 different counties. (Chemung and Steuben Nursing Facilities have opted to sign commitment to FLPPS) Communication and cooperation in obtaining information from some facilities has been extremely difficult. While all facilities have signed the letter of intent to join the PPS, the participation has been minimal.
a. Mitigation: A letter will be drafted by the governing body of STRIPPS to each facility/provider outlining expected level of participation. If a facility/provider is unable to continue the commitment required, a root cause analysis will be conducted to assist affected facility(s) to determine provider specific risks and mitigation factors. Some of the mitigation factors may be provider specific or may reflect suspected barriers. If there can be no resolution due to factors out of the realm of the PPS or the provider to overcome, a process will be explored to assist them in resigning from the PPS.

2. Varying capabilities and statuses of facilities that have a fully implemented/integrated electronic health records.
a. Facilities should receive education that tracking/trending improvements in quality of care to the residents can be achieved most efficiently with an electronic health record that allows increased accessibility, sharing of data, and analysis of data. Proof of education should be required from each participating facility.
b. The PPS is proposing to offer an E.H.R. lite system for facilities who do not have an implemented electronic health record and to make that available through a lease. Monitoring of E.H.R. implementation by the IT section of the PPS will be required measure successful mitigation to this risk.

3. Full engagement of the hospital systems in the INTERACT process. The facilities will need commitments from the hospital providers to identify and solve systemic issues which also contribute to re-hospitalizations and unnecessary emergency department visits.
a. Assistance, collaboration and streamlining process from the care transitions group will help overcome this risk.
b. Educational opportunities for hospital systems on evidenced based care transitions, pathways, and preventative protocols that can be implemented across all settings.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	720

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
0	0	0.00%	72	0.00%

Warning: Please note that your patients engaged to date does not meet your committed amount (72)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its actively engaged commitments for DY1, Q2.

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task INTERACT principles implemented at each participating SNF.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Nursing home to hospital transfers reduced.	Provider	Nursing Home	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task INTERACT 3.0 Toolkit used at each SNF.	Provider	Nursing Home	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1d. SNF INTERACT Project Champion to perform a baseline assessment of staff to identify existing INTERACT expertise within their facility and work with the Workforce Development and Transition Team (WDTT) to determine staffing needs .	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1e. Within each participating SNF, evaluate current processes and tools and compare them to the tools in the INTERACT program. Integrate INTERACT tools into the daily work flow using the INTERACT implementation guide.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1f. The PPS INTERACT Project team, PMO, and Finance Manager will incorporate the core components of the 2bvii project to the PPS budget and funds flow model. Once finalized and approved by the Finance Committee and Board of Directors the PPS will negotiate INTERACT implementation contracts with the associated SNFs.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1g. As part of the contracting process, identify an INTERACT Project Champion for each SNF to provide on-site project oversight as well as communication with the PPS PMO and Project Team for reporting purposes. PMO to draft a letter to	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
each facility/provider outlining expected level of participation in the project as well as benefits available for collaborating in these efforts with the PPS. If facility/provider is unable to continue the commitment required, PMO will conduct a root cause analysis to assist the affected facility(s) to determine provider specific risks and mitigation factors.									
Task 1h. INTERACT Champion at each contracted SNF facility to ensure INTERACT principles are incorporated into the facilities' Quality Assurance and Process Improvement (QAPI) process and report to PMO.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #2 Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	Project	N/A	In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Facility champion identified for each SNF.	Provider	Nursing Home	In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2b. Identify an INTERACT champion per facility.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2c. Identify an INTERACT Co-Champion per facility.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2d. Train INTERACT Champion and Co-Champion on INTERACT principles.	Project		In Progress	04/02/2015	12/31/2015	04/02/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #3 Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3c. Project team and Project Management Office to assess existing care pathways and other clinical tools for monitoring chronically ill patients. The project team and PMO will identify the common care paths and create educational tools and	Project		In Progress	04/01/2015	03/31/2016	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
present for review by the Clinical Governance Committee for review and adoption.									
Task 3d. The educational tools created in Step 3c will be distributed to the SNFs and hospitals by the Provider Relations to be used as guidance in evaluating and monitoring patients. As needed additional education can be provided by the project lead and/or the trainor from the Workforce team.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3e. Workforce team and Provider Relations will educate hospital representatives on care pathways and preventive protocols created in step 3c in effort to align these throughout the PPS.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3f. Incorporate care pathway tools into SNF daily procedures. Staff within the SNF to provide feedback as necessary to the INTERACT champion & co-champion within the SNF.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3g. The INTERACT champion, co-champions and project team will meet at a minimum of once a year to review INTERACT care paths and related practice guidelines. The project team will adjust as needed using the Clinical Governance Committee.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #4 Educate all staff on care pathways and INTERACT principles.	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Training program for all SNF staff established encompassing care pathways and INTERACT principles.	Provider	Nursing Home	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4b. Use INTERACT Champions in each facility to provide training sessions encompassing care pathways and INTERACT principles (e.g., annually or as seen appropriate by related parties) to all key staff including MD, FNP, PA etc. Record SNF training dates along with the number of staff trained. Review the content of the training annually with the Clinical Governance Committee and evaluate for adjustments needed.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4c. Each SNF will incorporate training of care pathways and INTERACT principles into new clinical staff orientation.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #5 Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
of life and end of life care.									
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5b. Social Services Departments within each participating SNF to evaluate current Advance Care Planning tools and validate that usage is reflected in policies and procedures.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5c. Social Services Departments within each participating SNF and facility INTERACT champion to ensure Advance Care Planning tools meet the requirements of the INTERACT program. The Social Services Department and SNF Interact Champion/Co-Champion will adjust tools as needed working with the PMO and advised by the Clinical Governance Committee. The entire Interdisciplinary Team within the SNF will be educated on any changes to the Care Planning Tools within the month following the updates.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5d. The facility INTERACT champion and/or co-champion will audit use of advance care planning tools within the SNF and provide audit results to the PMO for review with the Clinical Governance Committee. The audits must be performed annually at a minimum.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5e. Social Services Department within each participating SNF to conduct meetings with residents and family members using the facility established Advance Care Planning tools.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5f. The facility INTERACT champion and/or co-champion and Social Services Department within the SNF will reassess Advance Care Planning tools annually at a minimum. The INTERACT champion, co-champion and Social Services Department within the SNF will update the tools as required. The entire Interdisciplinary team within the SNF will be educated on any changes to the Care Planning Tools within the month following the updates.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #6 Create coaching program to facilitate and support	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	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
implementation.									
Task INTERACT coaching program established at each SNF.	Provider	Nursing Home	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6b. Identify an INTERACT Champion located within each SNF. This Champion will be used for train-the-trainer programs within each respective organization to facilitate sustainability.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 6c. Leverage Champions and facility Co-Champions in order to ensure continuity of training programs across units (facilities and RPUs).	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 6d. Integrate training efforts and needs with existing Performing Provider System (PPS) resources, such as the Workforce Strategy team and relationships built through the Provider Relations team.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 6e. Each SNF will prepare standardized progress reports (e.g., monthly) to the Care Compass Network PMO. The progress reports will include overview of key metrics, deliverables, as well as areas of success and implementation challenges at a minimum in order to assist the SNF during the implementation process.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Patients and families educated and involved in planning of care using INTERACT principles.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 7b. The Project Team, in conjunction with the PMO and Workforce Team (as needed) will create an educational strategy which will be leveraged for patient and family/caretakers distribution to supplement information found on INTERACT website regarding care planning. The strategy will outline the materials to be distributed, methods for refreshing materials for pertinence, as well as what the delivery method(s) will be for distribution. The plan will, at minimum, incorporate concepts as further outlined in the steps outlined in this plan.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task	Project		In Progress	04/01/2015	03/31/2016	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
7c. The PPS will collaborate and/or engage with local governing units (e.g., Social Service agencies) to facilitate patient and family/caretaker discussions with each participating facility.									
Task 7d. The PPS will facilitate the achievement of interdisciplinary meetings focused on advanced care planning for the PPS community of related providers.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 7e. Identify Stop and Watch tool in SNF admissions packet and discuss with family members.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 7f. The comprehensive training strategy, materials, and distribution methods (as well as targeted audiences) will be delivered on at minimum an annual basis beginning in DSRIP year 2.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #8 Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Hospital	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Nursing Home	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 8d. The 2bvii Project Team will engage with safety net Skilled Nursing Facilities (SNFs) in the development of enhanced communication tools which will allow for increased functionality such as the generation and delivery of CCD files or delivery of system generated reports which can be aligned with acute care hospital. As required, the PPS will promote SNF staff training on use of health information exchange with assistance of systems and functionality. Training will include, as identified, education with facilities regarding the sharing of data through data agreements such as the DURSA or BAA.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
8e. SNF facilities are to receive education to inform them tracking/trending improvements in quality of care can be achieved most efficiently with an electronic health record that allows increased accessibility, sharing of data and analysis of data. Proof of education from each participating facility shall be reported to the PMO.									
Task 8f. Each participating SNF to create and communicate a Nursing Home Capabilities List to local hospital emergency room staff, local hospital discharge planners and local hospital physicians at a minimum.	Project		In Progress	04/02/2015	09/30/2016	04/02/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #9 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Project	N/A	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 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	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 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	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Service and quality outcome measures are reported to all stakeholders.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 9e. Form a PPS quality committee that includes SNF representation.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 9f.After establishing baseline data the Interdisciplinary Team within the SNF will develop a quality improvement plan using the INTERACT quality improvement principles as a guide. Root cause analysis of transfers to hospitals to be used as data in development of the quality improvement plan. Each SNF to report out put of the quality improvement plan to the PMO office along with a timeline for implementing the quality improvement	Project		In Progress	04/01/2015	03/31/2016	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
plan. A progress report to be submitted by the SNF to the PMO to communicate progress of the recommended improvements on a pre-determined basis (e.g., monthly/quarterly as appropriate).									
Task 9g. The project team and PMO to identify metrics to be used (such as Attachment J metrics) through the Clinical Governance Committee. Additionally, alternative or substitutive interventions as identified during the root cause analysis process will be validated by the Clinical Governance Committee and Board of Directors prior to adoption by the 2bvii Project Team.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #10 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 10b. PMO and project team will review and determine criteria and metrics for counting/tracking patient engagement--EHR data, encounter data, INTERACT tool usage, etc. as well as the associated integration efforts for population health purposes with oversight from both the Clinical Governance Committee and the IT & Data Governance Committee.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 10c. The PPS will analyze SNFs for alignment opportunities with the identified criteria and metric requirements. As needed the PPS will pursue the facilitation of resources to track patients engaged in the project, such as the alignment of SNF EHR/EHR Lite tools with INTERACT toolkits.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 10d. The project team in conjunction with the Workforce team and IT team to identify workflows impacted due to new technology and document new workflows for the impacted SNFs.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 10e. Utilize the Workforce team to train staff on technology and workflow.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.										
Task INTERACT principles implemented at each participating SNF.										
Task Nursing home to hospital transfers reduced.	0	0	0	0	0	23	23	23	23	23
Task INTERACT 3.0 Toolkit used at each SNF.	0	0	0	0	0	9	9	9	9	9
Task 1d. SNF INTERACT Project Champion to perform a baseline assessment of staff to identify existing INTERACT expertise within their facility and work with the Workforce Development and Transition Team (WDTT) to determine staffing needs .										
Task 1e. Within each participating SNF, evaluate current processes and tools and compare them to the tools in the INTERACT program. Integrate INTERACT tools into the daily work flow using the INTERACT implementation guide.										
Task 1f. The PPS INTERACT Project team, PMO, and Finance Manager will incorporate the core components of the 2bvii project to the PPS budget and funds flow model. Once finalized and approved by the Finance Committee and Board of Directors the PPS will negotiate INTERACT implementation contracts with the associated SNFs.										
Task 1g. As part of the contracting process, identify an INTERACT Project Champion for each SNF to provide on-site project oversight as well as communication with the PPS PMO and Project Team for reporting purposes. PMO to draft a letter to each facility/provider outlining expected level of participation in the project as well as benefits available for collaborating in these efforts with the PPS. If facility/provider is unable to continue the commitment required, PMO will conduct a root cause analysis to assist the affected facility(s) to determine provider specific risks and mitigation factors.										
Task 1h. INTERACT Champion at each contracted SNF facility to ensure INTERACT principles are incorporated into the facilities' Quality Assurance and Process Improvement (QAPI) process and report to PMO.										
Milestone #2 Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Facility champion identified for each SNF.	0	0	0	0	0	0	0	0	0	0
Task 2b. Identify an INTERACT champion per facility.										
Task 2c. Identify an INTERACT Co-Champion per facility.										
Task 2d. Train INTERACT Champion and Co-Champion on INTERACT principles.										
Milestone #3 Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.										
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.										
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.										
Task 3c. Project team and Project Management Office to assess existing care pathways and other clinical tools for monitoring chronically ill patients. The project team and PMO will identify the common care paths and create educational tools and present for review by the Clinical Governance Committee for review and adoption.										
Task 3d. The educational tools created in Step 3c will be distributed to the SNFs and hospitals by the Provider Relations to be used as guidance in evaluating and monitoring patients. As needed additional education can be provided by the project lead and/or the trainor from the Workforce team.										
Task 3e. Workforce team and Provider Relations will educate hospital representatives on care pathways and preventive protocols created in step 3c in effort to align these throughout the PPS.										
Task 3f. Incorporate care pathway tools into SNF daily procedures. Staff within the SNF to provide feedback as necessary to the INTERACT champion & co-champion within the SNF.										
Task 3g. The INTERACT champion, co-champions and project team will meet at a minimum of once a year to review INTERACT care paths and related practice guidelines. The project team will										

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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
adjust as needed using the Clinical Governance Committee.										
Milestone #4 Educate all staff on care pathways and INTERACT principles.										
Task Training program for all SNF staff established encompassing care pathways and INTERACT principles.	0	0	0	0	0	0	0	0	0	0
Task 4b. Use INTERACT Champions in each facility to provide training sessions encompassing care pathways and INTERACT principles (e.g., annually or as seen appropriate by related parties) to all key staff including MD, FNP, PA etc. Record SNF training dates along with the number of staff trained. Review the content of the training annually with the Clinical Governance Committee and evaluate for adjustments needed.										
Task 4c. Each SNF will incorporate training of care pathways and INTERACT principles into new clinical staff orientation.										
Milestone #5 Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.										
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).										
Task 5b. Social Services Departments within each participating SNF to evaluate current Advance Care Planning tools and validate that usage is reflected in policies and procedures.										
Task 5c. Social Services Departments within each participating SNF and facility INTERACT champion to ensure Advance Care Planning tools meet the requirements of the INTERACT program. The Social Services Department and SNF Interact Champion/Co-Champion will adjust tools as needed working with the PMO and advised by the Clinical Governance Committee. The entire Interdisciplinary Team within the SNF will be educated on any changes to the Care Planning Tools within the month following the updates.										
Task 5d. The facility INTERACT champion and/or co-champion will audit use of advance care planning tools within the SNF and provide audit results to the PMO for review with the Clinical Governance Committee. The audits must be performed annually at a minimum.										

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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 5e. Social Services Department within each participating SNF to conduct meetings with residents and family members using the facility established Advance Care Planning tools.										
Task 5f. The facility INTERACT champion and/or co-champion and Social Services Department within the SNF will reassess Advance Care Planning tools annually at a minimum. The INTERACT champion, co-champion and Social Services Department within the SNF will update the tools as required. The entire Interdisciplinary team within the SNF will be educated on any changes to the Care Planning Tools within the month following the updates.										
Milestone #6 Create coaching program to facilitate and support implementation.										
Task INTERACT coaching program established at each SNF.	0	0	0	0	0	0	0	0	0	0
Task 6b. Identify an INTERACT Champion located within each SNF. This Champion will be used for train-the-trainer programs within each respective organization to facilitate sustainability.										
Task 6c. Leverage Champions and facility Co-Champions in order to ensure continuity of training programs across units (facilities and RPUs).										
Task 6d. Integrate training efforts and needs with existing Performing Provider System (PPS) resources, such as the Workforce Strategy team and relationships built through the Provider Relations team.										
Task 6e. Each SNF will prepare standardized progress reports (e.g., monthly) to the Care Compass Network PMO. The progress reports will include overview of key metrics, deliverables, as well as areas of success and implementation challenges at a minimum in order to assist the SNF during the implementation process.										
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.										
Task Patients and families educated and involved in planning of care using INTERACT principles.										
Task 7b. The Project Team, in conjunction with the PMO 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
Workforce Team (as needed) will create an educational strategy which will be leveraged for patient and family/caretakers distribution to supplement information found on INTERACT website regarding care planning. The strategy will outline the materials to be distributed, methods for refreshing materials for pertinence, as well as what the delivery method(s) will be for distribution. The plan will, at minimum, incorporate concepts as further outlined in the steps outlined in this plan.										
Task 7c. The PPS will collaborate and/or engage with local governing units (e.g., Social Service agencies) to facilitate patient and family/caretaker discussions with each participating facility.										
Task 7d. The PPS will facilitate the achievement of interdisciplinary meetings focused on advanced care planning for the PPS community of related providers.										
Task 7e. Identify Stop and Watch tool in SNF admissions packet and discuss with family members.										
Task 7f. The comprehensive training strategy, materials, and distribution methods (as well as targeted audiences) will be delivered on at minimum an annual basis beginning in DSRIP year 2.										
Milestone #8 Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	9	9	9
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task 8d. The 2bvii Project Team will engage with safety net Skilled Nursing Facilities (SNFs) in the development of enhanced communication tools which will allow for increased functionality such as the generation and delivery of CCD files or delivery of system generated reports which can be aligned with acute care hospital. As required, the PPS will promote SNF staff training on use of health information exchange with assistance of systems and functionality. Training will include, as identified, education										

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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 facilities regarding the sharing of data through data agreements such as the DURSA or BAA.										
Task 8e. SNF facilities are to receive education to inform them tracking/trending improvements in quality of care can be achieved most efficiently with an electronic health record that allows increased accessibility, sharing of data and analysis of data. Proof of education from each participating facility shall be reported to the PMO.										
Task 8f. Each participating SNF to create and communicate a Nursing Home Capabilities List to local hospital emergency room staff, local hospital discharge planners and local hospital physicians at a minimum.										
Milestone #9 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.										
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.										
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.										
Task Service and quality outcome measures are reported to all stakeholders.										
Task 9e. Form a PPS quality committee that includes SNF representation.										
Task 9f.After establishing baseline data the Interdisciplinary Team within the SNF will develop a quality improvement plan using the INTERACT quality improvement principles as a guide. Root cause analysis of transfers to hospitals to be used as data in development of the quality improvement plan. Each SNF to report out put of the quality improvement plan to the PMO office along with a timeline for implementing the quality improvement plan. A progress report to be submitted by the SNF to the PMO to communicate progress of the recommended improvements on a pre-determined basis (e.g., monthly/quarterly as appropriate).										

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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 9g. The project team and PMO to identify metrics to be used (such as Attachment J metrics) through the Clinical Governance Committee. Additionally, alternative or substitutive interventions as identified during the root cause analysis process will be validated by the Clinical Governance Committee and Board of Directors prior to adoption by the 2bvii Project Team.										
Milestone #10 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 10b. PMO and project team will review and determine criteria and metrics for counting/tracking patient engagement--EHR data, encounter data, INTERACT tool usage, etc. as well as the associated integration efforts for population health purposes with oversight from both the Clinical Governance Committee and the IT & Data Governance Committee.										
Task 10c. The PPS will analyze SNFs for alignment opportunities with the identified criteria and metric requirements. As needed the PPS will pursue the facilitation of resources to track patients engaged in the project, such as the alignment of SNF EHR/EHR Lite tools with INTERACT toolkits.										
Task 10d. The project team in conjunction with the Workforce team and IT team to identify workflows impacted due to new technology and document new workflows for the impacted SNFs.										
Task 10e. Utilize the Workforce team to train staff on technology and workflow.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.										
Task INTERACT principles implemented at each participating SNF.										
Task Nursing home to hospital transfers reduced.	23	23	23	23	23	23	23	23	23	23

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task INTERACT 3.0 Toolkit used at each SNF.	9	9	9	9	9	9	9	9	9	9
Task 1d. SNF INTERACT Project Champion to perform a baseline assessment of staff to identify existing INTERACT expertise within their facility and work with the Workforce Development and Transition Team (WDTT) to determine staffing needs .										
Task 1e. Within each participating SNF, evaluate current processes and tools and compare them to the tools in the INTERACT program. Integrate INTERACT tools into the daily work flow using the INTERACT implementation guide.										
Task 1f. The PPS INTERACT Project team, PMO, and Finance Manager will incorporate the core components of the 2bvii project to the PPS budget and funds flow model. Once finalized and approved by the Finance Committee and Board of Directors the PPS will negotiate INTERACT implementation contracts with the associated SNFs.										
Task 1g. As part of the contracting process, identify an INTERACT Project Champion for each SNF to provide on-site project oversight as well as communication with the PPS PMO and Project Team for reporting purposes. PMO to draft a letter to each facility/provider outlining expected level of participation in the project as well as benefits available for collaborating in these efforts with the PPS. If facility/provider is unable to continue the commitment required, PMO will conduct a root cause analysis to assist the affected facility(s) to determine provider specific risks and mitigation factors.										
Task 1h. INTERACT Champion at each contracted SNF facility to ensure INTERACT principles are incorporated into the facilities' Quality Assurance and Process Improvement (QAPI) process and report to PMO.										
Milestone #2 Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.										
Task Facility champion identified for each SNF.	0	0	0	0	0	0	0	0	0	0
Task 2b. Identify an INTERACT champion per facility.										
Task 2c. Identify an INTERACT Co-Champion per facility.										
Task 2d. Train INTERACT Champion and Co-Champion 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
INTERACT principles.										
Milestone #3 Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.										
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.										
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.										
Task 3c. Project team and Project Management Office to assess existing care pathways and other clinical tools for monitoring chronically ill patients. The project team and PMO will identify the common care paths and create educational tools and present for review by the Clinical Governance Committee for review and adoption.										
Task 3d. The educational tools created in Step 3c will be distributed to the SNFs and hospitals by the Provider Relations to be used as guidance in evaluating and monitoring patients. As needed additional education can be provided by the project lead and/or the trainor from the Workforce team.										
Task 3e. Workforce team and Provider Relations will educate hospital representatives on care pathways and preventive protocols created in step 3c in effort to align these throughout the PPS.										
Task 3f. Incorporate care pathway tools into SNF daily procedures. Staff within the SNF to provide feedback as necessary to the INTERACT champion & co-champion within the SNF.										
Task 3g. The INTERACT champion, co-champions and project team will meet at a minimum of once a year to review INTERACT care paths and related practice guidelines. The project team will adjust as needed using the Clinical Governance Committee.										
Milestone #4 Educate all staff on care pathways and INTERACT principles.										
Task Training program for all SNF staff established encompassing care pathways and INTERACT principles.	0	0	0	0	0	0	0	0	0	0

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 4b. Use INTERACT Champions in each facility to provide training sessions encompassing care pathways and INTERACT principles (e.g., annually or as seen appropriate by related parties) to all key staff including MD, FNP, PA etc. Record SNF training dates along with the number of staff trained. Review the content of the training annually with the Clinical Governance Committee and evaluate for adjustments needed.										
Task 4c. Each SNF will incorporate training of care pathways and INTERACT principles into new clinical staff orientation.										
Milestone #5 Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.										
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).										
Task 5b. Social Services Departments within each participating SNF to evaluate current Advance Care Planning tools and validate that usage is reflected in policies and procedures.										
Task 5c. Social Services Departments within each participating SNF and facility INTERACT champion to ensure Advance Care Planning tools meet the requirements of the INTERACT program. The Social Services Department and SNF Interact Champion/Co-Champion will adjust tools as needed working with the PMO and advised by the Clinical Governance Committee. The entire Interdisciplinary Team within the SNF will be educated on any changes to the Care Planning Tools within the month following the updates.										
Task 5d. The facility INTERACT champion and/or co-champion will audit use of advance care planning tools within the SNF and provide audit results to the PMO for review with the Clinical Governance Committee. The audits must be performed annually at a minimum.										
Task 5e. Social Services Department within each participating SNF to conduct meetings with residents and family members using the facility established Advance Care Planning tools.										
Task 5f. The facility INTERACT champion and/or co-champion and Social Services Department within the SNF will reassess Advance Care Planning tools annually at a minimum. 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
INTERACT champion, co-champion and Social Services Department within the SNF will update the tools as required. The entire Interdisciplinary team within the SNF will be educated on any changes to the Care Planning Tools within the month following the updates.										
Milestone #6 Create coaching program to facilitate and support implementation.										
Task INTERACT coaching program established at each SNF.	0	0	0	0	0	0	0	0	0	0
Task 6b. Identify an INTERACT Champion located within each SNF. This Champion will be used for train-the-trainer programs within each respective organization to facilitate sustainability.										
Task 6c. Leverage Champions and facility Co-Champions in order to ensure continuity of training programs across units (facilities and RPUs).										
Task 6d. Integrate training efforts and needs with existing Performing Provider System (PPS) resources, such as the Workforce Strategy team and relationships built through the Provider Relations team.										
Task 6e. Each SNF will prepare standardized progress reports (e.g., monthly) to the Care Compass Network PMO. The progress reports will include overview of key metrics, deliverables, as well as areas of success and implementation challenges at a minimum in order to assist the SNF during the implementation process.										
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.										
Task Patients and families educated and involved in planning of care using INTERACT principles.										
Task 7b. The Project Team, in conjunction with the PMO and Workforce Team (as needed) will create an educational strategy which will be leveraged for patient and family/caretakers distribution to supplement information found on INTERACT website regarding care planning. The strategy will outline the materials to be distributed, methods for refreshing materials for pertinence, as well as what the delivery method(s) will be for distribution. The plan will, at minimum, incorporate concepts as further outlined in the steps outlined in this plan.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 7c. The PPS will collaborate and/or engage with local governing units (e.g., Social Service agencies) to facilitate patient and family/caretaker discussions with each participating facility.										
Task 7d. The PPS will facilitate the achievement of interdisciplinary meetings focused on advanced care planning for the PPS community of related providers.										
Task 7e. Identify Stop and Watch tool in SNF admissions packet and discuss with family members.										
Task 7f. The comprehensive training strategy, materials, and distribution methods (as well as targeted audiences) will be delivered on at minimum an annual basis beginning in DSRIP year 2.										
Milestone #8 Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	9	9	9	9	9	9	9	9	9	9
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	23	23	23	23	23	23	23	23	23	23
Task 8d. The 2bvii Project Team will engage with safety net Skilled Nursing Facilities (SNFs) in the development of enhanced communication tools which will allow for increased functionality such as the generation and delivery of CCD files or delivery of system generated reports which can be aligned with acute care hospital. As required, the PPS will promote SNF staff training on use of health information exchange with assistance of systems and functionality. Training will include, as identified, education with facilities regarding the sharing of data through data agreements such as the DURSA or BAA.										
Task 8e. SNF facilities are to receive education to inform them tracking/trending improvements in quality of care can be achieved most efficiently with an electronic health record that allows increased accessibility, sharing of data and analysis of data. Proof of education from each participating facility shall be										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
reported to the PMO.										
Task 8f. Each participating SNF to create and communicate a Nursing Home Capabilities List to local hospital emergency room staff, local hospital discharge planners and local hospital physicians at a minimum.										
Milestone #9 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.										
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.										
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.										
Task Service and quality outcome measures are reported to all stakeholders.										
Task 9e. Form a PPS quality committee that includes SNF representation.										
Task 9f.After establishing baseline data the Interdisciplinary Team within the SNF will develop a quality improvement plan using the INTERACT quality improvement principles as a guide. Root cause analysis of transfers to hospitals to be used as data in development of the quality improvement plan. Each SNF to report out put of the quality improvement plan to the PMO office along with a timeline for implementing the quality improvement plan. A progress report to be submitted by the SNF to the PMO to communicate progress of the recommended improvements on a pre-determined basis (e.g., monthly/quarterly as appropriate).										
Task 9g. The project team and PMO to identify metrics to be used (such as Attachment J metrics) through the Clinical Governance Committee. Additionally, alternative or substitutive interventions as identified during the root cause analysis process will be validated by the Clinical Governance Committee and Board of Directors prior to adoption by the 2bvii Project Team.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #10 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 10b. PMO and project team will review and determine criteria and metrics for counting/tracking patient engagement--EHR data, encounter data, INTERACT tool usage, etc. as well as the associated integration efforts for population health purposes with oversight from both the Clinical Governance Committee and the IT & Data Governance Committee.										
Task 10c. The PPS will analyze SNFs for alignment opportunities with the identified criteria and metric requirements. As needed the PPS will pursue the facilitation of resources to track patients engaged in the project, such as the alignment of SNF EHR/EHR Lite tools with INTERACT toolkits.										
Task 10d. The project team in conjunction with the Workforce team and IT team to identify workflows impacted due to new technology and document new workflows for the impacted SNFs.										
Task 10e. Utilize the Workforce team to train staff on technology and workflow.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.	There are ten Milestones with associated steps for implementation in the INTERACT project, none of which were targeted for completion in the DY1, Q2 report. During Q2 the Care Compass Network Clinical Governance Committee was approved by the Board of Directors on 10/13/15 and subsequently began meeting with the primary focus of initial acclimation to the DSRIP program as well as initial review and endorsement of clinical protocols, guidelines, etc. related to the DSRIP projects. The approach for the INTERACT project, including tools & protocols is scheduled for review by the Clinical Governance Committee at the 10/8/15 meeting and approval by the Board on 10/13/15. Following this and the adoption of the PPS-wide contract the CCN PMO will begin contracting with the SNFs in the nine county region relative to the INTERACT project work. As of Q2, there are 23 identified SNFs in the PPS for participation in the project, two of which are actively or in process of using the INTERACT toolkit and will be initial pilot sites for project implementation and contracting in

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Milestone Name	Narrative Text
	Q3. For other project movements in Q2, the CCN Finance Manager met with project 2biv leads and PMO members to identify and incorporate core components into the funds flow model. Overall the project remains on track for achievement of speed and scale numbers in DY1, Q3 as well as the completion of upcoming tasks by DY1, Q3 as scheduled.
Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	There are ten Milestones with associated steps for implementation in the INTERACT project, none of which were targeted for completion in the DY1, Q2 report. During Q2 the Care Compass Network Clinical Governance Committee was approved by the Board of Directors on 10/13/15 and subsequently began meeting with the primary focus of initial acclimation to the DSRIP program as well as initial review and endorsement of clinical protocols, guidelines, etc. related to the DSRIP projects. The approach for the INTERACT project, including tools & protocols is scheduled for review by the Clinical Governance Committee at the 10/8/15 meeting and approval by the Board on 10/13/15. Following this and the adoption of the PPS-wide contract the CCN PMO will begin contracting with the SNFs in the nine county region relative to the INTERACT project work. As of Q2, there are 23 identified SNFs in the PPS for participation in the project, two of which are actively or in process of using the INTERACT toolkit and will be initial pilot sites for project implementation and contracting in Q3. For other project movements in Q2, the CCN Finance Manager met with project 2biv leads and PMO members to identify and incorporate core components into the funds flow model. Overall the project remains on track for achievement of speed and scale numbers in DY1, Q3 as well as the completion of upcoming tasks by DY1, Q3 as scheduled.
Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	There are ten Milestones with associated steps for implementation in the INTERACT project, none of which were targeted for completion in the DY1, Q2 report. During Q2 the Care Compass Network Clinical Governance Committee was approved by the Board of Directors on 10/13/15 and subsequently began meeting with the primary focus of initial acclimation to the DSRIP program as well as initial review and endorsement of clinical protocols, guidelines, etc. related to the DSRIP projects. The approach for the INTERACT project, including tools & protocols is scheduled for review by the Clinical Governance Committee at the 10/8/15 meeting and approval by the Board on 10/13/15. Following this and the adoption of the PPS-wide contract the CCN PMO will begin contracting with the SNFs in the nine county region relative to the INTERACT project work. As of Q2, there are 23 identified SNFs in the PPS for participation in the project, two of which are actively or in process of using the INTERACT toolkit and will be initial pilot sites for project implementation and contracting in Q3. For other project movements in Q2, the CCN Finance Manager met with project 2biv leads and PMO members to identify and incorporate core components into the funds flow model. Overall the project remains on track for achievement of speed and scale numbers in DY1, Q3 as well as the completion of upcoming tasks by DY1, Q3 as scheduled.
Educate all staff on care pathways and INTERACT principles.	There are ten Milestones with associated steps for implementation in the INTERACT project, none of which were targeted for completion in the DY1, Q2 report. During Q2 the Care Compass Network Clinical Governance Committee was approved by the Board of Directors on 10/13/15 and subsequently began meeting with the primary focus of initial acclimation to the DSRIP program as well as initial review and endorsement of clinical protocols, guidelines, etc. related to the DSRIP projects. The approach for the INTERACT project, including tools & protocols is scheduled for review by the Clinical Governance Committee at the 10/8/15 meeting and approval by the Board on 10/13/15. Following this and the adoption of the PPS-wide contract the CCN PMO will begin contracting with the SNFs in the nine county region relative to the INTERACT project work. As of Q2, there are 23 identified SNFs in the PPS for participation in the project, two of which are actively or in process of using the INTERACT toolkit and will be initial pilot sites for project implementation and contracting in Q3. For other project movements in Q2, the CCN Finance Manager met with project 2biv leads and PMO members to identify and incorporate core components into the funds flow model. Overall the project remains on track for achievement of speed and scale numbers in DY1, Q3 as well as the completion of upcoming tasks by DY1, Q3 as scheduled.
Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	There are ten Milestones with associated steps for implementation in the INTERACT project, none of which were targeted for completion in the DY1, Q2 report. During Q2 the Care Compass Network Clinical Governance Committee was approved by the Board of Directors on 10/13/15 and subsequently began meeting with the primary focus of initial acclimation to the DSRIP program as well as initial review and endorsement of clinical protocols, guidelines, etc. related to the DSRIP projects. The approach for the INTERACT project, including tools & protocols is scheduled for review by the Clinical Governance Committee at the 10/8/15 meeting and approval by the Board on 10/13/15. Following this and the adoption of the PPS-wide contract the CCN PMO will begin

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	contracting with the SNFs in the nine county region relative to the INTERACT project work. As of Q2, there are 23 identified SNFs in the PPS for participation in the project, two of which are actively or in process of using the INTERACT toolkit and will be initial pilot sites for project implementation and contracting in Q3. For other project movements in Q2, the CCN Finance Manager met with project 2biv leads and PMO members to identify and incorporate core components into the funds flow model. Overall the project remains on track for achievement of speed and scale numbers in DY1, Q3 as well as the completion of upcoming tasks by DY1, Q3 as scheduled.
Create coaching program to facilitate and support implementation.	There are ten Milestones with associated steps for implementation in the INTERACT project, none of which were targeted for completion in the DY1, Q2 report. During Q2 the Care Compass Network Clinical Governance Committee was approved by the Board of Directors on 10/13/15 and subsequently began meeting with the primary focus of initial acclimation to the DSRIP program as well as initial review and endorsement of clinical protocols, guidelines, etc. related to the DSRIP projects. The approach for the INTERACT project, including tools & protocols is scheduled for review by the Clinical Governance Committee at the 10/8/15 meeting and approval by the Board on 10/13/15. Following this and the adoption of the PPS-wide contract the CCN PMO will begin contracting with the SNFs in the nine county region relative to the INTERACT project work. As of Q2, there are 23 identified SNFs in the PPS for participation in the project, two of which are actively or in process of using the INTERACT toolkit and will be initial pilot sites for project implementation and contracting in Q3. For other project movements in Q2, the CCN Finance Manager met with project 2biv leads and PMO members to identify and incorporate core components into the funds flow model. Overall the project remains on track for achievement of speed and scale numbers in DY1, Q3 as well as the completion of upcoming tasks by DY1, Q3 as scheduled.
Educate patient and family/caretakers, to facilitate participation in planning of care.	There are ten Milestones with associated steps for implementation in the INTERACT project, none of which were targeted for completion in the DY1, Q2 report. During Q2 the Care Compass Network Clinical Governance Committee was approved by the Board of Directors on 10/13/15 and subsequently began meeting with the primary focus of initial acclimation to the DSRIP program as well as initial review and endorsement of clinical protocols, guidelines, etc. related to the DSRIP projects. The approach for the INTERACT project, including tools & protocols is scheduled for review by the Clinical Governance Committee at the 10/8/15 meeting and approval by the Board on 10/13/15. Following this and the adoption of the PPS-wide contract the CCN PMO will begin contracting with the SNFs in the nine county region relative to the INTERACT project work. As of Q2, there are 23 identified SNFs in the PPS for participation in the project, two of which are actively or in process of using the INTERACT toolkit and will be initial pilot sites for project implementation and contracting in Q3. For other project movements in Q2, the CCN Finance Manager met with project 2biv leads and PMO members to identify and incorporate core components into the funds flow model. Overall the project remains on track for achievement of speed and scale numbers in DY1, Q3 as well as the completion of upcoming tasks by DY1, Q3 as scheduled.
Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	There are ten Milestones with associated steps for implementation in the INTERACT project, none of which were targeted for completion in the DY1, Q2 report. During Q2 the Care Compass Network Clinical Governance Committee was approved by the Board of Directors on 10/13/15 and subsequently began meeting with the primary focus of initial acclimation to the DSRIP program as well as initial review and endorsement of clinical protocols, guidelines, etc. related to the DSRIP projects. The approach for the INTERACT project, including tools & protocols is scheduled for review by the Clinical Governance Committee at the 10/8/15 meeting and approval by the Board on 10/13/15. Following this and the adoption of the PPS-wide contract the CCN PMO will begin contracting with the SNFs in the nine county region relative to the INTERACT project work. As of Q2, there are 23 identified SNFs in the PPS for participation in the project, two of which are actively or in process of using the INTERACT toolkit and will be initial pilot sites for project implementation and contracting in Q3. For other project movements in Q2, the CCN Finance Manager met with project 2biv leads and PMO members to identify and incorporate core components into the funds flow model. Overall the project remains on track for achievement of speed and scale numbers in DY1, Q3 as well as the completion of upcoming tasks by DY1, Q3 as scheduled.
Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	There are ten Milestones with associated steps for implementation in the INTERACT project, none of which were targeted for completion in the DY1, Q2 report. During Q2 the Care Compass Network Clinical Governance Committee was approved by the Board of Directors on 10/13/15 and subsequently began meeting with the primary focus of initial acclimation to the DSRIP program as well as initial review and endorsement of clinical protocols, guidelines, etc.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	related to the DSRIP projects. The approach for the INTERACT project, including tools & protocols is scheduled for review by the Clinical Governance Committee at the 10/8/15 meeting and approval by the Board on 10/13/15. Following this and the adoption of the PPS-wide contract the CCN PMO will begin contracting with the SNFs in the nine county region relative to the INTERACT project work. As of Q2, there are 23 identified SNFs in the PPS for participation in the project, two of which are actively or in process of using the INTERACT toolkit and will be initial pilot sites for project implementation and contracting in Q3. For other project movements in Q2, the CCN Finance Manager met with project 2biv leads and PMO members to identify and incorporate core components into the funds flow model. As of Q2 the quality subcommittees within each RPU have been formed and will be meeting during Q3. Each of the 4 RPU Disease Management subcommittees include a representative from a Skilled Nursing Facility (SNF) located within each RPU. Overall the project remains on track for achievement of speed and scale numbers in DY1, Q3 as well as the completion of upcoming tasks (e.g., 1f and 1g) by DY1, Q3 as scheduled.
Use EHRs and other technical platforms to track all patients engaged in the project.	There are ten Milestones with associated steps for implementation in the INTERACT project, none of which were targeted for completion in the DY1, Q2 report. During Q2 the Care Compass Network Clinical Governance Committee was approved by the Board of Directors on 10/13/15 and subsequently began meeting with the primary focus of initial acclimation to the DSRIP program as well as initial review and endorsement of clinical protocols, guidelines, etc. related to the DSRIP projects. The approach for the INTERACT project, including tools & protocols is scheduled for review by the Clinical Governance Committee at the 10/8/15 meeting and approval by the Board on 10/13/15. Following this and the adoption of the PPS-wide contract the CCN PMO will begin contracting with the SNFs in the nine county region relative to the INTERACT project work. As of Q2, there are 23 identified SNFs in the PPS for participation in the project, two of which are actively or in process of using the INTERACT toolkit and will be initial pilot sites for project implementation and contracting in Q3. For other project movements in Q2, the CCN Finance Manager met with project 2biv leads and PMO members to identify and incorporate core components into the funds flow model. Overall the project remains on track for achievement of speed and scale numbers in DY1, Q3 as well as the completion of upcoming tasks by DY1, Q3 as scheduled.

Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

Three major risks have been identified in development of the Community Based Health Navigator (CBHN) project to assist patients to access healthcare services efficiently. These include the following along with the mitigation strategy that has developed to decrease the risks identified.
1) The first risk is that the target population will not be aware or utilize health care and community resources available. It was identified during the community needs assessments that a low percentage of Medicaid recipients were not aware of health care and community resources. The potential impact of this risk to the project is continued inefficient use of available resources, resulting in both continued poor health of the target population and high costs of the system. To mitigate the risk, strategic marketing and community outreach as well as branding, use of social media is necessary to increase awareness and understanding for the beneficiary population. A consistent message will be developed which will be clear and at a level of understanding to consider limited cognitive skills. Means of distribution will be used that are successful in reaching the Medicaid recipients. Multiple distribution sites for material will be determined and a coordinated effort will be made with other projects.
2) Our second risk comes out of first, namely that once engaged, the target population will not be able to get the services needed because there is not sufficient healthcare resources, especially primary care physicians. The impact of this risk is continued inefficient use of available resources, especially use of ER and emergency transport. Our mitigation strategy includes Regional Performing Units and clinical integration teams establishing mechanisms and protocols for reporting gaps in service needs. Community Health Advocates (CHA) will facilitate the connection to clinical services. CHA's will coordinate non-clinical resources and set processes to identify and report any issues. Information about community resources will be routinely updated and stored in data bases, categorized by county, in an effort to maximize utilization of current resources.
3) Our final risk is a lack of transportation for our target population, especially in rural areas. The impact of this to the project success is continued inefficient use of available resources, resulting in both continued poor health of the target population and high costs to the system, also continued inappropriate use of the ER and emergency transport. Our mitigation strategy includes 211 providers and CHA providers tracking gaps in transportation availability to primary care resources. Gaps will identify specific areas and times of day and week that Medicaid recipients have not been able to find transportation. Reports identifying this information will be elevated to the project management level. The project management will coordinate meetings with all transportation providers to review the gaps and work together to develop a transportation system to fill the gaps and provide the resources necessary. The meeting could include public transportation providers , Commercial providers, human service providers, volunteer transportation, county sponsored services and personal transportation providers. These providers will be organized to provide a Transportation Committee to provide expertise and planning around transportation- related issues to support the 2c.i. project. Coordination with other projects throughout the PPS provider area will also be considered to evaluate possible solutions and resources. We will also build on existing services and networks established within our PPS to help mitigate risks such as transportation.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	26,500

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
0	0		0	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.	Project	N/A	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Community-based health navigation services established.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1b. Identify PPS Partners - Care Compass Network will assess the current PPS landscape to identify existing/established CBOs who currently provide navigation services. Scope of services provided, training received, and ability to train others, potential credentialing, existing networks of navigation and navigation-related services, IT capabilities, and other pertinent areas of existing infrastructure and operations will be assessed via a Pre-Engagement Assessment created by the CBO Engagement Council.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1c. Develop Navigator Roles - Using the results of the Pre-Engagement Assessment, the Project 2ci Team, Project Management Office, and Workforce Team of Care Compass Network will work in tandem with the CBOs with established navigation services to develop and define the CCN Community Health Advocate (CCN is employing the term "community health advocate" to delineate between NYS Health Exchange Navigators and navigators specific to this project) role and the description of services provided by this role. Existing CHA competencies and functions will be modified to address any gaps in current services provided as indicated in the Community Needs Assessment. The Onboarding Quality Committees within each Regional Performing Unit (RPU) will monitor the progress and results of these roles on an ongoing basis.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 1d. Training and Resources - Care Compass Network's Workforce Team and the Project 2ci Team will work in conjunction with the contracted organizations providing navigation services to develop a robust training program/resource guide. An initial training will be mandatory for organizations who contract with the PPS to perform Project 2ci related navigation services, supplemented by a community related resource guide. An ongoing, regular training schedule will be established for quality improvement and efficiency. Inherent to ongoing training will be the cross-pollination of Community Health Advocates from across the PPS. Best practices will be discussed and assessed by CHAs from adjacent RPUs and neighboring PPSs as they are able to participate. Once this role's competencies and services provided have been approved and contracts have been executed between CCN and participating organizations, related training will delivered.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1e. Navigation Collaboration - The PPS will develop forums to assist Navigators in the identification and adoption of leading practices, lessons learned, overview of results (e.g., metrics to highlight whether navigated services resulted in reduced ED and IP admissions) and general 'tricks of the trade' which have been learned through first hand navigation experiences. Through these forums feedback on the PPS training and resources will be solicited to determine efficacy of materials, which in tandem with program metrics and results will allow the 2ci Project Team and PMO to gather suggestions to the Workforce team for plan modification (as needed).	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1f. Execute Contracts - The PPS project 2ci budget will be approved by the Finance Governance Committee and Board of Directors, after which PPS Contracts developed by the PPS leadership and Legal team will be leveraged by the PMO and Project 2ci Team to contract with organizations for community-based health navigation services.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #2	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	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
Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.									
Task Resource guide completed, detailing medical/behavioral/social community resources and care protocols developed by program oversight committee.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2b. The 2ci Project Team will develop a Program Oversight Group to develop a Community Care Resource Guide. The Program Oversight Group will be comprised of members from the 2ci Project Team, PMO, Workforce Development Team, as well as representatives from medical/behavioral health, 211 centers, community nursing, and social services providers (including faith based organizations that provide support for chronic illness, etc.). Once developed the Resource Guide will be approved by the Clinical Governance Committee and be used to supplement PPS navigation related training efforts (as outlined in Milestone 1). Review of this resource will occur annually at a minimum for any potential alterations.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2c. The Clinical Governance Committee, through the responsible Onboarding Quality Committee (e.g., an oversight committee) will review performance and adherence to estasblished policies, procedures, metric outcomes, and deliverables. As needed ammendments to the Community Care Resource Guide will be identified by the Program Oversight Group and/or Quality Committee and presented to the Clinical Governance Committee for endorsement. Any resource guide changes will be directly communicated, supplemented by training (if required), and openly published (e.g., CCN website, SharePoint) to ensure all PPS partners have access to PPS guidances.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2d. The Workforce Team will work in conjunction with the Project Management Office to modify training materials to train navigators using tools such as classroom techniques, small groups, 1-on-1 training, modeling, and/or shadowing. Regularly	Project		In Progress	04/01/2015	03/31/2016	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
scheduled re-training will be established to allow for new partners/CHAs to receive training.									
Milestone #3 Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Navigators recruited by residents in the targeted area, where possible.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3b. The PPS will leverage the Workforce Development Team to provide oversight to the creation/review of community navigator job descriptions, roles/responsibilities, with consideration for regional needs of the nine county PPS (as appropriate).	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3c. The Workforce Development Team will work with the Project Management Office to provide PPS partner organizations support related to their recruitment of Community Health Advocates/Community Navigators with consideration for how to obtain input from the local community talent pool.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3d. The Workforce Development Team and Provider Relations Team will collaborate with PPS Partners to confirm they have available tools and resources, including PPS developed resource guides to facilitate the training of new community navigators. As required by the PPS partner organization contract the existing and newly hired community navigators will receive and certify completion of PPS training materials.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Resource appropriately for the community navigators, evaluating placement and service type.	Project	N/A	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Navigator placement implemented based upon opportunity assessment.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Telephonic and web-based health navigator services implemented by type.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4c. The Project 2ci Team and PMO will perform an assessment of existing community navigators, including identification of potential locations and number of required navigators based on	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
established, navigator service type (e.g., in person, telephonic, web-based), and evolving regional needs and DSRIP requirements (e.g., project plan, speed and scale, etc.)									
Task 4d. The Project 2ci and PMO teams will create site location directory of navigator services by service type. As identified, staffing shortages (e.g., by skillset, staffing numbers, etc.) will be communicated to PPS partners, documented and presented to the associated Onboarding Quality Committees at the appropriate Regional Performing Unit, and a remediation plan/roadmap developed.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #5 Provide community navigators with access to non-clinical resources, such as transportation and housing services.	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Navigators have partnerships with transportation, housing, and other social services benefitting target population.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5b. Project Management Office will assess existing non-clinical resources and their relationships to CBOs providing navigation services in order to utilize and maximize current resource base.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5c. Project Management Office will coordinate maintenance and enhancement of existing non-clinical resources in the comprehensive resource guide for navigators.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5d. Project Management Office will ensure delivery of training and orient all community navigators to non-clinical resources by partnering with the eight participating providers using existing curriculums which will be reviewed and modified to create standard protocols then used to train navigators using classroom techniques, small groups, 1-on-1 training, modeling, and shadowing. Additionally, Industry on line training through associations or contractors will be included to provide additional support and reinforcement to understand vital concepts.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone #6 Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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 Case loads and discharge processes established for health navigators following patients longitudinally.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6b. The 2ci Project Team and PMO will collaborate with the Program Oversight Group to identify hot spotting opportunities/approaches for where navigators are needed within the PPS. Following initial assessments, the Program Oversight Group will help to monitor the optimal patient-to-community health advocate ratio by comparing previous ratios and workflows and what is needed for meeting established Speed and Scale needs.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 6c. The 2ci Project Team and PMO will collaborate with the Program Oversight Group to determine what constitues a 'graduation from the navigation program' to identify patients by status/buckets (e.g., Navigation services no longer required, On Watch for a certain period of time, Close Supervision Suggested, etc.). As appropriate standards and protocols, such as the definition of 'close supervision suggested' will be endorsed by the Clinical Governance Committee.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6d. The 2ci Project Team, PMO, and participating CBOs will develop discharge processes for patients who receive navigation services. Triggers for discharge, proper follow up post-discharge, and other methodological considerations will be borrowed from existing dicharge processes, synthesized with current and future needs, and/or created anew. These processes will be assessed and approved by the Clinical Governance Committee.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6e. As required, the IT & Data Governance Committee will be solicited to identify tools/resources required for the tracking of patient flows, databases, and/or reporting.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #7 Market the availability of community-based navigation services.	Project	N/A	In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Health navigator personnel and services marketed within designated communities.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 7b. The 2ci Project Team and PMO will conduct an assessment	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

Care Compass Network (PPS ID:44)

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
to identify community hot spots in need of community health advocates. Once complete, the Project 2ci Team will work in tandem with the Project Management Office along with the CCN marketing and outreach planning team to create a marketing plan which promotes the available service needs to place required workers in said hot spots.									
Task 7c. As part of the marketing plan, there will be targeted outreach strategies to different audiences (i.e., Providers, patients, community organizations, community leaders, etc.). The CCN Marketing and Communications team will reassess the efficacy of the marketing plan versus achievement of outcomes to determine if strategies need to be modified. Additionally, the PPS will collaborate with adjacent PPSs ('overlapping PPSs') to align communication strategies where possible.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #8 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 8b. The 2ci Project Team, in collaboration with the PMO and IT Workgroup will develop a set of standard Electronic Health Record (EHR) or other technical platform core requirements for organizations participating in the 2ci project to confirm navigated patient related services are properly documented and recorded and aligned with DSRIP needs.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 8c. As required, the PPS will provide technical assistance and training to CHA organizations to assure appropriate utilization and implementation of EMRs and/or other technical platforms to track all patients engaged in the 2ci project.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	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 Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
efficiently.										
Task Community-based health navigation services established.										
Task 1b. Identify PPS Partners - Care Compass Network will assess the current PPS landscape to identify existing/established CBOs who currently provide navigation services. Scope of services provided, training received, and ability to train others, potential credentialing, existing networks of navigation and navigation-related services, IT capabilities, and other pertinent areas of existing infrastructure and operations will be assessed via a Pre-Engagement Assessment created by the CBO Engagement Council.										
Task 1c. Develop Navigator Roles - Using the results of the Pre-Engagement Assessment, the Project 2ci Team, Project Management Office, and Workforce Team of Care Compass Network will work in tandem with the CBOs with established navigation services to develop and define the CCN Community Health Advocate (CCN is employing the term "community health advocate" to delineate between NYS Health Exchange Navigators and navigators specific to this project) role and the description of services provided by this role. Existing CHA competencies and functions will be modified to address any gaps in current services provided as indicated in the Community Needs Assessment. The Onboarding Quality Committees within each Regional Performing Unit (RPU) will monitor the progress and results of these roles on an ongoing basis.										
Task 1d. Training and Resources - Care Compass Network's Workforce Team and the Project 2ci Team will work in conjunction with the contracted organizations providing navigation services to develop a robust training program/resource guide. An initial training will be mandatory for organizations who contract with the PPS to perform Project 2ci related navigation services, supplemented by a community related resource guide. An ongoing, regular training schedule will be established for quality improvement and efficiency. Inherent to ongoing training will be the cross-pollination of Community Health Advocates from across the PPS. Best practices will be discussed and assessed by CHAs from adjacent RPUs and neighboring PPSs as they are able to participate. Once this role's competencies and services provided have been approved and contracts have been executed between CCN and										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
participating organizations, related training will delivered.										
Task 1e. Navigation Collaboration - The PPS will develop forums to assist Navigators in the identification and adoption of leading practices, lessons learned, overview of results (e.g., metrics to highlight whether navigated services resulted in reduced ED and IP admissions) and general 'tricks of the trade' which have been learned through first hand navigation experiences. Through these forums feedback on the PPS training and resources will be solicited to determine efficacy of materials, which in tandem with program metrics and results will allow the 2ci Project Team and PMO to gather suggestions to the Workforce team for plan modification (as needed).										
Task 1f. Execute Contracts - The PPS project 2ci budget will be approved by the Finance Governance Committee and Board of Directors, after which PPS Contracts developed by the PPS leadership and Legal team will be leveraged by the PMO and Project 2ci Team to contract with organizations for community-based health navigation services.										
Milestone #2 Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.										
Task Resource guide completed, detailing medical/behavioral/social community resources and care protocols developed by program oversight committee.										
Task 2b. The 2ci Project Team will develop a Program Oversight Group to develop a Community Care Resource Guide. The Program Oversight Group will be comprised of members from the 2ci Project Team, PMO, Workforce Development Team, as well as representatives from medical/behavioral health, 211 centers, community nursing, and social services providers (including faith based organizations that provide support for chronic illness, etc.). Once developed the Resource Guide will be approved by the Clinical Governance Committee and be used to supplement PPS navigation related training efforts (as outlined in Milestone 1). Review of this resource will occur annually at a minimum for any potential alterations.										
Task 2c. The Clinical Governance Committee, through the responsible										

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Onboarding Quality Committee (e.g., an oversight committee) will review performance and adherence to estasblished policies, procedures, metric outcomes, and deliverables. As needed ammendments to the Community Care Resource Guide will be identified by the Program Oversight Group and/or Quality Committee and presented to the Clinical Governance Committee for endorsement. Any resource guide changes will be directly communicated, supplemented by training (if required), and openly published (e.g., CCN website, SharePoint) to ensure all PPS partners have access to PPS guidances.										
Task 2d. The Workforce Team will work in conjunction with the Project Management Office to modify training materials to train navigators using tools such as classroom techniques, small groups, 1-on-1 training, modeling, and/or shadowing. Regularly scheduled re-training will be established to allow for new partners/CHAs to receive training.										
Milestone #3 Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.										
Task Navigators recruited by residents in the targeted area, where possible.										
Task 3b. The PPS will leverage the Workforce Development Team to provide oversight to the creation/review of community navigator job descriptions, roles/responsibilities, with consideration for regional needs of the nine county PPS (as appropriate).										
Task 3c. The Workforce Development Team will work with the Project Management Office to provide PPS partner organizations support related to their recruitment of Community Health Advocates/Community Navigators with consideration for how to obtain input from the local community talent pool.										
Task 3d. The Workforce Development Team and Provider Relations Team will collaborate with PPS Partners to confirm they have available tools and resources, including PPS developed resource guides to facilitate the training of new community navigators. As required by the PPS partner organization contract the existing and newly hired community navigators will receive and certify completion of PPS training materials.										
Milestone #4 Resource appropriately for the community navigators, evaluating placement and service type.										

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project 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 Navigator placement implemented based upon opportunity assessment.										
Task Telephonic and web-based health navigator services implemented by type.										
Task 4c. The Project 2ci Team and PMO will perform an assessment of existing community navigators, including identification of potential locations and number of required navigators based on established, navigator service type (e.g., in person, telephonic, web-based), and evolving regional needs and DSRIP requirements (e.g., project plan, speed and scale, etc.)										
Task 4d. The Project 2ci and PMO teams will create site location directory of navigator services by service type. As identified, staffing shortages (e.g., by skillset, staffing numbers, etc.) will be communicated to PPS partners, documented and presented to the associated Onboarding Quality Committees at the appropriate Regional Performing Unit, and a remediation plan/roadmap developed.										
Milestone #5 Provide community navigators with access to non-clinical resources, such as transportation and housing services.										
Task Navigators have partnerships with transportation, housing, and other social services benefitting target population.										
Task 5b. Project Management Office will assess existing non-clinical resources and their relationships to CBOs providing navigation services in order to utilize and maximize current resource base.										
Task 5c. Project Management Office will coordinate maintenance and enhancement of existing non-clinical resources in the comprehensive resource guide for navigators.										
Task 5d. Project Management Office will ensure delivery of training and orient all community navigators to non-clinical resources by partnering with the eight participating providers using existing curriculums which will be reviewed and modified to create standard protocols then used to train navigators using classroom techniques, small groups, 1-on-1 training, modeling, and shadowing. Additionally, Industry on line training through associations or contractors will be included to provide additional support and reinforcement to understand vital concepts.										

Care Compass Network (PPS ID:44)

Project 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 #6 Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.										
Task Case loads and discharge processes established for health navigators following patients longitudinally.										
Task 6b. The 2ci Project Team and PMO will collaborate with the Program Oversight Group to identify hot spotting opportunities/approaches for where navigators are needed within the PPS. Following initial assessments, the Program Oversight Group will help to monitor the optimal patient-to-community health advocate ratio by comparing previous ratios and workflows and what is needed for meeting established Speed and Scale needs.										
Task 6c. The 2ci Project Team and PMO will collaborate with the Program Oversight Group to determine what constitues a 'graduation from the navigation program' to identify patients by status/buckets (e.g., Navigation services no longer required, On Watch for a certain period of time, Close Supervision Suggested, etc.). As appropriate standards and protocols, such as the definition of 'close supervision suggested' will be endorsed by the Clinical Governance Committee.										
Task 6d. The 2ci Project Team, PMO, and participating CBOs will develop discharge processes for patients who receive navigation services. Triggers for discharge, proper follow up post-discharge, and other methodological considerations will be borrowed from existing dicharge processes, synthesized with current and future needs, and/or created anew. These processes will be assessed and approved by the Clinical Governance Committee.										
Task 6e. As required, the IT & Data Governance Committee will be solicited to identify tools/resources required for the tracking of patient flows, databases, and/or reporting.										
Milestone #7 Market the availability of community-based navigation services.										
Task Health navigator personnel and services marketed within designated communities.										
Task 7b. The 2ci Project Team and PMO will conduct an assessment to identify community hot spots in need of community health advocates. Once complete, the Project 2ci Team will work in										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
tandem with the Project Management Office along with the CCN marketing and outreach planning team to create a marketing plan which promotes the available service needs to place required workers in said hot spots.										
Task 7c. As part of the marketing plan, there will be targeted outreach strategies to different audiences (i.e., Providers, patients, community organizations, community leaders, etc.). The CCN Marketing and Communications team will reassess the efficacy of the marketing plan versus achievement of outcomes to determine if strategies need to be modified. Additionally, the PPS will collaborate with adjacent PPSs ('overlapping PPSs') to align communication strategies where possible.										
Milestone #8 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 8b. The 2ci Project Team, in collaboration with the PMO and IT Workgroup will develop a set of standard Electronic Health Record (EHR) or other technical platform core requirements for organizations participating in the 2ci project to confirm navigated patient related services are properly documented and recorded and aligned with DSRIP needs.										
Task 8c. As required, the PPS will provide technical assistance and training to CHA organizations to assure appropriate utilization and implementation of EMRs and/or other technical platforms to track all patients engaged in the 2ci project.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.										
Task Community-based health navigation services established.										
Task 1b. Identify PPS Partners - Care Compass Network will assess the current PPS landscape to identify existing/established CBOs who currently provide navigation services. Scope of services provided, training received, and ability to train others, potential										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
credentialing, existing networks of navigation and navigation-related services, IT capabilities, and other pertinent areas of existing infrastructure and operations will be assessed via a Pre-Engagement Assessment created by the CBO Engagement Council.										
Task 1c. Develop Navigator Roles - Using the results of the Pre-Engagement Assessment, the Project 2ci Team, Project Management Office, and Workforce Team of Care Compass Network will work in tandem with the CBOs with established navigation services to develop and define the CCN Community Health Advocate (CCN is employing the term "community health advocate" to delineate between NYS Health Exchange Navigators and navigators specific to this project) role and the description of services provided by this role. Existing CHA competencies and functions will be modified to address any gaps in current services provided as indicated in the Community Needs Assessment. The Onboarding Quality Committees within each Regional Performing Unit (RPU) will monitor the progress and results of these roles on an ongoing basis.										
Task 1d. Training and Resources - Care Compass Network's Workforce Team and the Project 2ci Team will work in conjunction with the contracted organizations providing navigation services to develop a robust training program/resource guide. An initial training will be mandatory for organizations who contract with the PPS to perform Project 2ci related navigation services, supplemented by a community related resource guide. An ongoing, regular training schedule will be established for quality improvement and efficiency. Inherent to ongoing training will be the cross-pollination of Community Health Advocates from across the PPS. Best practices will be discussed and assessed by CHAs from adjacent RPUs and neighboring PPSs as they are able to participate. Once this role's competencies and services provided have been approved and contracts have been executed between CCN and participating organizations, related training will delivered.										
Task 1e. Navigation Collaboration - The PPS will develop forums to assist Navigators in the identification and adoption of leading practices, lessons learned, overview of results (e.g., metrics to highlight whether navigated services resulted in reduced ED and IP admissions) and general 'tricks of the trade' which have been learned through first hand navigation experiences. Through these forums feedback on the PPS training and resources will be										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
solicited to determine efficacy of materials, which in tandem with program metrics and results will allow the 2ci Project Team and PMO to gather suggestions to the Workforce team for plan modification (as needed).										
Task 1f. Execute Contracts - The PPS project 2ci budget will be approved by the Finance Governance Committee and Board of Directors, after which PPS Contracts developed by the PPS leadership and Legal team will be leveraged by the PMO and Project 2ci Team to contract with organizations for community-based health navigation services.										
Milestone #2 Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.										
Task Resource guide completed, detailing medical/behavioral/social community resources and care protocols developed by program oversight committee.										
Task 2b. The 2ci Project Team will develop a Program Oversight Group to develop a Community Care Resource Guide. The Program Oversight Group will be comprised of members from the 2ci Project Team, PMO, Workforce Development Team, as well as representatives from medical/behavioral health, 211 centers, community nursing, and social services providers (including faith based organizations that provide support for chronic illness, etc.). Once developed the Resource Guide will be approved by the Clinical Governance Committee and be used to supplement PPS navigation related training efforts (as outlined in Milestone 1). Review of this resource will occur annually at a minimum for any potential alterations.										
Task 2c. The Clinical Governance Committee, through the responsible Onboarding Quality Committee (e.g., an oversight committee) will review performance and adherence to estasblished policies, procedures, metric outcomes, and deliverables. As needed ammendments to the Community Care Resource Guide will be identified by the Program Oversight Group and/or Quality Committee and presented to the Clinical Governance Committee for endorsement. Any resource guide changes will be directly communicated, supplemented by training (if required), and openly published (e.g., CCN website, SharePoint) to ensure all PPS partners have access to PPS guidances.										

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project 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 2d. The Workforce Team will work in conjunction with the Project Management Office to modify training materials to train navigators using tools such as classroom techniques, small groups, 1-on-1 training, modeling, and/or shadowing. Regularly scheduled re-training will be established to allow for new partners/CHAs to receive training.										
Milestone #3 Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.										
Task Navigators recruited by residents in the targeted area, where possible.										
Task 3b. The PPS will leverage the Workforce Development Team to provide oversight to the creation/review of community navigator job descriptions, roles/responsibilities, with consideration for regional needs of the nine county PPS (as appropriate).										
Task 3c. The Workforce Development Team will work with the Project Management Office to provide PPS partner organizations support related to their recruitment of Community Health Advocates/Community Navigators with consideration for how to obtain input from the local community talent pool.										
Task 3d. The Workforce Development Team and Provider Relations Team will collaborate with PPS Partners to confirm they have available tools and resources, including PPS developed resource guides to facilitate the training of new community navigators. As required by the PPS partner organization contract the existing and newly hired community navigators will receive and certify completion of PPS training materials.										
Milestone #4 Resource appropriately for the community navigators, evaluating placement and service type.										
Task Navigator placement implemented based upon opportunity assessment.										
Task Telephonic and web-based health navigator services implemented by type.										
Task 4c. The Project 2ci Team and PMO will perform an assessment of existing community navigators, including identification of potential locations and number of required navigators based on established, navigator service type (e.g., in person, telephonic,										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
web-based), and evolving regional needs and DSRIP requirements (e.g., project plan, speed and scale, etc.)										
Task 4d. The Project 2ci and PMO teams will create site location directory of navigator services by service type. As identified, staffing shortages (e.g., by skillset, staffing numbers, etc.) will be communicated to PPS partners, documented and presented to the associated Onboarding Quality Committees at the appropriate Regional Performing Unit, and a remediation plan/roadmap developed.										
Milestone #5 Provide community navigators with access to non-clinical resources, such as transportation and housing services.										
Task Navigators have partnerships with transportation, housing, and other social services benefitting target population.										
Task 5b. Project Management Office will assess existing non-clinical resources and their relationships to CBOs providing navigation services in order to utilize and maximize current resource base.										
Task 5c. Project Management Office will coordinate maintenance and enhancement of existing non-clinical resources in the comprehensive resource guide for navigators.										
Task 5d. Project Management Office will ensure delivery of training and orient all community navigators to non-clinical resources by partnering with the eight participating providers using existing curriculums which will be reviewed and modified to create standard protocols then used to train navigators using classroom techniques, small groups, 1-on-1 training, modeling, and shadowing. Additionally, Industry on line training through associations or contractors will be included to provide additional support and reinforcement to understand vital concepts.										
Milestone #6 Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.										
Task Case loads and discharge processes established for health navigators following patients longitudinally.										
Task 6b. The 2ci Project Team and PMO will collaborate with the Program Oversight Group to identify hot spotting opportunities/approaches for where navigators are needed within the PPS. Following initial assessments, the Program Oversight										

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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
Group will help to monitor the optimal patient-to-community health advocate ratio by comparing previous ratios and workflows and what is needed for meeting established Speed and Scale needs.										
Task 6c. The 2ci Project Team and PMO will collaborate with the Program Oversight Group to determine what constitues a 'graduation from the navigation program' to identify patients by status/buckets (e.g., Navigation services no longer required, On Watch for a certain period of time, Close Supervision Suggested, etc.). As appropriate standards and protocols, such as the definition of 'close supervision suggested' will be endorsed by the Clinical Governance Committee.										
Task 6d. The 2ci Project Team, PMO, and participating CBOs will develop discharge processes for patients who receive navigation services. Triggers for discharge, proper follow up post-discharge, and other methodological considerations will be borrowed from existing dicharge processes, synthesized with current and future needs, and/or created anew. These processes will be assessed and approved by the Clinical Governance Committee.										
Task 6e. As required, the IT & Data Governance Committee will be solicited to identify tools/resources required for the tracking of patient flows, databases, and/or reporting.										
Milestone #7 Market the availability of community-based navigation services.										
Task Health navigator personnel and services marketed within designated communities.										
Task 7b. The 2ci Project Team and PMO will conduct an assessment to identify community hot spots in need of community health advocates. Once complete, the Project 2ci Team will work in tandem with the Project Management Office along with the CCN marketing and outreach planning team to create a marketing plan which promotes the available service needs to place required workers in said hot spots.										
Task 7c. As part of the marketing plan, there will be targeted outreach strategies to different audiences (i.e., Providers, patients, community organizations, community leaders, etc.). The CCN Marketing and Communications team will reassess the efficacy of the marketing plan versus achievement of outcomes to determine if strategies need to be modified. Additionally, the PPS will collaborate with adjacent PPSs ('overlapping PPSs') 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
align communication strategies where possible.										
Milestone #8 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 8b. The 2ci Project Team, in collaboration with the PMO and IT Workgroup will develop a set of standard Electronic Health Record (EHR) or other technical platform core requirements for organizations participating in the 2ci project to confirm navigated patient related services are properly documented and recorded and aligned with DSRIP needs.										
Task 8c. As required, the PPS will provide technical assistance and training to CHA organizations to assure appropriate utilization and implementation of EMRs and/or other technical platforms to track all patients engaged in the 2ci project.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.	In April 2015, the Care Compass Network (CCN) Project 2ci Team developed an assessment to gauge the existing services, programs, and general level of readiness for CCN partner participation within the 2ci project. Among other questions, community-based organizations were asked to indicate their technical capabilities, locations of service, and how many community navigators (or roles capable of transforming into community navigators) they currently employed (Step 4c). Through the assessment the project team identified 8 navigator service organizations throughout the nine county PPS, comprised of 11 representatives. Following the review, the project team noted the well-rounded regional representation across the nine counties but identified a particular lack in the overall number of community navigators. This is being addressed through a strategic placement based on found hot spots. In June 2015, Care Compass Network (CCN) developed its Pre-Engagement Assessment through its Community-Based Organization Engagement Council. It was distributed to all participating providers within the PPS through advertisement at each of the June 2015 Stakeholder meetings. Therein, CCN sought to understand the level of readiness, predominant county served, IT development, and number of paid staff, among other inquiries. The goal of this assessment was to acquire a map of the services providers throughout the PPS and determine where gaps needed to be filled, who to contract with, and what projects providers would fit into. This information also served to allocate partners to their respective Regional Performing Unit (RPU) based on the geographic region

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	their organization served, leading to the development of RPU Operations and PAC meetings. Regional needs have been identified and addressed within each Regional Performing Unit's meetings.
Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.	In April 2015, the Care Compass Network (CCN) Project 2ci Team developed an assessment to gauge the existing services, programs, and general level of readiness for CCN partner participation within the 2ci project. Among other questions, community-based organizations were asked to indicate their technical capabilities, locations of service, and how many community navigators (or roles capable of transforming into community navigators) they currently employed (Step 4c). Through the assessment the project team identified 8 navigator service organizations throughout the nine county PPS, comprised of 11 representatives. Following the review, the project team noted the well-rounded regional representation across the nine counties but identified a particular lack in the overall number of community navigators. This is being addressed through a strategic placement based on found hot spots. In June 2015, Care Compass Network (CCN) developed its Pre-Engagement Assessment through its Community-Based Organization Engagement Council. It was distributed to all participating providers within the PPS through advertisement at each of the June 2015 Stakeholder meetings. Therein, CCN sought to understand the level of readiness, predominant county served, IT development, and number of paid staff, among other inquiries. The goal of this assessment was to acquire a map of the services providers throughout the PPS and determine where gaps needed to be filled, who to contract with, and what projects providers would fit into. This information also served to allocate partners to their respective Regional Performing Unit (RPU) based on the geographic region their organization served, leading to the development of RPU Operations and PAC meetings. Regional needs have been identified and addressed within each Regional Performing Unit's meetings.
Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.	In April 2015, the Care Compass Network (CCN) Project 2ci Team developed an assessment to gauge the existing services, programs, and general level of readiness for CCN partner participation within the 2ci project. Among other questions, community-based organizations were asked to indicate their technical capabilities, locations of service, and how many community navigators (or roles capable of transforming into community navigators) they currently employed (Step 4c). Through the assessment the project team identified 8 navigator service organizations throughout the nine county PPS, comprised of 11 representatives. Following the review, the project team noted the well-rounded regional representation across the nine counties but identified a particular lack in the overall number of community navigators. This is being addressed through a strategic placement based on found hot spots. In June 2015, Care Compass Network (CCN) developed its Pre-Engagement Assessment through its Community-Based Organization Engagement Council. It was distributed to all participating providers within the PPS through advertisement at each of the June 2015 Stakeholder meetings. Therein, CCN sought to understand the level of readiness, predominant county served, IT development, and number of paid staff, among other inquiries. The goal of this assessment was to acquire a map of the services providers throughout the PPS and determine where gaps needed to be filled, who to contract with, and what projects providers would fit into. This information also served to allocate partners to their respective Regional Performing Unit (RPU) based on the geographic region their organization served, leading to the development of RPU Operations and PAC meetings. Regional needs have been identified and addressed within each Regional Performing Unit's meetings.
Resource appropriately for the community navigators, evaluating placement and service type.	In April 2015, the Care Compass Network (CCN) Project 2ci Team developed an assessment to gauge the existing services, programs, and general level of readiness for CCN partner participation within the 2ci project. Among other questions, community-based organizations were asked to indicate their technical capabilities, locations of service, and how many community navigators (or roles capable of transforming into community navigators) they currently employed (Step 4c). Through the assessment the project team identified 8 navigator service organizations throughout the nine county PPS, comprised of 11 representatives. Following the review, the project team noted the well-rounded regional representation across the nine counties but identified a particular lack in the overall number of community navigators. This is being addressed through a strategic placement based on found hot spots. In June 2015, Care Compass Network (CCN) developed its Pre-Engagement Assessment through its Community-Based Organization Engagement Council.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	It was distributed to all participating providers within the PPS through advertisement at each of the June 2015 Stakeholder meetings. Therein, CCN sought to understand the level of readiness, predominant county served, IT development, and number of paid staff, among other inquiries. The goal of this assessment was to acquire a map of the services providers throughout the PPS and determine where gaps needed to be filled, who to contract with, and what projects providers would fit into. This information also served to allocate partners to their respective Regional Performing Unit (RPU) based on the geographic region their organization served, leading to the development of RPU Operations and PAC meetings. Regional needs have been identified and addressed within each Regional Performing Unit's meetings.
Provide community navigators with access to non-clinical resources, such as transportation and housing services.	In April 2015, the Care Compass Network (CCN) Project 2ci Team developed an assessment to gauge the existing services, programs, and general level of readiness for CCN partner participation within the 2ci project. Among other questions, community-based organizations were asked to indicate their technical capabilities, locations of service, and how many community navigators (or roles capable of transforming into community navigators) they currently employed (Step 4c). Through the assessment the project team identified 8 navigator service organizations throughout the nine county PPS, comprised of 11 representatives. Following the review, the project team noted the well-rounded regional representation across the nine counties but identified a particular lack in the overall number of community navigators. This is being addressed through a strategic placement based on found hot spots. In June 2015, Care Compass Network (CCN) developed its Pre-Engagement Assessment through its Community-Based Organization Engagement Council. It was distributed to all participating providers within the PPS through advertisement at each of the June 2015 Stakeholder meetings. Therein, CCN sought to understand the level of readiness, predominant county served, IT development, and number of paid staff, among other inquiries. The goal of this assessment was to acquire a map of the services providers throughout the PPS and determine where gaps needed to be filled, who to contract with, and what projects providers would fit into. This information also served to allocate partners to their respective Regional Performing Unit (RPU) based on the geographic region their organization served, leading to the development of RPU Operations and PAC meetings. Regional needs have been identified and addressed within each Regional Performing Unit's meetings.
Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.	In April 2015, the Care Compass Network (CCN) Project 2ci Team developed an assessment to gauge the existing services, programs, and general level of readiness for CCN partner participation within the 2ci project. Among other questions, community-based organizations were asked to indicate their technical capabilities, locations of service, and how many community navigators (or roles capable of transforming into community navigators) they currently employed (Step 4c). Through the assessment the project team identified 8 navigator service organizations throughout the nine county PPS, comprised of 11 representatives. Following the review, the project team noted the well-rounded regional representation across the nine counties but identified a particular lack in the overall number of community navigators. This is being addressed through a strategic placement based on found hot spots. In June 2015, Care Compass Network (CCN) developed its Pre-Engagement Assessment through its Community-Based Organization Engagement Council. It was distributed to all participating providers within the PPS through advertisement at each of the June 2015 Stakeholder meetings. Therein, CCN sought to understand the level of readiness, predominant county served, IT development, and number of paid staff, among other inquiries. The goal of this assessment was to acquire a map of the services providers throughout the PPS and determine where gaps needed to be filled, who to contract with, and what projects providers would fit into. This information also served to allocate partners to their respective Regional Performing Unit (RPU) based on the geographic region their organization served, leading to the development of RPU Operations and PAC meetings. Regional needs have been identified and addressed within each Regional Performing Unit's meetings.
Market the availability of community-based navigation services.	In April 2015, the Care Compass Network (CCN) Project 2ci Team developed an assessment to gauge the existing services, programs, and general level of readiness for CCN partner participation within the 2ci project. Among other questions, community-based organizations were asked to indicate their technical capabilities, locations of service, and how many community navigators (or roles capable of transforming into community navigators) they currently employed (Step 4c). Through the assessment the project team identified 8 navigator service organizations throughout the nine county PPS, comprised of 11

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	representatives. Following the review, the project team noted the well-rounded regional representation across the nine counties but identified a particular lack in the overall number of community navigators. This is being addressed through a strategic placement based on found hot spots. In June 2015, Care Compass Network (CCN) developed its Pre-Engagement Assessment through its Community-Based Organization Engagement Council. It was distributed to all participating providers within the PPS through advertisement at each of the June 2015 Stakeholder meetings. Therein, CCN sought to understand the level of readiness, predominant county served, IT development, and number of paid staff, among other inquiries. The goal of this assessment was to acquire a map of the services providers throughout the PPS and determine where gaps needed to be filled, who to contract with, and what projects providers would fit into. This information also served to allocate partners to their respective Regional Performing Unit (RPU) based on the geographic region their organization served, leading to the development of RPU Operations and PAC meetings. Regional needs have been identified and addressed within each Regional Performing Unit's meetings.
Use EHRs and other technical platforms to track all patients engaged in the project.	In April 2015, the Care Compass Network (CCN) Project 2ci Team developed an assessment to gauge the existing services, programs, and general level of readiness for CCN partner participation within the 2ci project. Among other questions, community-based organizations were asked to indicate their technical capabilities, locations of service, and how many community navigators (or roles capable of transforming into community navigators) they currently employed (Step 4c). Through the assessment the project team identified 8 navigator service organizations throughout the nine county PPS, comprised of 11 representatives. Following the review, the project team noted the well-rounded regional representation across the nine counties but identified a particular lack in the overall number of community navigators. This is being addressed through a strategic placement based on found hot spots. In June 2015, Care Compass Network (CCN) developed its Pre-Engagement Assessment through its Community-Based Organization Engagement Council. It was distributed to all participating providers within the PPS through advertisement at each of the June 2015 Stakeholder meetings. Therein, CCN sought to understand the level of readiness, predominant county served, IT development, and number of paid staff, among other inquiries. The goal of this assessment was to acquire a map of the services providers throughout the PPS and determine where gaps needed to be filled, who to contract with, and what projects providers would fit into. This information also served to allocate partners to their respective Regional Performing Unit (RPU) based on the geographic region their organization served, leading to the development of RPU Operations and PAC meetings. Regional needs have been identified and addressed within each Regional Performing Unit's meetings.

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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Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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Project 2.d.i – Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care

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

Instructions :

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

Risk A) The greatest challenge with implementing project 2di will be to identify the target population and obtain their consent for completing the PAM, allowing the PPS to track this information and connecting it to the RHIO. This challenge will be overcome through the use of a robust patient activation outreach worker team (the team tasked with actively seeking to engage patients outside the clinical setting and "hot-spotting"), as well as close collaboration with the community-based health navigation team (2ci). These combined efforts, along with the training efforts that will occur through the patient activation training team for safety-net providers in the network, will ensure that the maximum number of individuals complete the PAM. Additionally, the PPS plans to embed the PAM survey in all safety-net practices at a minimum and will implement a process whereby all patients without insurance and all patients with Medicaid coverage will be given the PAM if it is determined they have not yet completed the survey. Risk B) The next challenge with implementing project 2di will be engaging providers in the project and obtaining provider buy-in for administering the PAM survey. This will be overcome through development of a comprehensive incentive plan, which will compensate providers for their participation and will assign a value to each PAM survey that is collected. Additionall, the patient activation training team will work with the provider relations component of the PPS to inform providers about the overall DSRIP initiative and PPS objectives, in addition to patient activation and the PAM. Risk C) The final challenge will be the risk of not meeting the number of actively engaged in the timeline the PPS has committed to. There are several contributing factors that could impact the PPS's ability to meet the metrics: 1) The DOH plans to contract with Insignia on behalf of NYS. If the DOH does not finalize an agreement quickly enough, this could potentially put the PPS behind schedule in terms of onboarding/training individuals on the PAM; 2) The PPS could inadvertently omit key hotspots, or overlook areas outside of the healthcare system where the target populations congregate, thereby missing opportunities for conducting the PAM. This will be overcome by a thorough data analysis showing where the known LU and UI currently receive services, and working closely with non-health care CBO's to target individuals outside of the health care system; 3) If the PPS does not hire the right staff for both the training team and the outreach worker team, the process of recruiting and re-training additional staff could put the PPS behind in meeting its numbers. This will be overcome by ensuring that a broad range of individuals receive training in the PAM, and the efforts will initially start out in the 9 hospitals within the network, so that lessons learned can be applied as the project is expanded to other providers. Project 2di will work closely with the Workforce Department to ensure that the right skillset is matched up with each of the two position types.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	89,558

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
0	0		0	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	Project	N/A	In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1b. Assess the knowledge and potential readiness of willing Community Based Organizations (CBOs) and other partners through Pre-Engagement Assessment.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 1c. Determine whether or not the Performing Provider System (PPS) is held to the state contracting requirements with the aid of the Care Compass Network Compliance Officer and the Compliance & Audit Committee.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1d. Develop contracts to establish PPS and CBO/partner agreements.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	Project	N/A	In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Patient Activation Measure(R) (PAM(R)) training team established.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2b. Contract with Insignia for PAM training for select individuals on Project Team or from PPS partners (e.g., health systems, hospitals, CBOs, etc.) utilizing the PAM survey.	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 2c. Leverage the Project 11 Planning team to identify and solicit organizations and/or individuals to join the PAM Survey Training Team. In this effort the project planning team will leverage local expertise at the RPU level (through RPU Leads in the CBO Engagement Council) to educate and gauge partner interest and expertise for the initial round of Insignia training. In addition, the 2di Project Team will collaborate with the PPS Provider Relations team to identify CBOs for PAM survey training team/administration based on results from the PPS Pre-engagement Assessment (e.g., organizations with indicated skillsets/expertise in outreach/patient activation). Organizations attending the initial Insignia training session on 9/29/2015 will participate on the PAM training team.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2d. Members of the Care Compass Network PAM Training Team (e.g., those trained by Insignia on 9/29) will be contracted with the PPS, starting in October 2015, to receive payment for subsequently training either (a) their internal organization, or (b) training other PPS 2di participating organizations, in the utilization of the PAM Survey system. The Care Compass Network Project Management Office will centrally coordinate future training efforts, a process which will be aligned with the execution of partner contracts. The Care Compass Network Project Management team will subsequently track training and refresher course participation on an ongoing basis using a roster for individuals trained and monthly reports from partners/Trainers.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	Project	N/A	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3b. Identify who will conduct the analysis for "hot spots".	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3c. Identify "hot spots" by analyzing utilization patterns for the	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
uninsured using SPARCS (Statewide Planning And Research Cooperative System) "self-pay" category. Leveraging the local expertise of RPU members, assess emergency department and other utilization patterns. Additionally, focus will be given to Emergency Departments that serve a high percentage of the uninsured by zip code as tracked by hospitals.									
Task 3d. Identify "hot spots" by analyzing the utilization low-utilizing and/or non-utilizing Medicaid enrollee Salient related data and reports. Leveraging the local expertise from each of the four Regional Performance Unit members, the 2di Project Team will also assess non-healthcare resource use for both non-utilizing and low-utilizing Medicaid enrollees.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3e. Identify which CBOs are geographically and organizationally aligned to outreach to these populations through responses from Pre-engagement Assessment.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3f. Contract with CBOs for outreach endeavors and track deliverables by incorporating a monthly reporting system outline in contract terms. This effort will be aligned with the performance monitoring process happening at the RPU level wherein partner efforts to administer PAM surveys and engage patients is recorded and reported up to the Project Management Office at "hot spot" locations. Course correct where appropriate as advised by the RPU-specific Onboarding Quality Subcommittees which report to the PPS Clinical Governance Committee.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.	Project	N/A	In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Community engagement forums and other information-gathering mechanisms established and performed.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4b. Utilize a vendor (RMS) to distribute a panel which can be used to identify where community forums can be held.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 4c. Work with CBOs to facilitiate the forums to obtain input and engagement from the target populations.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 4d. Identify individuals or groups who are willing to do the presentations.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	Project	N/A	In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5b. Identify and document which providers and CBOs will participate in the various components of the 2di project. Revisit this list as appropriate based on on-going Hot Spot analysis (as described later within this milestone).	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 5c. The 2di Project Team will work with the Health Literacy and Cultural Competency Committee ("CCC") to review and develop training materials which promote appropriate health literacy and engagement approaches and awareness. This will be performed in addition to or in conjunction with the annually required Partner Organization cultural competency and health literacy training which will also be coordinated by the CCC.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5d. Identify the appropriate number of individuals from the associated partners/CBOs who would need to be trained in patient activation in order for the PPS to achieve the target speed and scale population based on the findings of the "hot spot" analysis.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5e. Using the PAM Survey Training Team convened on 9/29 through the facilitated Insignia Health training session, provide training on patient activation and PAM as a PPS to participating organizations. Similarly, the Care Compass Network Project Management Office will track training and refresher course participation on an ongoing basis using a roster for individuals trained and monthly reports from partners. Additionally, the appropriateness with regards to number of trained PAM members from throughout the PPS will be evaluated (e.g.,	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

Care Compass Network (PPS ID:44)

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
monthly) using Insignia standard reports, to determine if the PPS hot-spot and other planning models have allocated enough resources for patient activation related efforts. As needed plan modifications will be defined and coordinated through the appropriate clinical governance structures.									
Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.	Project	N/A	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 6b. Care Compass Network will develop a focus team to align the steps and deliverables associated with this milestone with HIPAA and legal requirements to receive MCO enrollee lists.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 6c. Non Utilizing - The PPS project team will develop a procedure/protocol for connecting non-utilizing enrollees with PCPs. The focus will aim to identify the intial PCP (if any) previously identified by the patient, from where the CCN care coordination or navigation services will attempt to consent the patient and educate them regarding the benefits of collaboration with a PCP and utilization of other PPS benefits.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 6d. Low Utilizing - The PPS project team will develop a	Project		In Progress	04/01/2015	03/31/2016	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
procedure/protocol for connecting low-utilizing patients with PCPs. The focus will aim to identify the patients corresponding PCP (if any) and utilize PPS care coordinationg or navigation services to re-establish patient connectivity to PCP resources already available to the member. As appropriate available claims data on recent encounters may be utilized to promote the re-engagement process with the PCP.									
Task 6e. As required, obtain input at the RPU/PPS level through the Clinical Governance Committee for related procedures and protocols.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	Project	N/A	In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 7b. Identify cohorts using PAM survey and assess initial baselines as compared to expected results. Using these, set intervals of improvement for each beneficiary cohort leveraging the Clinical Governance Committee structure ensuring that patient activation strategies are developed and updated annually as appropriate. Initial baselines to be determined based on data and trends available from Insignia and/or other sources (e.g., Salient).	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 7c. Review results to modify cohort or baselines at the beginning of each performance period as needed and set targeted intervals toward improvement.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 7d. Report changes in PAM activation level cohorts to Onboarding Subcommittees for performance monitoring. Additionally, the 2di Project Team will review ongoing PPS	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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results and trends with experts from Insignia Health to ensure proper distribution and avoidance of false positives and/or outliers have been properly identied and remediated.									
Milestone #8 Include beneficiaries in development team to promote preventive care.	Project	N/A	In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 8b. Create a PPS strategy for how beneficiaries will be selected, including the utilization of the RMS vendor.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 8c. Consult with RMS on tactics to engage beneficiaries in a manner that will result in their participation.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 8d. Identify preventive care specialists to educate beneficiaries in preventive care.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #9 Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP.	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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• The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.									
Task Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 9b. Once the contract with Insignia is finalized, obtain Insignia delivered training to identify and determine the utilization of PAM components.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 9c. Develop a plan B for if a patient doesn't want to consent to the RHIO but wants to participate in the PAM.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 9d. Talk with the Performance measurement group about how to accurately monitor and report requisite data.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Volume of non-emergent visits for UI, NU, and LU populations increased.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 10b. Utilize Salient data to identify changes to the NU/LU	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	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
population.									
Task 10c. Need to identify solution for tracking the UI.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 10d. Increase access and availability for non-emergent care for the target populations.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	Project	N/A	In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Community navigators identified and contracted.	Provider	PAM(R) Providers	In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	Provider	PAM(R) Providers	In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 11c. Discuss with Project 2.c.i team on the details of patient navigation.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 11d. Determine in conjunction with both Project 2.c.i team and the results of the Pre-engagement assessment which CBOs are willing and able to function as a group of community navigators.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 11e. Contract with selected CBOs.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	Project	N/A	Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Policies and procedures for customer service complaints and appeals developed.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 12b. Develop a PPS-wide patient-relations function.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 12c. Develop a communications channel between Medicaid recipients and PPS's patient-relations staff.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 12d. Organize regular meetings between patients-relations staff and project team participants to analyze complaints and	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2

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establish methods of remediating complaints.									
Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	Project	N/A	Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task List of community navigators formally trained in the PAM(R).	Provider	PAM(R) Providers	Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 13b. Get patient activation training for the CHAs and 211 staff (if needed)	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 13c. Organize regular meetings between community navigators and PAM surveyers for best practices and ongoing dialogue.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	Project	N/A	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.	Provider	PAM(R) Providers	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 14b. Assess "hot spots" locales.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 14c. Analyze Pre-Engagement assessment for CBOs located within "hot spots."	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 14d. Contract with CBOs in "hot spots" to allow navigators' placement.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	Project	N/A	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Navigators educated about insurance options and healthcare resources available to populations in this project.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 15b. Research the current landscape of insurance through NYS Health Exchange and other insurance providers/resources.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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15c. The 2di Project Team will leverage existing PPS information, such as the Pre-engagement assessment for partners who provide services specifically to these populations.									
Task 15d. Organize forum between navigators and PPS partners providing services specifically to these populations for education and informative purposes.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 15e. Obtain and/or develop training for navigators on insurance options and healthcare resources specific to UI, NU, and LU populations. Execution of training for navigators related to the 2di project will be incorporated to training also provided as a result of the 2ci project. Through the Project Management Office, Care Compass Network will track training and refresher course participation on an ongoing basis using a roster for individuals trained and monthly reports from partners.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 15f. At a minimum, PPS protocols will be reviewed on an annual basis. During this time, the 2di Project team will also review the current insurance options landscape and adjust the impacted training strategies accordingly.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	Project	N/A	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Timely access for navigator when connecting members to services.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 16b. Develop a priority matrix to assist with referring patients to necessary primary and preventative services in conjunction with the Clinical Governance Committee.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 16c. Analyze social determinants and mitigation strategies utilizing the expertise of the Clinical Governance Committee.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 16d. Execute the steps of Project 2.c.i including, but not limited to, developing protocols, training, and utilizing technical platforms to track patients in order to ensure appropriate and timely access for navigators.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Milestone #17 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
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	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 17b. Develop PPS-wide IT Vision and Strategy, including assessment of EHRs and other IT platforms and their utilization within all partners, through IT vendor.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 17c. Develop PPS-wide Population health management strategy via Population Health team, including patient registries for tracking purposes.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 17c. Collaborate among project participants to determine whether or not a patient has taken the PAM by both screening participants as well as coding appropriately for LUs, NUs, and the uninsured by using a shared IT resource.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.										
Task Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.										
Task 1b. Assess the knowledge and potential readiness of willing Community Based Organizations (CBOs) and other partners through Pre-Engagement Assessment.										
Task 1c. Determine whether or not the Performing Provider System (PPS) is held to the state contracting requirements with the aid of the Care Compass Network Compliance Officer and 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
Compliance & Audit Committee.										
Task 1d. Develop contracts to establish PPS and CBO/partner agreements.										
Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.										
Task Patient Activation Measure(R) (PAM(R)) training team established.										
Task 2b. Contract with Insignia for PAM training for select individuals on Project Team or from PPS partners (e.g., health systems, hospitals, CBOs, etc.) utilizing the PAM survey.										
Task 2c. Leverage the Project 11 Planning team to identify and solicit organizations and/or individuals to join the PAM Survey Training Team. In this effort the project planning team will leverage local expertise at the RPU level (through RPU Leads in the CBO Engagement Council) to educate and gauge partner interest and expertise for the initial round of Insignia training. In addition, the 2di Project Team will collaborate with the PPS Provider Relations team to identify CBOs for PAM survey training team/administration based on results from the PPS Pre-engagement Assessment (e.g., organizations with indicated skillsets/expertise in outreach/patient activation). Organizations attending the initial Insignia training session on 9/29/2015 will participate on the PAM training team.										
Task 2d. Members of the Care Compass Network PAM Training Team (e.g., those trained by Insignia on 9/29) will be contracted with the PPS, starting in October 2015, to receive payment for subsequently training either (a) their internal organization, or (b) training other PPS 2di participating organizations, in the utilization of the PAM Survey system. The Care Compass Network Project Management Office will centrally coordinate future training efforts, a process which will be aligned with the execution of partner contracts. The Care Compass Network Project Management team will subsequently track training and refresher course participation on an ongoing basis using a roster for individuals trained and monthly reports from partners/Trainers.										
Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency										

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rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.										
Task Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.										
Task 3b. Identify who will conduct the analysis for "hot spots".										
Task 3c. Identify "hot spots" by analyzing utilization patterns for the uninsured using SPARCS (Statewide Planning And Research Cooperative System) "self-pay" category. Leveraging the local expertise of RPU members, assess emergency department and other utilization patterns. Additionally, focus will be given to Emergency Departments that serve a high percentage of the uninsured by zip code as tracked by hospitals.										
Task 3d. Identify "hot spots" by analyzing the utilization low-utilizing and/or non-utilizing Medicaid enrollee Salient related data and reports. Leveraging the local expertise from each of the four Regional Performance Unit members, the 2di Project Team will also assess non-healthcare resource use for both non-utilizing and low-utilizing Medicaid enrollees.										
Task 3e. Identify which CBOs are geographically and organizationally aligned to outreach to these populations through responses from Pre-engagement Assessment.										
Task 3f. Contract with CBOs for outreach endeavors and track deliverables by incorporating a monthly reporting system outline in contract terms. This effort will be aligned with the performance monitoring process happening at the RPU level wherein partner efforts to administer PAM surveys and engage patients is recorded and reported up to the Project Management Office at "hot spot" locations. Course correct where appropriate as advised by the RPU-specific Onboarding Quality Subcommittees which report to the PPS Clinical Governance Committee.										
Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.										
Task Community engagement forums and other information-gathering mechanisms established and performed.										
Task 4b. Utilize a vendor (RMS) to distribute a panel which can be used to identify where community forums can be held.										

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Task 4c. Work with CBOs to facilitiate the forums to obtain input and engagement from the target populations.										
Task 4d. Identify individuals or groups who are willing to do the presentations.										
Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.										
Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".										
Task 5b. Identify and document which providers and CBOs will participate in the various components of the 2di project. Revisit this list as appropriate based on on-going Hot Spot analysis (as described later within this milestone).										
Task 5c. The 2di Project Team will work with the Health Literacy and Cultural Competency Committee ("CCC") to review and develop training materials which promote appropriate health literacy and engagement approaches and awareness. This will be performed in addition to or in conjunction with the annually required Partner Organization cultural competency and health literacy training which will also be coordinated by the CCC.										
Task 5d. Identify the appropriate number of individuals from the associated partners/CBOs who would need to be trained in patient activation in order for the PPS to achieve the target speed and scale population based on the findings of the "hot spot" analysis.										
Task 5e. Using the PAM Survey Training Team convened on 9/29 through the facilitated Insignia Health training session, provide training on patient activation and PAM as a PPS to participating organizations. Similarly, the Care Compass Network Project Management Office will track training and refresher course participation on an ongoing basis using a roster for individuals trained and monthly reports from partners. Additionally, the appropriateness with regards to number of trained PAM members from throughout the PPS will be evaluated (e.g., monthly) using Insignia standard reports, to determine if the PPS hot-spot and other planning models have allocated enough resources for patient activation related efforts. As needed plan modifications will be defined and coordinated through 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
appropriate clinical governance structures.										
Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.										
Task Procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.										
Task 6b. Care Compass Network will develop a focus team to align the steps and deliverables associated with this milestone with HIPAA and legal requirements to receive MCO enrollee lists.										
Task 6c. Non Utilizing - The PPS project team will develop a procedure/protocol for connecting non-utilizing enrollees with PCPs. The focus will aim to identify the intial PCP (if any) previously identified by the patient, from where the CCN care coordination or navigation services will attempt to consent the patient and educate them regarding the benefits of collaboration with a PCP and utilization of other PPS benefits.										
Task 6d. Low Utilizing - The PPS project team will develop a procedure/protocol for connecting low-utilizing patients with PCPs. The focus will aim to identify the patients corresponding PCP (if any) and utilize PPS care coordinationg or navigation services to re-establish patient connectivity to PCP resources already available to the member. As appropriate available claims data on recent encounters may be utilized to promote the re-engagement process with the PCP.										
Task 6e. As required, obtain input at the RPU/PPS level through 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
Clinical Governance Committee for related procedures and protocols.										
Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.										
Task For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).										
Task 7b. Identify cohorts using PAM survey and assess initial baselines as compared to expected results. Using these, set intervals of improvement for each beneficiary cohort leveraging the Clinical Governance Committee structure ensuring that patient activation strategies are developed and updated annually as appropriate. Initial baselines to be determined based on data and trends available from Insignia and/or other sources (e.g., Salient).										
Task 7c. Review results to modify cohort or baselines at the beginning of each performance period as needed and set targeted intervals toward improvement.										
Task 7d. Report changes in PAM activation level cohorts to Onboarding Subcommittees for performance monitoring. Additionally, the 2di Project Team will review ongoing PPS results and trends with experts from Insignia Health to ensure proper distribution and avoidance of false positives and/or outliers have been properly identied and remediated.										
Milestone #8 Include beneficiaries in development team to promote preventive care.										
Task Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.										
Task 8b. Create a PPS strategy for how beneficiaries will be selected, including the utilization of the RMS vendor.										
Task 8c. Consult with RMS on tactics to engage beneficiaries in a manner that will result in their participation.										
Task 8d. Identify preventive care specialists to educate beneficiaries in										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
preventive care.										
Milestone #9 Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.										
Task Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement										
Task 9b. Once the contract with Insignia is finalized, obtain Insignia										

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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
delivered training to identify and determine the utilization of PAM components.										
Task 9c. Develop a plan B for if a patient doesn't want to consent to the RHIO but wants to participate in the PAM.										
Task 9d. Talk with the Performance measurement group about how to accurately monitor and report requisite data.										
Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.										
Task Volume of non-emergent visits for UI, NU, and LU populations increased.										
Task 10b. Utilize Salient data to identify changes to the NU/LU population.										
Task 10c. Need to identify solution for tracking the UI.										
Task 10d. Increase access and availability for non-emergent care for the target populations.										
Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.										
Task Community navigators identified and contracted.	0	0	0	0	0	378	378	378	378	378
Task Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	0	0	0	0	0	378	378	378	378	378
Task 11c. Discuss with Project 2.c.i team on the details of patient navigation.										
Task 11d. Determine in conjunction with both Project 2.c.i team and the results of the Pre-engagement assessment which CBOs are willing and able to function as a group of community navigators.										
Task 11e. Contract with selected CBOs.										
Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Policies and procedures for customer service complaints and appeals developed.										
Task 12b. Develop a PPS-wide patient-relations function.										
Task 12c. Develop a communications channel between Medicaid recipients and PPS's patient-relations staff.										
Task 12d. Organize regular meetings between patients-relations staff and project team participants to analyze complaints and establish methods of remediating complaints.										
Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).										
Task List of community navigators formally trained in the PAM(R).	0	13	13	13	13	378	378	378	378	378
Task 13b. Get patient activation training for the CHAs and 211 staff (if needed)										
Task 13c. Organize regular meetings between community navigators and PAM surveyers for best practices and ongoing dialogue.										
Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.										
Task Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.	0	0	0	0	0	378	378	378	378	378
Task 14b. Assess "hot spots" locales.										
Task 14c. Analyze Pre-Engagement assessment for CBOs located within "hot spots."										
Task 14d. Contract with CBOs in "hot spots" to allow navigators' placement.										
Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.										
Task Navigators educated about insurance options and healthcare										

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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
resources available to populations in this project.										
Task 15b. Research the current landscape of insurance through NYS Health Exchange and other insurance providers/resources.										
Task 15c. The 2di Project Team will leverage existing PPS information, such as the Pre-engagement assessment for partners who provide services specifically to these populations.										
Task 15d. Organize forum between navigators and PPS partners providing services specifically to these populations for education and informative purposes.										
Task 15e. Obtain and/or develop training for navigators on insurance options and healthcare resources specific to UI, NU, and LU populations. Execution of training for navigators related to the 2di project will be incorporated to training also provided as a result of the 2ci project. Through the Project Management Office, Care Compass Network will track training and refresher course participation on an ongoing basis using a roster for individuals trained and monthly reports from partners.										
Task 15f. At a minimum, PPS protocols will be reviewed on an annual basis. During this time, the 2di Project team will also review the current insurance options landscape and adjust the impacted training strategies accordingly.										
Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.										
Task Timely access for navigator when connecting members to services.										
Task 16b. Develop a priority matrix to assist with referring patients to necessary primary and preventative services in conjunction with the Clinical Governance Committee.										
Task 16c. Analyze social determinants and mitigation strategies utilizing the expertise of the Clinical Governance Committee.										
Task 16d. Execute the steps of Project 2.c.i including, but not limited to, developing protocols, training, and utilizing technical platforms to track patients in order to ensure appropriate and timely access for navigators.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #17 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task 17b. Develop PPS-wide IT Vision and Strategy, including assessment of EHRs and other IT platforms and their utilization within all partners, through IT vendor.										
Task 17c. Develop PPS-wide Population health management strategy via Population Health team, including patient registries for tracking purposes.										
Task 17c. Collaborate among project participants to determine whether or not a patient has taken the PAM by both screening participants as well as coding appropriately for LUs, NUs, and the uninsured by using a shared IT resource.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.										
Task Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.										
Task 1b. Assess the knowledge and potential readiness of willing Community Based Organizations (CBOs) and other partners through Pre-Engagement Assessment.										
Task 1c. Determine whether or not the Performing Provider System (PPS) is held to the state contracting requirements with the aid of the Care Compass Network Compliance Officer and the Compliance & Audit Committee.										
Task 1d. Develop contracts to establish PPS and CBO/partner agreements.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.										
Task Patient Activation Measure(R) (PAM(R)) training team established.										
Task 2b. Contract with Insignia for PAM training for select individuals on Project Team or from PPS partners (e.g., health systems, hospitals, CBOs, etc.) utilizing the PAM survey.										
Task 2c. Leverage the Project 11 Planning team to identify and solicit organizations and/or individuals to join the PAM Survey Training Team. In this effort the project planning team will leverage local expertise at the RPU level (through RPU Leads in the CBO Engagement Council) to educate and gauge partner interest and expertise for the initial round of Insignia training. In addition, the 2di Project Team will collaborate with the PPS Provider Relations team to identify CBOs for PAM survey training team/administration based on results from the PPS Pre-engagement Assessment (e.g., organizations with indicated skillsets/expertise in outreach/patient activation). Organizations attending the initial Insignia training session on 9/29/2015 will participate on the PAM training team.										
Task 2d. Members of the Care Compass Network PAM Training Team (e.g., those trained by Insignia on 9/29) will be contracted with the PPS, starting in October 2015, to receive payment for subsequently training either (a) their internal organization, or (b) training other PPS 2di participating organizations, in the utilization of the PAM Survey system. The Care Compass Network Project Management Office will centrally coordinate future training efforts, a process which will be aligned with the execution of partner contracts. The Care Compass Network Project Management team will subsequently track training and refresher course participation on an ongoing basis using a roster for individuals trained and monthly reports from partners/Trainers.										
Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.										
Task Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.										

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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 3b. Identify who will conduct the analysis for "hot spots".										
Task 3c. Identify "hot spots" by analyzing utilization patterns for the uninsured using SPARCS (Statewide Planning And Research Cooperative System) "self-pay" category. Leveraging the local expertise of RPU members, assess emergency department and other utilization patterns. Additionally, focus will be given to Emergency Departments that serve a high percentage of the uninsured by zip code as tracked by hospitals.										
Task 3d. Identify "hot spots" by analyzing the utilization low-utilizing and/or non-utilizing Medicaid enrollee Salient related data and reports. Leveraging the local expertise from each of the four Regional Performance Unit members, the 2di Project Team will also assess non-healthcare resource use for both non-utilizing and low-utilizing Medicaid enrollees.										
Task 3e. Identify which CBOs are geographically and organizationally aligned to outreach to these populations through responses from Pre-engagement Assessment.										
Task 3f. Contract with CBOs for outreach endeavors and track deliverables by incorporating a monthly reporting system outline in contract terms. This effort will be aligned with the performance monitoring process happening at the RPU level wherein partner efforts to administer PAM surveys and engage patients is recorded and reported up to the Project Management Office at "hot spot" locations. Course correct where appropriate as advised by the RPU-specific Onboarding Quality Subcommittees which report to the PPS Clinical Governance Committee.										
Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.										
Task Community engagement forums and other information-gathering mechanisms established and performed.										
Task 4b. Utilize a vendor (RMS) to distribute a panel which can be used to identify where community forums can be held.										
Task 4c. Work with CBOs to facilitiate the forums to obtain input and engagement from the target populations.										
Task 4d. Identify individuals or groups who are willing to do the presentations.										

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Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.										
Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".										
Task 5b. Identify and document which providers and CBOs will participate in the various components of the 2di project. Revisit this list as appropriate based on on-going Hot Spot analysis (as described later within this milestone).										
Task 5c. The 2di Project Team will work with the Health Literacy and Cultural Competency Committee ("CCC") to review and develop training materials which promote appropriate health literacy and engagement approaches and awareness. This will be performed in addition to or in conjunction with the annually required Partner Organization cultural competency and health literacy training which will also be coordinated by the CCC.										
Task 5d. Identify the appropriate number of individuals from the associated partners/CBOs who would need to be trained in patient activation in order for the PPS to achieve the target speed and scale population based on the findings of the "hot spot" analysis.										
Task 5e. Using the PAM Survey Training Team convened on 9/29 through the facilitated Insignia Health training session, provide training on patient activation and PAM as a PPS to participating organizations. Similarly, the Care Compass Network Project Management Office will track training and refresher course participation on an ongoing basis using a roster for individuals trained and monthly reports from partners. Additionally, the appropriateness with regards to number of trained PAM members from throughout the PPS will be evaluated (e.g., monthly) using Insignia standard reports, to determine if the PPS hot-spot and other planning models have allocated enough resources for patient activation related efforts. As needed plan modifications will be defined and coordinated through the appropriate clinical governance structures.										
Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10).										

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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
• This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.										
Task Procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.										
Task 6b. Care Compass Network will develop a focus team to align the steps and deliverables associated with this milestone with HIPAA and legal requirements to receive MCO enrollee lists.										
Task 6c. Non Utilizing - The PPS project team will develop a procedure/protocol for connecting non-utilizing enrollees with PCPs. The focus will aim to identify the intial PCP (if any) previously identified by the patient, from where the CCN care coordination or navigation services will attempt to consent the patient and educate them regarding the benefits of collaboration with a PCP and utilization of other PPS benefits.										
Task 6d. Low Utilizing - The PPS project team will develop a procedure/protocol for connecting low-utilizing patients with PCPs. The focus will aim to identify the patients corresponding PCP (if any) and utilize PPS care coordinationg or navigation services to re-establish patient connectivity to PCP resources already available to the member. As appropriate available claims data on recent encounters may be utilized to promote the re-engagement process with the PCP.										
Task 6e. As required, obtain input at the RPU/PPS level through the Clinical Governance Committee for related procedures and protocols.										
Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each										

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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
cohort at the beginning of each performance period.										
Task For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).										
Task 7b. Identify cohorts using PAM survey and assess initial baselines as compared to expected results. Using these, set intervals of improvement for each beneficiary cohort leveraging the Clinical Governance Committee structure ensuring that patient activation strategies are developed and updated annually as appropriate. Initial baselines to be determined based on data and trends available from Insignia and/or other sources (e.g., Salient).										
Task 7c. Review results to modify cohort or baselines at the beginning of each performance period as needed and set targeted intervals toward improvement.										
Task 7d. Report changes in PAM activation level cohorts to Onboarding Subcommittees for performance monitoring. Additionally, the 2di Project Team will review ongoing PPS results and trends with experts from Insignia Health to ensure proper distribution and avoidance of false positives and/or outliers have been properly identied and remediated.										
Milestone #8 Include beneficiaries in development team to promote preventive care.										
Task Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.										
Task 8b. Create a PPS strategy for how beneficiaries will be selected, including the utilization of the RMS vendor.										
Task 8c. Consult with RMS on tactics to engage beneficiaries in a manner that will result in their participation.										
Task 8d. Identify preventive care specialists to educate beneficiaries in preventive care.										
Milestone #9 Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service.										

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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
• If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.										
Task Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement										
Task 9b. Once the contract with Insignia is finalized, obtain Insignia delivered training to identify and determine the utilization of PAM components.										
Task 9c. Develop a plan B for if a patient doesn't want to consent to the RHIO but wants to participate in the PAM.										
Task 9d. Talk with the Performance measurement group about how 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
accurately monitor and report requisite data.										
Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.										
Task Volume of non-emergent visits for UI, NU, and LU populations increased.										
Task 10b. Utilize Salient data to identify changes to the NU/LU population.										
Task 10c. Need to identify solution for tracking the UI.										
Task 10d. Increase access and availability for non-emergent care for the target populations.										
Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.										
Task Community navigators identified and contracted.	378	378	378	378	378	378	378	378	378	378
Task Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	378	378	378	378	378	378	378	378	378	378
Task 11c. Discuss with Project 2.c.i team on the details of patient navigation.										
Task 11d. Determine in conjunction with both Project 2.c.i team and the results of the Pre-engagement assessment which CBOs are willing and able to function as a group of community navigators.										
Task 11e. Contract with selected CBOs.										
Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.										
Task Policies and procedures for customer service complaints and appeals developed.										
Task 12b. Develop a PPS-wide patient-relations function.										
Task 12c. Develop a communications channel between Medicaid										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
recipients and PPS's patient-relations staff.										
Task 12d. Organize regular meetings between patients-relations staff and project team participants to analyze complaints and establish methods of remediating complaints.										
Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).										
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Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.										
Task Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.	378	378	378	378	378	378	378	378	378	378
Task 14b. Assess "hot spots" locales.										
Task 14c. Analyze Pre-Engagement assessment for CBOs located within "hot spots."										
Task 14d. Contract with CBOs in "hot spots" to allow navigators' placement.										
Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.										
Task Navigators educated about insurance options and healthcare resources available to populations in this project.										
Task 15b. Research the current landscape of insurance through NYS Health Exchange and other insurance providers/resources.										
Task 15c. The 2di Project Team will leverage existing PPS										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
information, such as the Pre-engagement assessment for partners who provide services specifically to these populations.										
Task 15d. Organize forum between navigators and PPS partners providing services specifically to these populations for education and informative purposes.										
Task 15e. Obtain and/or develop training for navigators on insurance options and healthcare resources specific to UI, NU, and LU populations. Execution of training for navigators related to the 2di project will be incorporated to training also provided as a result of the 2ci project. Through the Project Management Office, Care Compass Network will track training and refresher course participation on an ongoing basis using a roster for individuals trained and monthly reports from partners.										
Task 15f. At a minimum, PPS protocols will be reviewed on an annual basis. During this time, the 2di Project team will also review the current insurance options landscape and adjust the impacted training strategies accordingly.										
Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.										
Task Timely access for navigator when connecting members to services.										
Task 16b. Develop a priority matrix to assist with referring patients to necessary primary and preventative services in conjunction with the Clinical Governance Committee.										
Task 16c. Analyze social determinants and mitigation strategies utilizing the expertise of the Clinical Governance Committee.										
Task 16d. Execute the steps of Project 2.c.i including, but not limited to, developing protocols, training, and utilizing technical platforms to track patients in order to ensure appropriate and timely access for navigators.										
Milestone #17 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone										

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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
reporting.										
Task 17b. Develop PPS-wide IT Vision and Strategy, including assessment of EHRs and other IT platforms and their utilization within all partners, through IT vendor.										
Task 17c. Develop PPS-wide Population health management strategy via Population Health team, including patient registries for tracking purposes.										
Task 17c. Collaborate among project participants to determine whether or not a patient has taken the PAM by both screening participants as well as coding appropriately for LUs, NUs, and the uninsured by using a shared IT resource.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	sculley	Other	44_PMDL3603_1_2_20151215124344_2ai_update_from_IA.pdf	We cannot update project 2ai since it was originally flagged as passing. Comment for 2di Milestone 2 was meant for 2ai Milestone 2 & attachment shows CCN submitted enough for 2ai.	12/15/2015 12:43 PM
	sculley	Other	44_PMDL3603_1_2_20151215120136_Initial_Feedback_from_the_IA_12-1-15_v2.xlsx	Milestone 2 for Project 2di was not due until 12/31/15. Per discussion 12/8 with the IA, the IA to research the comment and provide clarification to CCN.	12/15/2015 12:01 PM
Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	rachaelm	Screenshots	44_PMDL3603_1_2_20151028133359_SharePoint - 2di Procedure.jpg	Additional supporting documentation - screenshot of Care Compass Network's SharePoint site with date of upload to establish completion of Milestone 12 by the DY1, Q2 target.	10/28/2015 01:33 PM
	rachaelm	Screenshots	44_PMDL3603_1_2_20151028133148_CCN Website - Compliance Hotline.jpg	Additional supporting document - screenshot of the section of the Care Compass Network website with Compliance Hotline information.	10/28/2015 01:31 PM
	rachaelm	Policies/Procedures	44_PMDL3603_1_2_20151028132627_2.d.i Complaints and Customer Service Procedure.pdf	As per required documentation, the procedure established for Care Compass Network regarding customer service complaints and appeals.	10/28/2015 01:26 PM
Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	rachaelm	Training Documentation	44_PMDL3603_1_2_20151028140607_Insignia Training Roster.pdf	Additional supporting document - sign-in sheet for Insignia-provided training conducted on September 29, 2015 (may be compared with Navigator Training Roster extract)	10/28/2015 02:06 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	rachaelm	Training Documentation	44_PMDL3603_1_2_20151028140405_DSRIP Training Deck September 2015.pptx	As per Milestone 13 requirements, training materials from Insignia-provided training conducted on September 29, 2015.	10/28/2015 02:04 PM
	rachaelm	Training Documentation	44_PMDL3603_1_2_20151028134318_Navigator Training Roster.xlsx	As per Milestone 13 requirements, a list of community navigators formally trained in the PAM® with details specified as well as project 2ci distribution list for reference	10/28/2015 01:43 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	In Progress – This Milestone and related steps are due in DY1, Q3. As of DY1, Q2, Care Compass Network (CCN) remains on track to complete these steps by DY1, Q3. During the DY1, Q2 timeframe, CCN distributed its draft Partner Organization Agreement to its partners for 30-day comment period. Upon the receipt of comments and the closing of the 30-day period, input was aggregated for review by the legal team and CCN leadership. The contract will subsequently be presented to the Board of Directors and is projected to be finalized early on in DY1, Q3, with contracting beginning shortly thereafter. The Onboarding Quality Committees (RPU-allocated subcommittees of the Clinical Governance Committee) will monitor partner performance at the local, regional level and report results to the PPS-wide Clinical Governance Committee to ensure sufficient and appropriate engagement of partners in the 2di project. The Pre-Engagement Assessment was distributed in June of 2015 to partner organizations. As responses were collected from partners and potential partners, the readiness and willingness of partners to engage in projects was determined (Complete - Step 1b). Care Compass Network will engage in further efforts as contracts are initiated in pursuit of completion of this milestone.
Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	In Progress – A contract with Insignia was approved by the Board of Directors on August 11, 2015 and signed inclusive of two 3-hour training sessions to be made available for PPS partners (Complete - Step 2b). While the PPS was concurrently negotiating and finalizing the contract, the Care Compass Network (CCN) Project Management Office (PMO) communicated with CCN partners through existing forums such as the Coordinating Council and Project 11 Planning team and review of the pre-engagement assessment to solicit appropriate membership to the 2di Training Team (Complete - Step 2c). In this effort, consideration was given to organizations represented, regions represented, and skillsets and service types represented. Two Insignia-hosted training sessions for PAM® survey administration and activation techniques were held on September 29, 2015 at the CCN offices in Vestal, NY, from which members who completed one of the two sessions were eligible to join the Training Team. The Insignia training session held on September 29 yielded 31 attendees who were then invited to be part of the Care Compass Network Training Team. Upon the finalization of a contract and subsequent execution with CCN partners for project 2di, members from the Training Team will begin to train the PPS partners in Project 11 PAM® survey techniques. The training team is set to begin meeting in DY1, Q3 and focusing efforts as contracting begins. Overall completion of the remaining steps and milestone remain on target for completion by DY1, Q3.
Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	
Survey the targeted population about healthcare needs in the PPS' region.	In Progress – The Community Health Needs Assessment Committee created a Panel Management Committee to work with the vendor, Research & Marketing Strategies, Inc (RMS), comprised of members of the Community Needs Assessment Committee, the Communications Committee, and the vendor itself. The Panel Management Committee determined that hosting an online community forum would be the most efficient means of eliciting community

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	feedback, given Care Compass Network's (CCN's) large geographic coverage. Feedback from our panel of community members is fluid and on-going; thus far, CCN has received feedback from 620 active panel members, inclusive of Medicaid beneficiaries from across the nine county PPS region (Complete - Step 4b). RMS has also identified an additional 1,338 individuals who have expressed interest in additional engagement strategies. This panel has been established as of DY1, Q2 and will remain in place throughout the five year DSRIP demonstration period for use by the Project 11 team as needed. Monthly touch points with panel members occur each month to keep them engaged and to support bi-directional feedback. Three survey touchpoints have been completed: Website perception, Community health needs, and engagement preferences. Details regarding these are as follows: Website perception survey: 7/8/15-7/27/15. Response rate 18% (101/572) Community needs survey: 8/24-9/8. Response rate: 31% (189/602) Communications / Engagement Preference study: 9/18-present. Outreach to CBOs to elicit further participation by patients and providers (groups for whom RMS is actively recruiting additional participation) occurs at the CCN Project Advisory Council meetings and at RPU stakeholder meetings (Step 4c). Panel cards and other "take-aways" are distributed to CBO stakeholders who are asked to invite their clients to participate. In DY1, Q3, RMS will be working with RPU leads, the project management office, and provider relations to discuss strategies to grow and make use of the patient and provider panel groups based on CCN needs. Additionally, individuals from core groups of the CCN Project Advisory Council (CCN staff, project leads, Mothers and Babies, the Rural Health Network of South Central New York, UHS, and Lourdes Hospital) have been identified to do presentations at community groups. The presenters use a standardized presentation to inform the public about DSRIP and invite their participation in the community panel (Step 4d). Overall completion of the remaining steps and milestone remain on target for completion by DY1, Q3.
Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	In Progress – Providers that will participate in the training portion of the 2di project were identified prior to the Insignia-led training session on September 29, 2015 by the Project Management Office (PMO) in conjunction with input from several forums including the 2di project team, Regional Performing Unit (RPU) Leads, and stakeholder meetings. Participants in additional components of the project will be determined as they begin and as the Hot Spot analysis commences in order to strategically approach speed and scale commitments (Complete - Step 5b). Channels of communication are established between the Project Management Office (PMO) and the Cultural Competency Committee. Rachael Mott, the Care Compass Network (CCN) PMO staff member allocated to the 2di project regularly attends the bi-weekly Cultural Competency Committee meetings. CCN remains on track for completion of the remaining tasks and milestone by DY1, Q3 as scheduled. A review of Insignia training materials and patient activation coaching techniques to ensure the inclusion of culturally competent approaches will be completed by the Cultural Competency Committee in DY1, Q3. Additionally, the CCN PMO will also coordinate the review of Insignia-provided training materials and/or guidance to the Clinical Governance Committee to either receive endorsement of utilization of the Insignia materials or identification of gaps in the Insignia provided training toolkit. CCN's funds flow and budget includes an initial estimate of individuals that need to be trained in patient activation across the PPS in order to achieve speed and scale targets. A flexible budgeting model has been adopted by the PPS to allow these initial budgeted estimates to be modified going forward as needed, such as following the completion of "hot spot" analysis and on-going review by the project team.
Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
• Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.	
Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	In Progress – Care Compass Network (CCN) did not have any speed and scale commitments in DY1, Q2 and had received Insignia training on September 29, 2015 after which the training team began to review the associated materials and CCN 2di approach. As of the DY1, Q2 timeframe, the PPS has high level cohorts identified, starting with the three primary cohorts for project eligibility (e.g., uninsured, low utilizers, and non-utilizers) as well as expected cohorts based on collaboration with PPSs who had started PAM® surveys in the DY1, Q2 timeframe such large populations of patients who initially appear to 'score too high', identification of adjacent PPS locations who may potentially PAM® patients who also encounter the CCN partners, and potential hot spot areas based on the three primary cohorts such as Emergency Departments or food pantries (Complete - Step 7b). As CCN contracts with members for 2di in DY1, Q3 and begins to receive the results of the PAM® surveys, the PMO team and Project 11 team will continually collaborate to refine or expand the cohort list and present summaries of these cohorts to the Onboarding Quality Committees.
Include beneficiaries in development team to promote preventive care.	In Progress - Care Compass Network (CCN) has utilized a vendor, Research & Marketing Strategies, Inc. (RMS) to develop a panel including healthcare providers, community-based organizations, community members, the uninsured, and Medicaid beneficiaries. The strategy of CCN is to continue to utilize this panel as a method for engaging with the Medicaid beneficiary throughout the five year waiver period (Complete - Step 8b). CCN has utilized the RMS panel as a means of PPS-wide strategy for eliciting expansive beneficiary participation including the "refer a friend" program, social media advertising, information and links on the front page of the Care Compass Network website, identification of "CONNECTORS", and the webinar on panel development (Complete - Step 8c). These are all elements of the aforementioned RMS panel. On a monthly basis, the Communications Committee meets with RMS to discuss progress to date on recruitment and retention strategies for beneficiary participation. Several strategies are currently being used: "refer a friend", participation invitations from CBOs providing services to beneficiaries, "take-aways" and other promotional materials, and an easy to find link to the survey on the CCN website. RMS also maintains a dashboard to track progress. An online screening questionnaire portion of the Community Needs Assessment retained demographic information from respondents in order to follow up and ask more detailed questions. In the DY1, Q3 timeframe, the remaining component of this milestone, utilization of preventive care specialists, will be finalized for the education of beneficiaries. This milestone remains on track for completion by the DY1, Q3 date.
Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program.	In Progress – The Care Compass Network (CCN) / Insignia contract for the license fee of PAM® surveys, training, instruction, and flourish website usage was approved by the Board of Directors on August 11, 2015 and signed inclusive of two 3-hour training sessions to be made available for PPS partners. These sessions were held on September 29, 2015 yielding 31 participants. Of these 31 participants, 4 were Care Compass Network project management staff, in order to inform the utilization of PAM components for the PPS (Complete - Step 9b). As PAM® surveys are administered; the Flourish® database will establish the number of patients screened by engagement level. Partners contracted with Care Compass Network will report their employees that have been trained to the project management office on a monthly basis. Furthermore, any future PCP bridges or MCO links established will be recorded and reported by partner organizations. In pursuit of the completion of this milestone, discussions have been initiated surrounding patient consents, performance monitoring, and reporting. Respectively, consent strategies have been discussed with the Care Compass Network Compliance Officer and will be addressed by the Care Compass

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Milestone Name	Narrative Text
• On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.	Network Compliance & Audit Committee in DY1, Q3 while performance has begun to be discussed by the performance measurement / Salient team for each project. The remaining steps and milestone remain on target for completion by DY1, Q3.
Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	
Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	In Progress – Discussions with the Project 2.c.i team took place in DY1, Q2 especially surrounding the availability of training. Navigation staff attended the Insignia-led training on September 29, 2015 as well in order to capitalize on their experience in patient navigation moving forward with the 2.d.i Patient Activation project implementation. In this central forum, with the assistance/oversight of the Insignia PAM® Instructor, the CCN Trainers, members of the 2ci team, and Project Management Office (PMO) staff discussed the details of patient navigation (Complete - Step 11c). The PMO, 2.d.i, and 2.c.i teams have leveraged the pre-existing members as well as the pre-engagement survey to identify PPS partners who are willing to participate in navigation related work (Complete - Step 11d) and have been working in DY1, Q2 to fully understand the DOH requirement for Community Health Advocates (CHAs) and how to integrate/educate these requirements across CCN partners to determine who are initially eligible to provide navigation services for the purposes of DSRIP. Moving into DY1, Q3, the project teams will be working with the Clinical Governance Committee to establish CHA navigation protocols which will be the baseline for partner contracting. Overall progress for the remaining steps and milestones remains on target for completion by the DY1, Q3 timeframe.
Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	Complete – The PPS-wide patient relations function was established in DY1, Q2 through the initial hiring of two full time Provider Relations / Outreach staff, operating in the interim as Patient Relations staff, in early July and late August (Complete - Step 12b). Furthermore, as the PPS enters the contracting period in DY1, Q3, an additional two staff will be joining Care Compass Network (CCN) in October and November. A CCN Procedure for customer service complaints and appeals was developed (Complete - Step 12a) collaboratively between the CCN Project Management Office (PMO) and the CCN Compliance Officer prior to complete project implementation to allow for communication between Medicaid recipients and the PPS staff (Complete - Step 12c). The most recent version of this procedure was completed on September 29, 2015. As seen in the attached screenshot, this was uploaded to SharePoint for PPS-wide access of September 30, 2015. Currently, the procedure in place fields patient relation calls primarily through the Compliance Hotline, the number for which is publically available on the Care Compass Network website. A screenshot of this section of the website is also attached with the DY, Q2 submission. The Compliance Hotline operates as the communications channel between Medicaid recipients and patient-relations and/or compliance staff. As of DY1, Q2, the infrastructure to support the complaints and receive customer service have been established, however there have been no reported complaints. As such, the frequency of 'regular

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	meetings' (Complete - Step 12d) beyond the normally scheduled project team meetings will be determined following the receipt of complaints or other communications. Additionally, the PPS PMO and project team will continue to collaborate to ensure proper education is available regarding the existence of these tools. Provided, the above Milestone 12 and the associated Steps are reported as Complete in DY1, Q2.
Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	Complete – During the development of the training team roster, the PPS Project Management Office (PMO) team collaborated with the 2ci project team to ensure Community Health Advocates' (CHAs) organizations could participate in the Insignia-provided training. On September 29, 2015, Insignia conducted an initial training session for Care Compass Network (CCN) specifically targeted at individuals interested in training other members of the PPS via the Train the Trainer model. Topics covered during the Insignia training session included PAM® survey administration, Coaching for Activation ®, and Flourish® use. In attendance at this training meeting were 13 members representing organizations who provide navigation services as identified by the 2.c.i Project Team (see attached for list) (Complete - Step 13a; Complete - Step 13b). Activation training was included in the Insignia training sessions held in the Coaching for Activation® segment. At this training, appropriate assistance for individuals based on their PAM® score as well as introduction of utilizing the Coaching for Activation® portal to retrieve Activation Level-appropriate materials was covered. Following the training session, the CCN PMO included these members in the 2di Project Team listserv. Additionally, the existing 2ci project team navigation meetings include trained PAM® surveyors who are also a part of the 2di Training Team (Complete- Step 13c). Moving into the DY1, Q3 contracting period these regular meetings will be used to engage discussions on PAM®-related cohorts, positive and negative PAM® experiences, successful techniques, and/or initial CCN PAM® results will be reviewed by these teams in order to collaborate and develop best practices as the patient activation project is implemented. Provided, the above Milestone 13 and the associated Steps are reported as Complete in DY1, Q2.
Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	
Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	
Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	

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	
Milestone #12	Pass & Ongoing	
Milestone #13	Pass & Ongoing	
Milestone #14	Pass & Ongoing	
Milestone #15	Pass & Ongoing	
Milestone #16	Pass & Ongoing	
Milestone #17	Pass & Ongoing	

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

#1 Risk – There is a risk that there is not a sufficient number of PCMH level 3 providers in the PPS. As a result, if not proactively managed through more care coordination or we may lose interest of the current PCMH Level 3 providers already in our network. To mitigate this risk we will determine levels of readiness of the participating Primary Care Physcians (PCPs) through the PreEngagement Survey. We will also provide metrics demonstrating increased productivity and improved health outcomes.
#2 Risk - A second risk is that Medicaid patients may access primary care through the ED or Walk-in settings and won't be captured. To mitigate this risk, we will engage ED and walk-ins with 3ai project.
#3 Risk – A third risk is that patients are too spread out within PPS. This poses a risk to integrating services in a way that reaches patients.
Mitigation – continuous education to providers
#4 Risk – A fourth risk is the expected limited resources for community based management. To mitigate this risk we will collaborate with other projects, as well as within the PPS RPU infrastructure to identify overlap in resources to consolidate where possible (for example, using population health resources to identify the most effective services for patients).
#5 Risks – A final risk is noted in instances where primary care providers may not be aware of behavioral health solutions. To mitigate this risk, we will make available education and training for providers.

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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**
DY4,Q4	53,970

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
0	0		0	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Model 1	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 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	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Behavioral health services are co-located within PCMH/APC practices and are available.		Provider	Mental Health	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1c. The 3ai Project Team will perform a review of PPS partners to understand the number of Medicaid recipients, facility PCMH status, and overall readiness/interest level of the site to participate in project 3ai. Following the assessment, a series of primary care (PC) pilot sites will be identified for project 3ai.		Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1d. The PPS will engage with the associated partners and provide support and/or incentives to PC sites to attain Level 3 PCMH status (for example, by developing a PCMH Quality Committee in the North Regional Performance Unit (RPU) to facilitate the region's attainment of Level 3 PCMH status, by contracting with a consultant as mentioned in Project 2.a.i's Implementation Plan, and/or via the Change Management Subcommittee of the IT Committee). The 3ai Project Team and associated Behavioral Health Quality Committees will develop and monitor performance metrics on productivity and health outcomes to support and		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
encourage attainment of PCMH status (to address Risk #1).										
Task 1e. The 3ai Project Team and CCN PMO will work with PC sites to confirm necessary waivers, licensure, and/or certification or inclusion of new services on operating certificate and/or designation an Integrated Outpatient Services Clinic are in place.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1f. The 3ai Project Team and CCN will confirm and document each integrated site has negotiated contracts with Managed Care Organizations (as required) to reflect delivery of on site behavioral health (BH) services.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1g. The CCN PMO will promote the integration of differing cultures in primary and Behavioral Health (BH) care by developing and disseminating training, and encouraging cross specialty shadowing and collaboration. (Risk #5) The PMO will leverage the training functionality developed by the Workforce Development team as well as the Provider Relations team to assist with program development and program dissemination.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1h. The 3ai Project Team and CCN PMO to develop a strategy to engage partner Emergency Departments and Walk-In Clinics in project plans in order to address patients not being captured due to seeking primary care in ED or Walk-In clinics (Risk #2). Implement strategies to address this issue, as appropriate.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 1	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Coordinated evidence-based care protocols are in place,		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

Care Compass Network (PPS ID:44)

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
including medication management and care engagement processes.										
Task 2c. Develop collaborative care protocols for integrating evidence based Behavioral Health screening tools into PC sites. Protocols will be approved by the Clinical Governance Committee and recertified on an annual basis.		Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2d. Develop protocols for assessment, crisis/high risk response plan, and treatment, including integrated care plan, follow-up, and management/monitoring of response to treatment in the case of positive screening results. Protocols will be endorsed by the Clinical Governance Committee and approved by the Board of Directors and be recertified by Clinical Governance Committee at minimum annually.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2e. Protocols will be endorsed by the Clinical Governance Committee and approved by the Board of Directors and be recertified by Clinical Governance Committee at minimum annually to allow continuous process improvement, as indicated.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 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	04/01/2015	03/31/2018	04/01/2015	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	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Screenings are documented in Electronic Health Record.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task		Provider	Practitioner - Primary	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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
Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.			Care Provider (PCP)							
Task 3e. 3ai Team to identify leading evidenced-based standardized BH screening tools (including PHQ-2, PHQ-9, SBIRT and OASAS-approved tools for SA). Submit tool(s) for approval to the Clinical Governance Committee for PPS-wide adoption. Clinical Governance to recertify annually.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3f. 3ai Team to identify appropriate staffing models based on NYS guidelines and regulations. Contracts with PC sites will reflect the recommendations from the 3ai Team.		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3g.Client-facing staff will receive training on basic behavioral health challenges most commonly seen in primary care, including depression, substance use and anxiety, as well as recognizing the signs and symptoms of more complex conditions. PMO will coordinate development of training material with approval from the Clinical Governance Committee. Workforce Committee will implement training.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 3h. Client-facing staff will receive PPS facilitated training on BH screening tool, how to integrate screening into patient work flow, add information to patient chart, referral and follow up. The 3ai project team, PMO, and Workforce Development team will coordinate development of training material with approval from the Clinical Governance Committee with special consideration for how planning and implementation efforts can be achieved without interfering with existing practice flows. The Workforce Project Manager and Provider Relations team will oversee the direct implementation and delivery of training.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 3i. The Care Compass Network PMO will perform implementation related reviews and/or reporting		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	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
requirements to confirm and document PC sites incorporate into policies the implementation of BH screenings for clients.										
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 1	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4c. The Care Compass Network PMO and PC sites will develop timelines for waiver approval to integrate BH and PC Medical Record.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4d. The 3ai Project Team, in collaboration with the Workforce Development and PMO teams will develop training material to educate PC staff regarding elements of a BH Medical Record with approval from the Clinical Governance Committee. Workforce Committee and Provider Relations teams will subsequently implement training.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4e. CCN will engage with the PC site to develop efficient flow of clinical information between providers using CQI principals.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4f. CCN engages with PC site to track actively engaged patients by reporting on frequency of screening, referral, and follow up for milestone reporting using the EHR.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	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	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
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	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Mental Health	In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 5d. The 3ai Project Team will perform a review of PPS BH partners to understand the number of Medicaid recipients, facility PCMH status, and overall readiness/interest level of the site to participate in project 3ai. Following the assessment, a series of BH pilot sites will be identified for project 3ai. Potential Article 31 Clinics offer a combination of mental health services, substance abuse treatment, and services for the developmentally disabled. CCN PMO and BH sites will identify space for medical procedures in accordance with DOH/OMH/OASAS regulations and/or Integrated Outpatient Services requirements, and apply for waivers/licenses as appropriate.		Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5e. The PPS will engage with the associated partners and provide support and/or incentives to ensure integrated sites have negotiated contracts with Managed Care Organizations (MCOs) to reflect delivery of on site primary care services with no medically unreasonable treatment limits and in keeping with state parity and other insurance laws. CCN PMO and Behavioral Health Subcommittee to support integrated sites' development through the development and dissemination of best practices. Note: Article 31 sites have authority or secured waivers that allow for on-site preventative and evaluation and management (E/M) services.		Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5f. Logistics of Integration - BH sites will complete necessary physical space and/or workflow accommodations to provide integrated services. CCN PMO, CCN Compliance, IT and Change Management committees will assist sites in completing logistical		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
requirements of integration.										
Task 5g. BH sites will offer primary care services during all practice hours. CCN will ensure behavioral health clinic policies and procedures reflect U.S. Preventive Services Task Force recommended screenings for all clinic clients, such as: lipids, hypertension, tobacco, alcohol, and breast/colon/cervical cancer. Related clinical standards adopted by the PPS will be prepared by the 3ai Project Team and PMO and presented to the Clinical Governance Committee and Board of Directors for approval.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 2	Project	N/A	In Progress	04/01/2015	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.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	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	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6c. CCN PMO/Provider Relations will reach out to partners to gather information regarding existing practice protocols for care engagement, screening, assessment, medication management, and treatment.		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 6d. RPU Behavioral Health Subcommittees to adopt/develop protocols for care engagement, screening, assessment, crisis/high risk response plan, medication management and treatment including development of an integrated care plan, follow - up, and management for at least one target condition (e.g. diabetes, hypertension, obesity, chronic pain). Protocols will be based on the US Preventative Task Force Guidances. Clinical Governance will approve protocols and recertify annually.		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
6e. Develop collaborative care models for integrated services. Establish criteria for collaboration between providers, including opporunities for cross training in PC and BH settings, to ensure a comprehensive care plan is developed and executed for patients. CCN RPU leaders, in their roles on the Behavioral Health Subcommittees, will initiate and implement opportunities for cross training.										
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	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Screenings are documented in Electronic Health Record.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
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	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 7e. The 3ai Project Team and Care Compass Network PMO/Provider Relations to survey PPS Partners to identify existing evidence-based screening tools leveraged by participating providers. The 3ai Project Team will propose a minimum level of screening required of PPS Partners, for approval and annual recertification by the CCN Clinical Governance Committee and PPS-wide adoption.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 7f. Client facing staff will complete training on chronic illness management including common physical health		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	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
medications, preventive care, and chronic conditions. PMO will coordinate development of training material with approval from the Clinical Governance Committee. Workforce Project Manager and Provider Relations will facilitate the delivery and tracking of training.										
Task 7g. The Care Compass Network PMO will perform implementation related reviews and/or reporting requirements to confirm and document BH sites have incorporated into policies the implementation of U.S. Preventive Task Force recommended screenings for all clients.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 7h. Client-facing staff receives training on Preventive screening tool(s), how to integrate screening into patient work flow, add information to patient chart, referral and follow up. PMO will coordinate development of training material with approval from the Clinical Governance Committee. Workforce Project Manager and Provider Relations will facilitate the delivery and tracking of training.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 2	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 8c. The 3ai Project Team and CCN PMO will work with PC sites to confirm BH sites have obtained necessary waivers to be able to integrate BH and PC Medical Record.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 8d. CCN PMO to develop educational tools for BH staff regarding elements of a PC Medical Record with approval from the Clinical Governance Committee. Workforce Project Manager and Provider Relations will facilitate the		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	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
delivery and tracking of training.										
Task 8e. CCN will engage with the PC site to develop efficient flow of clinical information between providers using CQI principals.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 8f. CCN engages with PC site to track actively engaged patients by reporting on frequency of screening, referral, and follow up for milestone reporting using the EHR.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
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, offering course in counseling, monitoring depression symptoms for treatment response, and completing a		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
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 sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.										

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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 All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.	0	0	0	0	0	0	0	0	0	0
Task Behavioral health services are co-located within PCMH/APC practices and are available.	0	0	0	0	0	0	0	0	0	0
Task 1c. The 3ai Project Team will perform a review of PPS partners to understand the number of Medicaid recipients, facility PCMH status, and overall readiness/interest level of the site to participate in project 3ai. Following the assessment, a series of primary care (PC) pilot sites will be identified for project 3ai.										
Task 1d. The PPS will engage with the associated partners and provide support and/or incentives to PC sites to attain Level 3 PCMH status (for example, by developing a PCMH Quality Committee in the North Regional Performance Unit (RPU) to facilitate the region's attainment of Level 3 PCMH status, by contracting with a consultant as mentioned in Project 2.a.i's Implementation Plan, and/or via the Change Management Subcommittee of the IT Committee). The 3ai Project Team and associated Behavioral Health Quality Committees will develop and monitor performance metrics on productivity and health outcomes to support and encourage attainment of PCMH status (to address Risk #1).										
Task 1e. The 3ai Project Team and CCN PMO will work with PC sites to confirm necessary waivers, licensure, and/or certification or inclusion of new services on operating certificate and/or designation an Integrated Outpatient Services Clinic are in place.										
Task 1f. The 3ai Project Team and CCN will confirm and document each integrated site has negotiated contracts with Managed Care Organizations (as required) to reflect delivery of on site behavioral health (BH) services.										
Task 1g. The CCN PMO will promote the integration of differing cultures in primary and Behavioral Health (BH) care by developing and disseminating training, and encouraging cross specialty shadowing and collaboration. (Risk #5) The PMO will leverage the training functionality developed by the Workforce Development team as well as the Provider Relations team to assist with program development and program dissemination.										
Task 1h. The 3ai Project Team and CCN PMO to develop a strategy to										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
engage partner Emergency Departments and Walk-In Clinics in project plans in order to address patients not being captured due to seeking primary care in ED or Walk-In clinics (Risk #2). Implement strategies to address this issue, as appropriate.										
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices.										
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.										
Task 2c. Develop collaborative care protocols for integrating evidence based Behavioral Health screening tools into PC sites. Protocols will be approved by the Clinical Governance Committee and recertified on an annual basis.										
Task 2d. Develop protocols for assessment, crisis/high risk response plan, and treatment, including integrated care plan, follow-up, and management/monitoring of response to treatment in the case of positive screening results. Protocols will be endorsed by the Clinical Governance Committee and approved by the Board of Directors and be recertified by Clinical Governance Committee at minimum annually.										
Task 2e. Protocols will be endorsed by the Clinical Governance Committee and approved by the Board of Directors and be recertified by Clinical Governance Committee at minimum annually to allow continuous process improvement, as indicated.										
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,										

Care Compass Network (PPS ID:44)

Project 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	0	0	0	0	0	0	0	0	0
Task 3e. 3ai Team to identify leading evidenced-based standardized BH screening tools (including PHQ-2, PHQ-9, SBIRT and OASAS-approved tools for SA). Submit tool(s) for approval to the Clinical Governance Committee for PPS-wide adoption. Clinical Governance to recertify annually.										
Task 3f. 3ai Team to identify appropriate staffing models based on NYS guidelines and regulations. Contracts with PC sites will reflect the recommendations from the 3ai Team.										
Task 3g.Client-facing staff will receive training on basic behavioral health challenges most commonly seen in primary care, including depression, substance use and anxiety, as well as recognizing the signs and symptoms of more complex conditions. PMO will coordinate development of training material with approval from the Clinical Governance Committee. Workforce Committee will implement training.										
Task 3h. Client-facing staff will receive PPS facilitated training on BH screening tool, how to integrate screening into patient work flow, add information to patient chart, referral and follow up. The 3ai project team, PMO, and Workforce Development team will coordinate development of training material with approval from the Clinical Governance Committee with special consideration for how planning and implementation efforts can be achieved without interfering with existing practice flows. The Workforce Project Manager and Provider Relations team will oversee the direct implementation and delivery of training.										
Task 3i. The Care Compass Network PMO will perform implementation related reviews and/or reporting requirements to confirm and document PC sites incorporate into policies the implementation of BH screenings for clients.										
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										

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Delivery System Reform Incentive Payment Project

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Care Compass Network (PPS ID:44)

Project 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.										
Task 4c. The Care Compass Network PMO and PC sites will develop timelines for waiver approval to integrate BH and PC Medical Record.										
Task 4d. The 3ai Project Team, in collaboration with the Workforce Development and PMO teams will develop training material to educate PC staff regarding elements of a BH Medical Record with approval from the Clinical Governance Committee. Workforce Committee and Provider Relations teams will subsequently implement training.										
Task 4e. CCN will engage with the PC site to develop efficient flow of clinical information between providers using CQI principals.										
Task 4f. CCN engages with PC site to track actively engaged patients by reporting on frequency of screening, referral, and follow up for milestone reporting using the EHR.										
Milestone #5 Co-locate primary care services at behavioral health sites.										
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.	0	0	0	0	0	0	0	0	0	0
Task Primary care services are co-located within behavioral Health practices and are available.	0	0	0	0	0	0	0	0	0	0
Task Primary care services are co-located within behavioral Health practices and are available.	0	0	0	0	0	0	0	0	0	0
Task 5d. The 3ai Project Team will perform a review of PPS BH partners to understand the number of Medicaid recipients, facility PCMH status, and overall readiness/interest level of the site to participate in project 3ai. Following the assessment, a series of BH pilot sites will be identified for project 3ai. Potential Article 31 Clinics offer a combination of mental health services, substance abuse treatment, and services for the developmentally disabled. CCN PMO and BH sites will identify space for medical procedures in accordance with DOH/OMH/OASAS regulations and/or Integrated Outpatient Services requirements, and apply for waivers/licenses as appropriate.										
Task 5e. The PPS will engage with the associated partners and										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
provide support and/or incentives to ensure integrated sites have negotiated contracts with Managed Care Organizations (MCOs) to reflect delivery of on site primary care services with no medically unreasonable treatment limits and in keeping with state parity and other insurance laws. CCN PMO and Behavioral Health Subcommittee to support integrated sites' development through the development and dissemination of best practices. Note: Article 31 sites have authority or secured waivers that allow for on-site preventative and evaluation and management (E/M) services.										
Task 5f. Logistics of Integration - BH sites will complete necessary physical space and/or workflow accommodations to provide integrated services. CCN PMO, CCN Compliance, IT and Change Management committees will assist sites in completing logistical requirements of integration.										
Task 5g. BH sites will offer primary care services during all practice hours. CCN will ensure behavioral health clinic policies and procedures reflect U.S. Preventive Services Task Force recommended screenings for all clinic clients, such as: lipids, hypertension, tobacco, alcohol, and breast/colon/cervical cancer. Related clinical standards adopted by the PPS will be prepared by the 3ai Project Team and PMO and presented to the Clinical Governance Committee and Board of Directors for approval.										
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 6c. CCN PMO/Provider Relations will reach out to partners to gather information regarding existing practice protocols for care engagement, screening, assessment, medication management, and treatment.										
Task 6d. RPU Behavioral Health Subcommittees to adopt/develop protocols for care engagement, screening, assessment, crisis/high risk response plan, medication management and treatment including development of an integrated care plan,										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
follow - up, and management for at least one target condition (e.g. diabetes, hypertension, obesity, chronic pain). Protocols will be based on the US Preventative Task Force Guidances. Clinical Governance will approve protocols and recertify annually.										
Task 6e. Develop collaborative care models for integrated services. Establish criteria for collaboration between providers, including opporunities for cross training in PC and BH settings, to ensure a comprehensive care plan is developed and executed for patients. CCN RPU leaders, in their roles on the Behavioral Health Subcommittees, will initiate and implement opportunities for cross training.										
Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.										
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.										
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	0	0	0	0	0	0	0	0	0	0
Task 7e. The 3ai Project Team and Care Compass Network PMO/Provider Relations to survey PPS Partners to identify existing evidence-based screening tools leveraged by participating providers. The 3ai Project Team will propose a minimum level of screening required of PPS Partners, for approval and annual recertification by the CCN Clinical Governance Committee and PPS-wide adoption.										
Task 7f. Client facing staff will complete training on chronic illness management including common physical health medications, preventive care, and chronic conditions. PMO will coordinate development of training material with approval from the Clinical Governance Committee. Workforce Project Manager and Provider Relations will facilitate the delivery and tracking of										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
training.										
Task 7g. The Care Compass Network PMO will perform implementation related reviews and/or reporting requirements to confirm and document BH sites have incorporated into policies the implementation of U.S. Preventive Task Force recommended screenings for all clients.										
Task 7h. Client-facing staff receives training on Preventive screening tool(s), how to integrate screening into patient work flow, add information to patient chart, referral and follow up. PMO will coordinate development of training material with approval from the Clinical Governance Committee. Workforce Project Manager and Provider Relations will facilitate the delivery and tracking of training.										
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 8c. The 3ai Project Team and CCN PMO will work with PC sites to confirm BH sites have obtained necessary waivers to be able to integrate BH and PC Medical Record.										
Task 8d. CCN PMO to develop educational tools for BH staff regarding elements of a PC Medical Record with approval from the Clinical Governance Committee. Workforce Project Manager and Provider Relations will facilitate the delivery and tracking of training.										
Task 8e. CCN will engage with the PC site to develop efficient flow of clinical information between providers using CQI principals.										
Task 8f. CCN engages with PC site to track actively engaged patients by reporting on frequency of screening, referral, and follow up for milestone reporting using the EHR.										
Milestone #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	0	0	0	0	0	0	0	0	0	0

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.										
Task Policies and procedures include process for consulting with Psychiatrist.										
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.										
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.										
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Milestone #13 Measure outcomes as required in the IMPACT Model.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Milestone #14 Provide "stepped care" as required by the IMPACT Model.										
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.										
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.	0	0	0	0	0	0	0	0	0	0
Task Behavioral health services are co-located within PCMH/APC practices and are available.	0	0	0	0	0	0	0	0	0	0
Task 1c. The 3ai Project Team will perform a review of PPS partners to understand the number of Medicaid recipients, facility PCMH status, and overall readiness/interest level of the site to participate in project 3ai. Following the assessment, a series of primary care (PC) pilot sites will be identified for project 3ai.										
Task 1d. The PPS will engage with the associated partners and provide support and/or incentives to PC sites to attain Level 3 PCMH status (for example, by developing a PCMH Quality Committee in the North Regional Performance Unit (RPU) to facilitate the region's attainment of Level 3 PCMH status, by contracting with a consultant as mentioned in Project 2.a.i's Implementation Plan, and/or via the Change Management Subcommittee of the IT Committee). The 3ai Project Team and associated Behavioral Health Quality Committees will develop and monitor performance metrics on productivity and health outcomes to support and encourage attainment of PCMH status (to address Risk #1).										
Task 1e. The 3ai Project Team and CCN PMO will work with PC sites to confirm necessary waivers, licensure, and/or certification or inclusion of new services on operating certificate and/or designation an Integrated Outpatient Services Clinic are 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
Task 1f. The 3ai Project Team and CCN will confirm and document each integrated site has negotiated contracts with Managed Care Organizations (as required) to reflect delivery of on site behavioral health (BH) services.										
Task 1g. The CCN PMO will promote the integration of differing cultures in primary and Behavioral Health (BH) care by developing and disseminating training, and encouraging cross specialty shadowing and collaboration. (Risk #5) The PMO will leverage the training functionality developed by the Workforce Development team as well as the Provider Relations team to assist with program development and program dissemination.										
Task 1h. The 3ai Project Team and CCN PMO to develop a strategy to engage partner Emergency Departments and Walk-In Clinics in project plans in order to address patients not being captured due to seeking primary care in ED or Walk-In clinics (Risk #2). Implement strategies to address this issue, as appropriate.										
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices.										
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.										
Task 2c. Develop collaborative care protocols for integrating evidence based Behavioral Health screening tools into PC sites. Protocols will be approved by the Clinical Governance Committee and recertified on an annual basis.										
Task 2d. Develop protocols for assessment, crisis/high risk response plan, and treatment, including integrated care plan, follow-up, and management/monitoring of response to treatment in the case of positive screening results. Protocols will be endorsed by the Clinical Governance Committee and approved by the Board of Directors and be recertified by Clinical Governance Committee at minimum annually.										
Task 2e. Protocols will be endorsed by the Clinical Governance Committee and approved by the Board of Directors and be										

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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
recertified by Clinical Governance Committee at minimum annually to allow continuous process improvement, as indicated.										
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.										
Task Policies and procedures are in place to facilitate and document completion of screenings.										
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	0	0	0	0	0	0	0	0	0	0
Task 3e. 3ai Team to identify leading evidenced-based standardized BH screening tools (including PHQ-2, PHQ-9, SBIRT and OASAS-approved tools for SA). Submit tool(s) for approval to the Clinical Governance Committee for PPS-wide adoption. Clinical Governance to recertify annually.										
Task 3f. 3ai Team to identify appropriate staffing models based on NYS guidelines and regulations. Contracts with PC sites will reflect the recommendations from the 3ai Team.										
Task 3g.Client-facing staff will receive training on basic behavioral health challenges most commonly seen in primary care, including depression, substance use and anxiety, as well as recognizing the signs and symptoms of more complex conditions. PMO will coordinate development of training material with approval from the Clinical Governance Committee. Workforce Committee will implement training.										
Task 3h. Client-facing staff will receive PPS facilitated training on BH screening tool, how to integrate screening into patient work flow, add information to patient chart, referral and follow up. The 3ai project team, PMO, and Workforce Development team will coordinate development of training material with approval from the Clinical Governance Committee with special consideration for how planning and implementation efforts can be achieved										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
without interfering with existing practice flows. The Workforce Project Manager and Provider Relations team will oversee the direct implementation and delivery of training.										
Task 3i. The Care Compass Network PMO will perform implementation related reviews and/or reporting requirements to confirm and document PC sites incorporate into policies the implementation of BH screenings for clients.										
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 4c. The Care Compass Network PMO and PC sites will develop timelines for waiver approval to integrate BH and PC Medical Record.										
Task 4d. The 3ai Project Team, in collaboration with the Workforce Development and PMO teams will develop training material to educate PC staff regarding elements of a BH Medical Record with approval from the Clinical Governance Committee. Workforce Committee and Provider Relations teams will subsequently implement training.										
Task 4e. CCN will engage with the PC site to develop efficient flow of clinical information between providers using CQI principals.										
Task 4f. CCN engages with PC site to track actively engaged patients by reporting on frequency of screening, referral, and follow up for milestone reporting using the EHR.										
Milestone #5 Co-locate primary care services at behavioral health sites.										
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.	0	0	0	0	0	0	0	0	0	0
Task Primary care services are co-located within behavioral Health practices and are available.	0	0	0	0	0	0	0	0	0	0
Task Primary care services are co-located within behavioral Health practices and are available.	0	0	0	0	0	0	0	0	0	0

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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 5d. The 3ai Project Team will perform a review of PPS BH partners to understand the number of Medicaid recipients, facility PCMH status, and overall readiness/interest level of the site to participate in project 3ai. Following the assessment, a series of BH pilot sites will be identified for project 3ai. Potential Article 31 Clinics offer a combination of mental health services, substance abuse treatment, and services for the developmentally disabled. CCN PMO and BH sites will identify space for medical procedures in accordance with DOH/OMH/OASAS regulations and/or Integrated Outpatient Services requirements, and apply for waivers/licenses as appropriate.										
Task 5e. The PPS will engage with the associated partners and provide support and/or incentives to ensure integrated sites have negotiated contracts with Managed Care Organizations (MCOs) to reflect delivery of on site primary care services with no medically unreasonable treatment limits and in keeping with state parity and other insurance laws. CCN PMO and Behavioral Health Subcommittee to support integrated sites' development through the development and dissemination of best practices. Note: Article 31 sites have authority or secured waivers that allow for on-site preventative and evaluation and management (E/M) services.										
Task 5f. Logistics of Integration - BH sites will complete necessary physical space and/or workflow accommodations to provide integrated services. CCN PMO, CCN Compliance, IT and Change Management committees will assist sites in completing logistical requirements of integration.										
Task 5g. BH sites will offer primary care services during all practice hours. CCN will ensure behavioral health clinic policies and procedures reflect U.S. Preventive Services Task Force recommended screenings for all clinic clients, such as: lipids, hypertension, tobacco, alcohol, and breast/colon/cervical cancer. Related clinical standards adopted by the PPS will be prepared by the 3ai Project Team and PMO and presented to the Clinical Governance Committee and Board of Directors for approval.										
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.										

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Care Compass Network (PPS ID:44)

Project 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 Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.										
Task 6c. CCN PMO/Provider Relations will reach out to partners to gather information regarding existing practice protocols for care engagement, screening, assessment, medication management, and treatment.										
Task 6d. RPU Behavioral Health Subcommittees to adopt/develop protocols for care engagement, screening, assessment, crisis/high risk response plan, medication management and treatment including development of an integrated care plan, follow - up, and management for at least one target condition (e.g. diabetes, hypertension, obesity, chronic pain). Protocols will be based on the US Preventative Task Force Guidances. Clinical Governance will approve protocols and recertify annually.										
Task 6e. Develop collaborative care models for integrated services. Establish criteria for collaboration between providers, including opporunities for cross training in PC and BH settings, to ensure a comprehensive care plan is developed and executed for patients. CCN RPU leaders, in their roles on the Behavioral Health Subcommittees, will initiate and implement opportunities for cross training.										
Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.										
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.										
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	0	0	0	0	0	0	0	0	0	0

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Care Compass Network (PPS ID:44)

Project 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 7e. The 3ai Project Team and Care Compass Network PMO/Provider Relations to survey PPS Partners to identify existing evidence-based screening tools leveraged by participating providers. The 3ai Project Team will propose a minimum level of screening required of PPS Partners, for approval and annual recertification by the CCN Clinical Governance Committee and PPS-wide adoption.										
Task 7f. Client facing staff will complete training on chronic illness management including common physical health medications, preventive care, and chronic conditions. PMO will coordinate development of training material with approval from the Clinical Governance Committee. Workforce Project Manager and Provider Relations will facilitate the delivery and tracking of training.										
Task 7g. The Care Compass Network PMO will perform implementation related reviews and/or reporting requirements to confirm and document BH sites have incorporated into policies the implementation of U.S. Preventive Task Force recommended screenings for all clients.										
Task 7h. Client-facing staff receives training on Preventive screening tool(s), how to integrate screening into patient work flow, add information to patient chart, referral and follow up. PMO will coordinate development of training material with approval from the Clinical Governance Committee. Workforce Project Manager and Provider Relations will facilitate the delivery and tracking of training.										
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 8c. The 3ai Project Team and CCN PMO will work with PC sites to confirm BH sites have obtained necessary waivers to be able to integrate BH and PC Medical Record.										
Task 8d. CCN PMO to develop educational tools for BH staff regarding elements of a PC Medical Record with approval from the Clinical										

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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
Governance Committee. Workforce Project Manager and Provider Relations will facilitate the delivery and tracking of training.										
Task 8e. CCN will engage with the PC site to develop efficient flow of clinical information between providers using CQI principals.										
Task 8f. CCN engages with PC site to track actively engaged patients by reporting on frequency of screening, referral, and follow up for milestone reporting using the EHR.										
Milestone #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	0	0	0	0	0	0	0	0	0	0
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.										
Task Policies and procedures include process for consulting with 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.										

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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 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.										

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.	The Care Compass Network (CCN) plan for project 3ai includes Model 1 and Model 2, including a total of eight Milestones with associated steps for implementation, none of which were targeted for DY1, Q2 completion. Each of the Milestones and tasks are being reported as In Progress for DY1, Q2. In the Q2 period CCN has made significant progress on the 3ai Integration of Behavioral Health and Primary Care project. The 3ai Team Leaders and the CCN Project Management Office have begun to identify pilot primary care sites for participation in Model 1 and Model 2 across the PPS. For Model 1, CCN will initially focus efforts on sites that have already achieved PCMH recognition, have a significant Medicaid patient population, and have a significant patient base with existing behavioral health needs. Based on initial assessments by the project team these pilot sites will predominantly come from within the main hospital based primary care networks from Lourdes (South Regional Performance Unit (RPU)), UHS (South and East RPU), and Guthrie (West RPU). For Model 2, CCN efforts will initially focus on two identified Article 31 pilot sites located in Schuyler and Cortland counties, both in the CCN North RPU. Based on review of Salient data by the Salient team this spread by Region indicates appropriate support of the beneficiary presence, whereby initial models show the South RPU comprised of roughly 46% of the CCN beneficiaries and the North RPU containing roughly 30% of the CCN beneficiaries. In September the 3ai Project Team prepared a core set of screening tools and treatment protocols which were subsequently presented to and approved by

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	the Clinical Governance Committee at the 10/8/15 meeting as well as the Board of Directors at the 10/13/15 meeting. These movements position the project team well for contracting arrangements in the DY1, Q3 period. Evidence-based screening tools prepared in DY1, Q2 and subsequently approved in DY1, Q3 included the following: PHQ-9 (Depression), GAD-7 (General Anxiety Disorder), CAGE-AID, DAST, AUDIT (Substance Abuse, Drug Abuse, Alcohol Abuse), PC-PTSD, PCL (Trauma), and a Suicide and Violence screening tool (short form and longer form follow up). In addition, the screening material used within the Behavior Health Works software application (vendor solution) was approved by the Clinical Governance Committee; this software application is being vetted for use by CCN partners to integrate behavioral health and physical medical information within the EHR and track actively engaged patients. In its clinical governance structure, CCN has established RPU-level quality committees to provide oversight for the behavioral health projects. Each of these four bodies will influence collaborative treatment models for primary care, facilitate cross training among primary care givers and behavioral health specialists, and monitor performance. The committees will adopt evidence-based protocols for care engagement, screening, assessment, crisis/high risk response plans, medication management, and treatment. Committees for the four RPUs have begun to meet in October to establish their charters and meeting frequency. The 3ai Project Team and CCN have identified a potential IT solution which will enable project partners to track all actively engaged patients and integrate behavioral and physical medicine within a single medical chart. The vendor selection process is part of CCN's overall IT Systems and Processes roadmap. CCN expects the roadmap to be completed by DY1, Q3, including a timeline for the vendor selection process. CCN is in a position to begin contracting with partners to bring our pilot sites on line under the 3ai project. It is our intent to have these pilot sites up and running by the end of DY1, Q3 for Model 1 and DY1, Q4 for Model2.
Develop collaborative evidence-based standards of care including medication management and care engagement process.	The Care Compass Network (CCN) plan for project 3ai includes Model 1 and Model 2, including a total of eight Milestones with associated steps for implementation, none of which were targeted for DY1, Q2 completion. Each of the Milestones and tasks are being reported as In Progress for DY1, Q2. In the Q2 period CCN has made significant progress on the 3ai Integration of Behavioral Health and Primary Care project. The 3ai Team Leaders and the CCN Project Management Office have begun to identify pilot primary care sites for participation in Model 1 and Model 2 across the PPS. For Model 1, CCN will initially focus efforts on sites that have already achieved PCMH recognition, have a significant Medicaid patient population, and have a significant patient base with existing behavioral health needs. Based on initial assessments by the project team these pilot sites will predominantly come from within the main hospital based primary care networks from Lourdes (South Regional Performance Unit (RPU)), UHS (South and East RPU), and Guthrie (West RPU). For Model 2, CCN efforts will initially focus on two identified Article 31 pilot sites located in Schuyler and Cortland counties, both in the CCN North RPU. Based on review of Salient data by the Salient team this spread by Region indicates appropriate support of the beneficiary presence, whereby initial models show the South RPU comprised of roughly 46% of the CCN beneficiaries and the North RPU containing roughly 30% of the CCN beneficiaries. In September the 3ai Project Team prepared a core set of screening tools and treatment protocols which were subsequently presented to and approved by the Clinical Governance Committee at the 10/8/15 meeting as well as the Board of Directors at the 10/13/15 meeting. These movements position the project team well for contracting arrangements in the DY1, Q3 period. Evidence-based screening tools prepared in DY1, Q2 and subsequently approved in DY1, Q3 included the following: PHQ-9 (Depression), GAD-7 (General Anxiety Disorder), CAGE-AID, DAST, AUDIT (Substance Abuse, Drug Abuse, Alcohol Abuse), PC-PTSD, PCL (Trauma), and a Suicide and Violence screening tool (short form and longer form follow up). In addition, the screening material used within the Behavior Health Works software application (vendor solution) was approved by the Clinical Governance Committee; this software application is being vetted for use by CCN partners to integrate behavioral health and physical medical information within the EHR and track actively engaged patients. In its clinical governance structure, CCN has established RPU-level quality committees to provide oversight for the behavioral health projects. Each of these four bodies will influence collaborative treatment models for primary care, facilitate cross training among primary care givers and behavioral health specialists,

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	and monitor performance. The committees will adopt evidence-based protocols for care engagement, screening, assessment, crisis/high risk response plans, medication management, and treatment. Committees for the four RPUs have begun to meet in October to establish their charters and meeting frequency. The 3ai Project Team and CCN have identified a potential IT solution which will enable project partners to track all actively engaged patients and integrate behavioral and physical medicine within a single medical chart. The vendor selection process is part of CCN's overall IT Systems and Processes roadmap. CCN expects the roadmap to be completed by DY1, Q3, including a timeline for the vendor selection process. CCN is in a position to begin contracting with partners to bring our pilot sites on line under the 3ai project. It is our intent to have these pilot sites up and running by the end of DY1, Q3 for Model 1 and DY1, Q4 for Model2.
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.	The Care Compass Network (CCN) plan for project 3ai includes Model 1 and Model 2, including a total of eight Milestones with associated steps for implementation, none of which were targeted for DY1, Q2 completion. Each of the Milestones and tasks are being reported as In Progress for DY1, Q2. In the Q2 period CCN has made significant progress on the 3ai Integration of Behavioral Health and Primary Care project. The 3ai Team Leaders and the CCN Project Management Office have begun to identify pilot primary care sites for participation in Model 1 and Model 2 across the PPS. For Model 1, CCN will initially focus efforts on sites that have already achieved PCMH recognition, have a significant Medicaid patient population, and have a significant patient base with existing behavioral health needs. Based on initial assessments by the project team these pilot sites will predominantly come from within the main hospital based primary care networks from Lourdes (South Regional Performance Unit (RPU)), UHS (South and East RPU), and Guthrie (West RPU). For Model 2, CCN efforts will initially focus on two identified Article 31 pilot sites located in Schuyler and Cortland counties, both in the CCN North RPU. Based on review of Salient data by the Salient team this spread by Region indicates appropriate support of the beneficiary presence, whereby initial models show the South RPU comprised of roughly 46% of the CCN beneficiaries and the North RPU containing roughly 30% of the CCN beneficiaries. In September the 3ai Project Team prepared a core set of screening tools and treatment protocols which were subsequently presented to and approved by the Clinical Governance Committee at the 10/8/15 meeting as well as the Board of Directors at the 10/13/15 meeting. These movements position the project team well for contracting arrangements in the DY1, Q3 period. Evidence-based screening tools prepared in DY1, Q2 and subsequently approved in DY1, Q3 included the following: PHQ-9 (Depression), GAD-7 (General Anxiety Disorder), CAGE-AID, DAST, AUDIT (Substance Abuse, Drug Abuse, Alcohol Abuse), PC-PTSD, PCL (Trauma), and a Suicide and Violence screening tool (short form and longer form follow up). In addition, the screening material used within the Behavior Health Works software application (vendor solution) was approved by the Clinical Governance Committee; this software application is being vetted for use by CCN partners to integrate behavioral health and physical medical information within the EHR and track actively engaged patients. In its clinical governance structure, CCN has established RPU-level quality committees to provide oversight for the behavioral health projects. Each of these four bodies will influence collaborative treatment models for primary care, facilitate cross training among primary care givers and behavioral health specialists, and monitor performance. The committees will adopt evidence-based protocols for care engagement, screening, assessment, crisis/high risk response plans, medication management, and treatment. Committees for the four RPUs have begun to meet in October to establish their charters and meeting frequency. The 3ai Project Team and CCN have identified a potential IT solution which will enable project partners to track all actively engaged patients and integrate behavioral and physical medicine within a single medical chart. The vendor selection process is part of CCN's overall IT Systems and Processes roadmap. CCN expects the roadmap to be completed by DY1, Q3, including a timeline for the vendor selection process. CCN is in a position to begin contracting with partners to bring our pilot sites on line under the 3ai project. It is our intent to have these pilot sites up and running by the end of DY1, Q3 for Model 1 and DY1, Q4 for Model2.

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Use EHRs or other technical platforms to track all patients engaged in this project.	The Care Compass Network (CCN) plan for project 3ai includes Model 1 and Model 2, including a total of eight Milestones with associated steps for implementation, none of which were targeted for DY1, Q2 completion. Each of the Milestones and tasks are being reported as In Progress for DY1, Q2. In the Q2 period CCN has made significant progress on the 3ai Integration of Behavioral Health and Primary Care project. The 3ai Team Leaders and the CCN Project Management Office have begun to identify pilot primary care sites for participation in Model 1 and Model 2 across the PPS. For Model 1, CCN will initially focus efforts on sites that have already achieved PCMH recognition, have a significant Medicaid patient population, and have a significant patient base with existing behavioral health needs. Based on initial assessments by the project team these pilot sites will predominantly come from within the main hospital based primary care networks from Lourdes (South Regional Performance Unit (RPU)), UHS (South and East RPU), and Guthrie (West RPU). For Model 2, CCN efforts will initially focus on two identified Article 31 pilot sites located in Schuyler and Cortland counties, both in the CCN North RPU. Based on review of Salient data by the Salient team this spread by Region indicates appropriate support of the beneficiary presence, whereby initial models show the South RPU comprised of roughly 46% of the CCN beneficiaries and the North RPU containing roughly 30% of the CCN beneficiaries. In September the 3ai Project Team prepared a core set of screening tools and treatment protocols which were subsequently presented to and approved by the Clinical Governance Committee at the 10/8/15 meeting as well as the Board of Directors at the 10/13/15 meeting. These movements position the project team well for contracting arrangements in the DY1, Q3 period. Evidence-based screening tools prepared in DY1, Q2 and subsequently approved in DY1, Q3 included the following: PHQ-9 (Depression), GAD-7 (General Anxiety Disorder), CAGE-AID, DAST, AUDIT (Substance Abuse, Drug Abuse, Alcohol Abuse), PC-PTSD, PCL (Trauma), and a Suicide and Violence screening tool (short form and longer form follow up). In addition, the screening material used within the Behavior Health Works software application (vendor solution) was approved by the Clinical Governance Committee; this software application is being vetted for use by CCN partners to integrate behavioral health and physical medical information within the EHR and track actively engaged patients. In its clinical governance structure, CCN has established RPU-level quality committees to provide oversight for the behavioral health projects. Each of these four bodies will influence collaborative treatment models for primary care, facilitate cross training among primary care givers and behavioral health specialists, and monitor performance. The committees will adopt evidence-based protocols for care engagement, screening, assessment, crisis/high risk response plans, medication management, and treatment. Committees for the four RPUs have begun to meet in October to establish their charters and meeting frequency. The 3ai Project Team and CCN have identified a potential IT solution which will enable project partners to track all actively engaged patients and integrate behavioral and physical medicine within a single medical chart. The vendor selection process is part of CCN's overall IT Systems and Processes roadmap. CCN expects the roadmap to be completed by DY1, Q3, including a timeline for the vendor selection process. CCN is in a position to begin contracting with partners to bring our pilot sites on line under the 3ai project. It is our intent to have these pilot sites up and running by the end of DY1, Q3 for Model 1 and DY1, Q4 for Model2.
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	CCN is in a position to begin contracting with partners to bring our pilot sites on line under the 3ai project. It is our intent to have these pilot sites up and running by the end of DY1, Q3 for Model 1 and DY1, Q4 for Model2.
Use EHRs or other technical platforms to track all patients engaged in this project.	The Care Compass Network (CCN) plan for project 3ai includes Model 1 and Model 2, including a total of eight Milestones with associated steps for implementation, none of which were targeted for DY1, Q2 completion. Each of the Milestones and tasks are being reported as In Progress for DY1, Q2. In the Q2 period CCN has made significant progress on the 3ai Integration of Behavioral Health and Primary Care project. The 3ai Team Leaders and the CCN Project Management Office have begun to identify pilot primary care sites for participation in Model 1 and Model 2 across the PPS. For Model 1, CCN will initially focus efforts on sites that have already achieved PCMH recognition, have a significant Medicaid patient population, and have a significant patient base with existing behavioral health needs. Based on initial assessments by the project team these pilot sites will predominantly come from within the main hospital based primary care networks from Lourdes (South Regional Performance Unit (RPU)), UHS (South and East RPU), and Guthrie (West RPU). For Model 2, CCN efforts will initially focus on two identified Article 31 pilot sites located in Schuyler and Cortland counties, both in the CCN North RPU. Based on review of Salient data by the Salient team this spread by Region indicates appropriate support of the beneficiary presence, whereby initial models show the South RPU comprised of roughly 46% of the CCN beneficiaries and the North RPU containing roughly 30% of the CCN beneficiaries. In September the 3ai Project Team prepared a core set of screening tools and treatment protocols which were subsequently presented to and approved by the Clinical Governance Committee at the 10/8/15 meeting as well as the Board of Directors at the 10/13/15 meeting. These movements position the project team well for contracting arrangements in the DY1, Q3 period. Evidence-based screening tools prepared in DY1, Q2 and subsequently approved in DY1, Q3 included the following: PHQ-9 (Depression), GAD-7 (General Anxiety Disorder), CAGE-AID, DAST, AUDIT (Substance Abuse, Drug Abuse, Alcohol Abuse), PC-PTSD, PCL (Trauma), and a Suicide and Violence screening tool (short form and longer form follow up). In addition, the screening material used within the Behavior Health Works software application (vendor solution) was approved by the Clinical Governance Committee; this software application is being vetted for use by CCN partners to integrate behavioral health and physical medical information within the EHR and track actively engaged patients. In its clinical governance structure, CCN has established RPU-level quality committees to provide oversight for the behavioral health projects. Each of these four bodies will influence collaborative treatment models for primary care, facilitate cross training among primary care givers and behavioral health specialists, and monitor performance. The committees will adopt evidence-based protocols for care engagement, screening, assessment, crisis/high risk response plans, medication management, and treatment. Committees for the four RPUs have begun to meet in October to establish their charters and meeting frequency. The 3ai Project Team and CCN have identified a potential IT solution which will enable project partners to track all actively engaged patients and integrate behavioral and physical medicine within a single medical chart. The vendor selection process is part of CCN's overall IT Systems and Processes roadmap. CCN expects the roadmap to be completed by DY1, Q3, including a timeline for the vendor selection process. CCN is in a position to begin contracting with partners to bring our pilot sites on line under the 3ai project. It is our intent to have these pilot sites up and running by the end of DY1, Q3 for Model 1 and DY1, Q4 for Model2.
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.	

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Designate a Psychiatrist meeting requirements of the IMPACT Model.	
Measure outcomes as required in the IMPACT Model.	
Provide "stepped care" as required by the IMPACT Model.	
Use EHRs or other technical platforms to track all patients engaged in this project.	

Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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Project 3.a.ii – Behavioral health community crisis stabilization services

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

Instructions :

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

1) Risk: Lack of buy-in by community, providers, and law enforcement. For well over 30 years, response personnel have been trained that when an individual experiences a behavioral health crisis and is not considered safe, the individual should be transported to the nearest hospital emergency department. Most after-hour phone messages indicate that if the individual is in crisis they should go to the emergency department. Creating acceptance and trust throughout the community that an alternative approach to a behavioral health crisis can be safe and effective will be a challenge, particularly when services such as mobile crisis, respite, and peer support have not been traditionally available and/or have not been consistently utilized. To mitigate this risk will take careful development of education and training throughout the PPS about this project and its benefits. This education will need to be part of an overall strategy of the PPS to change the perception of how health care and behavioral health care services will be provided within the region. In addition, there will need to be a focus on encouraging the community members to allow individuals, other than law enforcement, into their homes or other community settings to provide the intervention.
2) Our second risk centers on the lack of, or use of, a consistent evidence based screening/assessment tool with appropriate decision matrix regarding level of care. At present there is a patchwork of crisis intervention strategies throughout the PPS, each developed by the individual agency that provides the service. Part of the success of this project will be to ensure that evidence based, standardized tools are used as the basis of the assessment, decision making, and data collection process. Gaining acceptance and utilization by behavioral health providers will require time, training, follow-through, and data that can demonstrate that this approach provides better outcomes for the individual in crisis. To mitigate this risk, the Behavioral Health team leaders have interviewed a vendor who has validated, evidence based screening and assessment tools for all levels of Behavioral Health projects. This would provide a way of providing standardized screenings, assessments, level of care decisions and also collection of necessary data.
3) Our third risk is the lack of ability to share protected health information in a real time, crisis situation. Providers will need to have access to a secure portal and there will need to be clear protocols regarding what information can be shared throughout a crisis event. Because no one agency will be providing all of the services within this project, there may be confusion regarding what information can be shared with whom, and when. Lack of clarity, solid protocols, and training regarding data sharing may result in providers not using the services appropriately which would reduce the effectiveness of this project. In addition, a method for obtaining Individual consent will have to be developed. To mitigate this we will work to ensure that clarification, written protocols, and training occur prior to and throughout the implementation of the project. It is important that all providers understand and operate under all privacy and security regulations for sharing of private data and protected health information. The PPS will need to develop and implement an appropriate consent form.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	3,200

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
0	0	0.00%	160	0.00%

Warning: Please note that your patients engaged to date does not meet your committed amount (160)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its actively engaged commitments for DY1, Q2.

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS has established a crisis intervention program that includes outreach, mobile crisis, and intensive crisis services.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1b. 3aii Team will develop a crisis intervention program and perform an assessment to determine, for each Regional Performance Unit (RPU) as well as overlapping PPSs, which agencies (including the respective local governance units "LGUs" for each of the nine counties) or individual provider(s) can best meet the project needs. Project components will include mobile crisis intervention, phone triage, observation beds, and community respite services. Engaged agencies/individuals are expected to include county mental health agencies, Directors of Community Services, law enforcement, and CBOs offering behavioral health and respite services. Program will create alternative ways (compared to ED admission) for patients and families to seek out crisis stabilization services, especially in cases when patient does not require intensive inpatient care. Program approaches for each RPU are listed in steps 1c-1f within this milestone.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1c. Based on initial assessments of overall PPS partner readiness and willingness to participate in the project, the 3aii Project Team will initially pursue engaging a crisis intervention program through a mobilized Southern RPU (Broome/Tioga Counties) to fully implement a total Crisis Stabilization Service built on the existing CPEP services housed by PPS member United Health Services Hospitals (UHSH). Engaged services	Project		In Progress	04/01/2015	03/31/2016	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
are expected to include a minimum of phone triage, mobile crisis, and observation beds. The PPS will also collaborate with Catholic Charities for the development of community based crisis respite beds/apartments.									
Task 1d. Repeat model for the North RPU by identifying available resources, readiness, and adjusting plan as necessary for local needs. CCN PMO will coordinate services with PPSs with overlapping coverage to identify economies of scale.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1e. Repeat model for the West RPU by identifying available resources, readiness, and adjusting plan as necessary for local needs. CCN PMO will coordinate services with PPSs with overlapping coverage to identify economies of scale.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1f. Repeat model for the East RPU by identifying available resources, readiness, and adjusting plan as necessary for local needs. CCN PMO will coordinate services with PPSs with overlapping coverage to identify economies of scale.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #2 Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.	Project	N/A	In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task PPS has implemented diversion management protocol with PPS Hospitals (specifically Emergency Departments).	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 2b. The 3aii Project Team will develop a PPS profiling map of health homes, emergency room, and hospital services to understand existing linkages and workflows for each RPU. As a result of the assessment, a phased approach for remediation of missing or enhanced linkages, including communication requirements will be prepared.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2c. Using the profiling map the 3aii Project Team will engage CBOs, ED, and hospitals to develop and implement diversion protocols from ED and inpatient services. Protocols prepared by these workgroups will be presented to the Clinical Governance Committee and Board of Directors for approval - and recertified	Project		In Progress	04/01/2015	03/31/2016	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
annually for pertinence. The 3aii Project Team and PMO will develop educational material related to Crisis Stabilization Services offered under this program for law enforcement and the medical community (e.g., barrier identified as Risk #1) and leverage the Workforce Team and Provider Relations to distribute and communicate education/training. Materials prepared will also be made centrally available to all PPS members by posting to the CCN website, SharePoint, etc.									
Milestone #3 Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.	Project	N/A	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS has engaged MCO in negotiating coverage of services under this project and/or MCO provides coverage for services in project.	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 3b. The PPS would have an initial conversation with the MCOs to discuss the approach on how to include services not currently covered today. The discussion will outline a framework which will include a summary whereby the the CCN PMO will conduct a quantitative and qualitative needs assessment of the affected population to understand service array utilization of the continuum of care, the organizations providing them, and corresponding expected level of effort. In addition, the PPS will seek to understand needed services to address related issues of the affected population not currently covered by Medicaid. For example, this will help to understand what services in the community would effectively help to avoid utilization of more expensive services.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3c. With an understanding on the approach, the PPS PMO and Analytics team will perform a review of available data to identify trends and understand the continuum of care to develop a prototype model for crisis management whose intent is to reduce hospital leverage / ED use. Other key stakeholders to include in this review include police departments, EMT transports, etc. Upon completion the PPS will meet with MCOs to share the data and analysis and work together to develop a payment	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4

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methodology to include currently uncovered services that are found to be essential in avoiding hopsital use for this population.									
Milestone #4 Develop written treatment protocols with consensus from participating providers and facilities.	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Regularly scheduled formal meetings are held to develop consensus on treatment protocols.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Coordinated treatment care protocols are in place.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4c. Develop written Crisis Stabilization protocols in tandem with the 3aii Project Team, participating agencies, providers, CBOs, and collaboration with other PPSs. Once developed, the protocols will be submitted to the Clinical Governance Committee (CGC) and Board of Directors for approval. Each year, the CGC will approve and recertify previously adopted protocols. (Risk #3) On an ongoing basis, the respective regional performance unit Behavioral Health Subcommittee will provide oversight and monitoring for adherence and efficacy of plans. Provider remediation or protocol amendment (e.g., based on regional customization or alignment with new leading practices) will be made available to the Clinical Governance Committee.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4d. CCN will require participating agencies, providers, and CBOs to follow the adopted training related to the agreed upon protocols as part of the contracting process.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #5 Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS includes at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services in provider network	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS evaluates access to psychiatric services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and	Provider	Safety Net Hospital	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
implements improvement steps.									
Task 5c. The 3aii Project Team and CCN PMO will pursue contracting with identified hospitals within the PPS based off evaluation of implementation criteria such as offering of specialty psychiatric services/crisis oriented-psychiatric services, and overall readiness/willingness to engage in 3aii related work. Based on the initial assessments, the 3aii Project Team expects to engage with United Health Services, Inc., Cayuga Medical Center, and Cortland Regional Medical Center for this project.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5d. On at least an annual basis, the 3aii Project Team and PMO will present to each regional performance unit Behavioral Health Subcommittee (e.g., 3aii Quality Committee) an evaluation and report of crisis-oriented psychiatric services availability, geographic access, wait times, etc. to identify areas for improved access. As required and advised by the BH Quality Committee, the PMO will implement improvement plans (e.g., such as improvement efforts or program expansion efforts).	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).	Project	N/A	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS includes hospitals with observation unit or off campus crisis residence locations for crisis monitoring.	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	Provider	Safety Net Hospital	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	Provider	Safety Net Clinic	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment,	Provider	Safety Net Mental Health	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 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
geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.									
Task 6e. Using the review performed of 3aii related health care linkages and workflows, the Project 3aii Team and PMO will pursue contracts (as necessary) with PPS health care providers to offer observation beds in Safety Net Hospitals. Team has initially identified a Phase I approach for collaboration with Cortland Regional Medical Center and Cayuga Medical Center for the expansion of access to observation units. In Phase II the 3aii Project Team will identify strategies for the remaining regions/providers.	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 6f. CCN PMO to contract with PPS CBOs to maintain community-based respite beds (safety net clinics and/or safety net behavioral health providers) that offer crisis intervention and observation services within the community for those individuals who can be stabilized outside of hospital setting.	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 6g. Annually, PMO will present to RPU Behavioral Health Subcommittees an evaluation of off-campus residence service availability, geographic access, wait times, etc. to identify areas for improved access. PMO implements improvement plans.	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Milestone #7 Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.	Project	N/A	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS includes mobile crisis teams to help meet crisis stabilization needs of the community.	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Coordinated evidence-based care protocols for mobile crisis teams are in place.	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 7c. The 3aii Project Team to perform an assessment of PPS needs (e.g., based on community needs assessment, Salient data, etc.) as well as PPS Partner service offerings, capabilities, and readiness/ability to partner with CCN in the deployment of mobile crisis teams to provide crisis stabilization services using	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
evidenced-based protocols developed by medical staff. Based on initial reviews the 3aii Project Team has identified the UHS Comprehensive Psychiatric Emergency Program (CPEP) as a pilot in delivery of the mobile intervention services to the PPS.									
Task 7d. The PPS, in collaboration with existing leading practices and partner protocols will develop/adopt evidence-based protocols for mobile intervention for use by mobile intervention teams. Identified protocol(s) will be endorsed by the Clinical Governance Committee, approved by the Board of Directors, and subsequently recertified on, at minimum, an annual basis by the Clinical Governance Committee.	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 7e. The 3aii Project Team will identify strategies to provide/deliver mobile crisis teams/services throughout the PPS as needs exist (e.g., by RPU.)	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 7f. Annually, the PMO will present to RPU Behavioral Health Subcommittees (e.g., 3aii Quality Committees by region) an evaluation of mobile crisis service availability, geographic access, wait times, etc. to identify areas for improved access. The PMO will collaborate with partners to implement improvement plans identified by the quality committees (as required by PPS partner contracts).	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Milestone #8 Ensure that all PPS safety net providers have actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY	Provider	Safety Net Practitioner - Non-Primary Care	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
requirements.		Provider (PCP)							
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 Alerts and secure messaging functionality are used to facilitate crisis intervention services.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 8g. 3aii Team to identify EHR or other IT platform(s) for behavioral health screening/assessment tool, collection, sharing and storage of data. EHR or other IT platform(s) to meets several requirements which facilitate intervention services (for example, integrated medical/behavioral health record, ability to track patients, ability to report agency-level performance metrics, RHIO/SHIN-NY connectivity, alerts and secure messaging). CCN PMO to coordinate review and approval of IT solutions with the IT Committee (and the associated review processes) and align vendor solutions with project needs as well as the broader IT Vision of the PPS.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 8h. The PPS will execute a contract with the selected vendor for the delivery of services. The CCN PMO/Provider Relations to oversee roll out of EHR or other IT platform to contracted agencies, providers, and CBOs offering crisis stabilization services. Rollout includes readiness assessment, training, workflow optimization, and go live. (Risk #3) As part of the implementation process, PPS Partners will be required to submit documentation such as certifications, training attestations/rosters, or system reports to confirm achievement of key implementation/integration milestones.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #9 Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.	Project	N/A	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has implemented central triage service among psychiatrists	Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
and behavioral health providers.									
Task 9b. The PPS (through collaboration by the project team as well as stakeholders) will identify potential providers of a central triage service crisis stabilization services, as outlined by the PPS and/or by the respective regional performance unit. As part of this process, the 3aii Project Team will perform an assessment to align project requirements with the availability and needs of the community (e.g., central triage service). A strategy will be developed to connect triage service provider(s) identified with participating providers of behavioral health services, mobile intervention, inpatient observation, and community respite services. The finalized plans will serve as a baseline for operating/contractual agreements with PPS members participating in project 3aii.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 9c. As part of the Care Compass Network contract, the centralized phone triage provider(s) will be required to use a standard assessment tool, approved by the Clinical Governance Committee and recertified annually.	Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Milestone #10 Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task PPS has created an active quality subcommittee that reports to PPS quality committee that is representative of medical and behavioral health staff and is specifically focused on integration of primary care and behavioral health services within practice sites and other behavioral health project initiatives. Note: Only one quality sub-committee is required for medical and behavioral health integration projects in Domain 3a.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
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	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics listed in Attachment J	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Domain 3 Behavioral Health Metrics.									
Task PPS quality subcommittee conducts and/or reviews self-audits to ensure compliance with processes and procedures developed for this project.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Service and quality outcome measures are reported to all stakeholders including PPS quality committee.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 10f. CCN to seat Regional Performance Unit Behavioral Health Subcommittees. Each committee will be comprised of local medical and behavioral health experts who can evaluate the crisis stabilization program and integration of primary care and behavioral health services.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 10g. CCN PMO regularly reports key quality metrics (including Appendix J metrics Domain 3 Behavioral Health metrics) to RPU Behavioral Health Subcommittees. Behavioral Health Subcommittees identifies opportunities for quality improvement; PMO develops implementation plans, committee and PMO evaluate results of quality improvement initiatives. CCN to distribute service and quality outcome measures to Care Compass Network quality committee(s) as well as to the stakeholders through platforms such as the Stakeholders meeting and/or website.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #11 Use EHRs or other technical platforms to track all patients engaged in this project.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11b. 3aii Team to identify EHR or other IT platform(s) for behavioral health screening/assessment tool, collection, sharing and storage of data. EHR or other IT platform(s) to meets several requirements which facilitate intervention services (for example, integrated medical/behavioral health record, ability to track patients, ability to report agency-level performance metrics, RHIO/SHIN-NY connectivity, alerts and secure messaging).	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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
CCN PMO to execute a contract with the selected vendor.									
Task 11c. CCN PMO/Provider Relations to oversee roll out of EHR or other IT platform to contracted agencies, providers, and CBOs offering crisis stabilization services. Rollout includes readiness assessment, training, workflow optimization, and go live. (Risk #3)	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11d. The IT Project Manager and 3aii Project Team will prepare a validation checklist to be used as each partner completes implementation and related connectivity requirements. After the initial assessment, the PPS Population Health team will provide feedback regarding the accuracy/validity of data to PPS partners to promote the accuracy, completion, timeliness, and validity of data transmitted and gathered/reported in the EHR/technical platform and related interfaces.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.										
Task PPS has established a crisis intervention program that includes outreach, mobile crisis, and intensive crisis services.										
Task 1b. 3aii Team will develop a crisis intervention program and perform an assessment to determine, for each Regional Performance Unit (RPU) as well as overlapping PPSs, which agencies (including the respective local governance units "LGUs" for each of the nine counties) or individual provider(s) can best meet the project needs. Project components will include mobile crisis intervention, phone triage, observation beds, and community respite services. Engaged agencies/individuals are expected to include county mental health agencies, Directors of Community Services, law enforcement, and CBOs offering behavioral health and respite services. Program will create alternative ways (compared to ED admission) for patients and families to seek out crisis stabilization services, especially in cases when patient does not require intensive inpatient care. Program approaches for each RPU are listed in steps 1c-1f										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
within this milestone.										
Task 1c. Based on initial assessments of overall PPS partner readiness and willingness to participate in the project, the 3aii Project Team will initially pursue engaging a crisis intervention program through a mobilized Southern RPU (Broome/Tioga Counties) to fully implement a total Crisis Stabilization Service built on the existing CPEP services housed by PPS member United Health Services Hospitals (UHSH). Engaged services are expected to include a minimum of phone triage, mobile crisis, and observation beds. The PPS will also collaborate with Catholic Charities for the development of community based crisis respite beds/apartments.										
Task 1d. Repeat model for the North RPU by identifying available resources, readiness, and adjusting plan as necessary for local needs. CCN PMO will coordinate services with PPSs with overlapping coverage to identify economies of scale.										
Task 1e. Repeat model for the West RPU by identifying available resources, readiness, and adjusting plan as necessary for local needs. CCN PMO will coordinate services with PPSs with overlapping coverage to identify economies of scale.										
Task 1f. Repeat model for the East RPU by identifying available resources, readiness, and adjusting plan as necessary for local needs. CCN PMO will coordinate services with PPSs with overlapping coverage to identify economies of scale.										
Milestone #2 Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.										
Task PPS has implemented diversion management protocol with PPS Hospitals (specifically Emergency Departments).										
Task 2b. The 3aii Project Team will develop a PPS profiling map of health homes, emergency room, and hospital services to understand existing linkages and workflows for each RPU. As a result of the assessment, a phased approach for remediation of missing or enhanced linkages, including communication requirements will be prepared.										
Task 2c. Using the profiling map the 3aii Project Team will engage CBOs, ED, and hospitals to develop and implement diversion										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
protocols from ED and inpatient services. Protocols prepared by these workgroups will be presented to the Clinical Governance Committee and Board of Directors for approval - and recertified annually for pertinence. The 3aii Project Team and PMO will develop educational material related to Crisis Stabilization Services offered under this program for law enforcement and the medical community (e.g., barrier identified as Risk #1) and leverage the Workforce Team and Provider Relations to distribute and communicate education/training. Materials prepared will also be made centrally available to all PPS members by posting to the CCN website, SharePoint, etc.										
Milestone #3 Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.										
Task PPS has engaged MCO in negotiating coverage of services under this project and/or MCO provides coverage for services in project.										
Task 3b. The PPS would have an initial conversation with the MCOs to discuss the approach on how to include services not currently covered today. The discussion will outline a framework which will include a summary whereby the the CCN PMO will conduct a quantitative and qualitative needs assessment of the affected population to understand service array utilization of the continuum of care, the organizations providing them, and corresponding expected level of effort. In addition, the PPS will seek to understand needed services to address related issues of the affected population not currently covered by Medicaid. For example, this will help to understand what services in the community would effectively help to avoid utilization of more expensive services.										
Task 3c. With an understanding on the approach, the PPS PMO and Analytics team will perform a review of available data to identify trends and understand the continuum of care to develop a prototype model for crisis management whose intent is to reduce hospital leverage / ED use. Other key stakeholders to include in this review include police departments, EMT transports, etc. Upon completion the PPS will meet with MCOs to share the data and analysis and work together to develop a payment methodology to include currently uncovered services that are found to be essential in avoiding hopsital use for this population.										
Milestone #4 Develop written treatment protocols with consensus from										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
participating providers and facilities.										
Task Regularly scheduled formal meetings are held to develop consensus on treatment protocols.										
Task Coordinated treatment care protocols are in place.										
Task 4c. Develop written Crisis Stabilization protocols in tandem with the 3aii Project Team, participating agencies, providers, CBOs, and collaboration with other PPSs. Once developed, the protocols will be submitted to the Clinical Governance Committee (CGC) and Board of Directors for approval. Each year, the CGC will approve and recertify previously adopted protocols. (Risk #3) On an ongoing basis, the respective regional performance unit Behavioral Health Subcommittee will provide oversight and monitoring for adherence and efficacy of plans. Provider remediation or protocol amendment (e.g., based on regional customization or alignment with new leading practices) will be made available to the Clinical Governance Committee.										
Task 4d. CCN will require participating agencies, providers, and CBOs to follow the adopted training related to the agreed upon protocols as part of the contracting process.										
Milestone #5 Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.										
Task PPS includes at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services in provider network										
Task PPS evaluates access to psychiatric services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	0	0	0	0	0	3	3	3	3	3
Task 5c. The 3aii Project Team and CCN PMO will pursue contracting with identified hospitals within the PPS based off evaluation of implementation criteria such as offering of specialty psychiatric services/crisis oriented-psychiatric services, and overall readiness/willingness to engage in 3aii related work. Based on the initial assessments, the 3aii Project Team expects to engage with United Health Services, Inc., Cayuga Medical Center, and Cortland Regional Medical Center for 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 5d. On at least an annual basis, the 3aii Project Team and PMO will present to each regional performance unit Behavioral Health Subcommittee (e.g., 3aii Quality Committee) an evaluation and report of crisis-oriented psychiatric services availability, geographic access, wait times, etc. to identify areas for improved access. As required and advised by the BH Quality Committee, the PMO will implement improvement plans (e.g., such as improvement efforts or program expansion efforts).										
Milestone #6 Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).										
Task PPS includes hospitals with observation unit or off campus crisis residence locations for crisis monitoring.										
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	0	0	0	0	0	3	3	3	3	3
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	0	0	0	0	0	0	0	0	0	0
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	0	0	0	0	0	12	12	12	12	12
Task 6e. Using the review performed of 3aii related health care linkages and workflows, the Project 3aii Team and PMO will pursue contracts (as necessary) with PPS health care providers to offer observation beds in Safety Net Hospitals. Team has initially identified a Phase I approach for collaboration with Cortland Regional Medical Center and Cayuga Medical Center for the expansion of access to observation units. In Phase II the 3aii Project Team will identify strategies for the remaining regions/providers.										
Task 6f. CCN PMO to contract with PPS CBOs to maintain community-based respite beds (safety net clinics and/or safety net behavioral health providers) that offer crisis intervention and observation services within the community for those individuals										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
who can be stabilized outside of hospital setting.										
Task 6g. Annually, PMO will present to RPU Behavioral Health Subcommittees an evaluation of off-campus residence service availability, geographic access, wait times, etc. to identify areas for improved access. PMO implements improvement plans.										
Milestone #7 Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.										
Task PPS includes mobile crisis teams to help meet crisis stabilization needs of the community.										
Task Coordinated evidence-based care protocols for mobile crisis teams are in place.										
Task 7c. The 3aii Project Team to perform an assessment of PPS needs (e.g., based on community needs assessment, Salient data, etc.) as well as PPS Partner service offerings, capabilities, and readiness/ability to partner with CCN in the deployment of mobile crisis teams to provide crisis stabilization services using evidenced-based protocols developed by medical staff. Based on initial reviews the 3aii Project Team has identified the UHS Comprehensive Psychiatric Emergency Program (CPEP) as a pilot in delivery of the mobile intervention services to the PPS.										
Task 7d. The PPS, in collaboration with existing leading practices and partner protocols will develop/adopt evidence-based protocols for mobile intervention for use by mobile intervention teams. Identified protocol(s) will be endorsed by the Clinical Governance Committee, approved by the Board of Directors, and subsequently recertified on, at minimum, an annual basis by the Clinical Governance Committee.										
Task 7e. The 3aii Project Team will identify strategies to provide/deliver mobile crisis teams/services throughout the PPS as needs exist (e.g., by RPU.)										
Task 7f. Annually, the PMO will present to RPU Behavioral Health Subcommittees (e.g., 3aii Quality Committees by region) an evaluation of mobile crisis service availability, geographic access, wait times, etc. to identify areas for improved access. The PMO will collaborate with partners to implement improvement plans identified by the quality committees (as										

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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
required by PPS partner contracts).										
Milestone #8 Ensure that all PPS safety net providers have actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	3	3	3	3	3
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	12	12	12	12	12
Task Alerts and secure messaging functionality are used to facilitate crisis intervention services.										
Task 8g. 3aii Team to identify EHR or other IT platform(s) for behavioral health screening/assessment tool, collection, sharing and storage of data. EHR or other IT platform(s) to meets several requirements which facilitate intervention services (for example, integrated medical/behavioral health record, ability to track patients, ability to report agency-level performance metrics, RHIO/SHIN-NY connectivity, alerts and secure messaging). CCN PMO to coordinate review and approval of IT solutions with the IT Committee (and the associated review processes) and align vendor solutions with project needs as well as the broader IT Vision of the PPS.										
Task 8h. The PPS will execute a contract with the selected vendor for the delivery of services. The CCN PMO/Provider Relations to oversee roll out of EHR or other IT platform to contracted agencies, providers, and CBOs offering crisis stabilization services. Rollout includes readiness assessment, training, workflow optimization, and go live. (Risk #3) As part of the										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
implementation process, PPS Partners will be required to submit documentation such as certifications, training attestations/rosters, or system reports to confirm achievement of key implementation/integration milestones.										
Milestone #9 Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.										
Task PPS has implemented central triage service among psychiatrists and behavioral health providers.										
Task 9b. The PPS (through collaboration by the project team as well as stakeholders) will identify potential providers of a central triage service crisis stabilization services, as outlined by the PPS and/or by the respective regional performance unit. As part of this process, the 3aii Project Team will perform an assessment to align project requirements with the availability and needs of the community (e.g., central triage service). A strategy will be developed to connect triage service provider(s) identified with participating providers of behavioral health services, mobile intervention, inpatient observation, and community respite services. The finalized plans will serve as a baseline for operating/contractual agreements with PPS members participating in project 3aii.										
Task 9c. As part of the Care Compass Network contract, the centralized phone triage provider(s) will be required to use a standard assessment tool, approved by the Clinical Governance Committee and recertified annually.										
Milestone #10 Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.										
Task PPS has created an active quality subcommittee that reports to PPS quality committee that is representative of medical and behavioral health staff and is specifically focused on integration of primary care and behavioral health services within practice sites and other behavioral health project initiatives. Note: Only one quality sub-committee is required for medical and behavioral health integration projects in Domain 3a.										
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics listed in Attachment J Domain 3 Behavioral Health Metrics.										
Task PPS quality subcommittee conducts and/or reviews self-audits to ensure compliance with processes and procedures developed for this project.										
Task Service and quality outcome measures are reported to all stakeholders including PPS quality committee.										
Task 10f. CCN to seat Regional Performance Unit Behavioral Health Subcommittees. Each committee will be comprised of local medical and behavioral health experts who can evaluate the crisis stabilization program and integration of primary care and behavioral health services.										
Task 10g. CCN PMO regularly reports key quality metrics (including Appendix J metrics Domain 3 Behavioral Health metrics) to RPU Behavioral Health Subcommittees. Behavioral Health Subcommittees identifies opportunities for quality improvement; PMO develops implementation plans, committee and PMO evaluate results of quality improvement initiatives. CCN to distribute service and quality outcome measures to Care Compass Network quality committee(s) as well as to the stakeholders through platforms such as the Stakeholders meeting and/or website.										
Milestone #11 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 11b. 3aii Team to identify EHR or other IT platform(s) for behavioral health screening/assessment tool, collection, sharing and storage of data. EHR or other IT platform(s) to meets several requirements which facilitate intervention services (for example, integrated medical/behavioral health record, ability to track patients, ability to report agency-level performance metrics, RHIO/SHIN-NY connectivity, alerts and secure messaging). CCN PMO to execute a contract with the selected vendor.										
Task 11c. CCN PMO/Provider Relations to oversee roll out of EHR or other IT platform to contracted agencies, providers, and CBOs										

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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
offering crisis stabilization services. Rollout includes readiness assessment, training, workflow optimization, and go live. (Risk #3)										
Task 11d. The IT Project Manager and 3aii Project Team will prepare a validation checklist to be used as each partner completes implementation and related connectivity requirements. After the initial assessment, the PPS Population Health team will provide feedback regarding the accuracy/validity of data to PPS partners to promote the accuracy, completion, timeliness, and validity of data transmitted and gathered/reported in the EHR/technical platform and related interfaces.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.										
Task PPS has established a crisis intervention program that includes outreach, mobile crisis, and intensive crisis services.										
Task 1b. 3aii Team will develop a crisis intervention program and perform an assessment to determine, for each Regional Performance Unit (RPU) as well as overlapping PPSs, which agencies (including the respective local governance units "LGUs" for each of the nine counties) or individual provider(s) can best meet the project needs. Project components will include mobile crisis intervention, phone triage, observation beds, and community respite services. Engaged agencies/individuals are expected to include county mental health agencies, Directors of Community Services, law enforcement, and CBOs offering behavioral health and respite services. Program will create alternative ways (compared to ED admission) for patients and families to seek out crisis stabilization services, especially in cases when patient does not require intensive inpatient care. Program approaches for each RPU are listed in steps 1c-1f within this milestone.										
Task 1c. Based on initial assessments of overall PPS partner readiness and willingness to participate in the project, the 3aii Project Team will initially pursue engaging a crisis intervention program through a mobilized Southern RPU (Broome/Tioga Counties) to fully implement a total Crisis Stabilization Service built on the existing CPEP services housed by PPS member										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
United Health Services Hospitals (UHSH). Engaged services are expected to include a minimum of phone triage, mobile crisis, and observation beds. The PPS will also collaborate with Catholic Charities for the development of community based crisis respite beds/apartments.										
Task 1d. Repeat model for the North RPU by identifying available resources, readiness, and adjusting plan as necessary for local needs. CCN PMO will coordinate services with PPSs with overlapping coverage to identify economies of scale.										
Task 1e. Repeat model for the West RPU by identifying available resources, readiness, and adjusting plan as necessary for local needs. CCN PMO will coordinate services with PPSs with overlapping coverage to identify economies of scale.										
Task 1f. Repeat model for the East RPU by identifying available resources, readiness, and adjusting plan as necessary for local needs. CCN PMO will coordinate services with PPSs with overlapping coverage to identify economies of scale.										
Milestone #2 Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.										
Task PPS has implemented diversion management protocol with PPS Hospitals (specifically Emergency Departments).										
Task 2b. The 3aii Project Team will develop a PPS profiling map of health homes, emergency room, and hospital services to understand existing linkages and workflows for each RPU. As a result of the assessment, a phased approach for remediation of missing or enhanced linkages, including communication requirements will be prepared.										
Task 2c. Using the profiling map the 3aii Project Team will engage CBOs, ED, and hospitals to develop and implement diversion protocols from ED and inpatient services. Protocols prepared by these workgroups will be presented to the Clinical Governance Committee and Board of Directors for approval - and recertified annually for pertinence. The 3aii Project Team and PMO will develop educational material related to Crisis Stabilization Services offered under this program for law enforcement and the medical community (e.g., barrier identified as Risk #1) and leverage the Workforce Team and Provider Relations to distribute and communicate education/training. Materials										

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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
prepared will also be made centrally available to all PPS members by posting to the CCN website, SharePoint, etc.										
Milestone #3 Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.										
Task PPS has engaged MCO in negotiating coverage of services under this project and/or MCO provides coverage for services in project.										
Task 3b. The PPS would have an initial conversation with the MCOs to discuss the approach on how to include services not currently covered today. The discussion will outline a framework which will include a summary whereby the the CCN PMO will conduct a quantitative and qualitative needs assessment of the affected population to understand service array utilization of the continuum of care, the organizations providing them, and corresponding expected level of effort. In addition, the PPS will seek to understand needed services to address related issues of the affected population not currently covered by Medicaid. For example, this will help to understand what services in the community would effectively help to avoid utilization of more expensive services.										
Task 3c. With an understanding on the approach, the PPS PMO and Analytics team will perform a review of available data to identify trends and understand the continuum of care to develop a prototype model for crisis management whose intent is to reduce hospital leverage / ED use. Other key stakeholders to include in this review include police departments, EMT transports, etc. Upon completion the PPS will meet with MCOs to share the data and analysis and work together to develop a payment methodology to include currently uncovered services that are found to be essential in avoiding hopsital use for this population.										
Milestone #4 Develop written treatment protocols with consensus from participating providers and facilities.										
Task Regularly scheduled formal meetings are held to develop consensus on treatment protocols.										
Task Coordinated treatment care protocols are in place.										
Task 4c. Develop written Crisis Stabilization protocols in tandem with the 3aii Project Team, participating agencies, providers, CBOs,										

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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 collaboration with other PPSs. Once developed, the protocols will be submitted to the Clinical Governance Committee (CGC) and Board of Directors for approval. Each year, the CGC will approve and recertify previously adopted protocols. (Risk #3) On an ongoing basis, the respective regional performance unit Behavioral Health Subcommittee will provide oversight and monitoring for adherence and efficacy of plans. Provider remediation or protocol amendment (e.g., based on regional customization or alignment with new leading practices) will be made available to the Clinical Governance Committee.										
Task 4d. CCN will require participating agencies, providers, and CBOs to follow the adopted training related to the agreed upon protocols as part of the contracting process.										
Milestone #5 Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.										
Task PPS includes at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services in provider network										
Task PPS evaluates access to psychiatric services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	3	3	3	3	3	3	3	3	3	3
Task 5c. The 3aii Project Team and CCN PMO will pursue contracting with identified hospitals within the PPS based off evaluation of implementation criteria such as offering of specialty psychiatric services/crisis oriented-psychiatric services, and overall readiness/willingness to engage in 3aii related work. Based on the initial assessments, the 3aii Project Team expects to engage with United Health Services, Inc., Cayuga Medical Center, and Cortland Regional Medical Center for this project.										
Task 5d. On at least an annual basis, the 3aii Project Team and PMO will present to each regional performance unit Behavioral Health Subcommittee (e.g., 3aii Quality Committee) an evaluation and report of crisis-oriented psychiatric services availability, geographic access, wait times, etc. to identify areas for improved access. As required and advised by the BH Quality Committee, the PMO will implement improvement plans (e.g., such as improvement efforts or program expansion efforts).										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #6 Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).										
Task PPS includes hospitals with observation unit or off campus crisis residence locations for crisis monitoring.										
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	3	3	3	3	3	3	3	3	3	3
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	0	0	0	0	0	0	0	0	0	0
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	12	12	12	12	12	12	12	12	12	12
Task 6e. Using the review performed of 3aii related health care linkages and workflows, the Project 3aii Team and PMO will pursue contracts (as necessary) with PPS health care providers to offer observation beds in Safety Net Hospitals. Team has initially identified a Phase I approach for collaboration with Cortland Regional Medical Center and Cayuga Medical Center for the expansion of access to observation units. In Phase II the 3aii Project Team will identify strategies for the remaining regions/providers.										
Task 6f. CCN PMO to contract with PPS CBOs to maintain community-based respite beds (safety net clinics and/or safety net behavioral health providers) that offer crisis intervention and observation services within the community for those individuals who can be stabilized outside of hospital setting.										
Task 6g. Annually, PMO will present to RPU Behavioral Health Subcommittees an evaluation of off-campus residence service availability, geographic access, wait times, etc. to identify areas for improved access. PMO implements improvement plans.										
Milestone #7 Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical										

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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
staff.										
Task PPS includes mobile crisis teams to help meet crisis stabilization needs of the community.										
Task Coordinated evidence-based care protocols for mobile crisis teams are in place.										
Task 7c. The 3aii Project Team to perform an assessment of PPS needs (e.g., based on community needs assessment, Salient data, etc.) as well as PPS Partner service offerings, capabilities, and readiness/ability to partner with CCN in the deployment of mobile crisis teams to provide crisis stabilization services using evidenced-based protocols developed by medical staff. Based on initial reviews the 3aii Project Team has identified the UHS Comprehensive Psychiatric Emergency Program (CPEP) as a pilot in delivery of the mobile intervention services to the PPS.										
Task 7d. The PPS, in collaboration with existing leading practices and partner protocols will develop/adopt evidence-based protocols for mobile intervention for use by mobile intervention teams. Identified protocol(s) will be endorsed by the Clinical Governance Committee, approved by the Board of Directors, and subsequently recertified on, at minimum, an annual basis by the Clinical Governance Committee.										
Task 7e. The 3aii Project Team will identify strategies to provide/deliver mobile crisis teams/services throughout the PPS as needs exist (e.g., by RPU.)										
Task 7f. Annually, the PMO will present to RPU Behavioral Health Subcommittees (e.g., 3aii Quality Committees by region) an evaluation of mobile crisis service availability, geographic access, wait times, etc. to identify areas for improved access. The PMO will collaborate with partners to implement improvement plans identified by the quality committees (as required by PPS partner contracts).										
Milestone #8 Ensure that all PPS safety net providers have actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.										

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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 demonstrates integration of medical and behavioral health record within individual patient records.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	3	3	3	3	3	3	3	3	3	3
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	12	12	12	12	12	12	12	12	12	12
Task Alerts and secure messaging functionality are used to facilitate crisis intervention services.										
Task 8g. 3aii Team to identify EHR or other IT platform(s) for behavioral health screening/assessment tool, collection, sharing and storage of data. EHR or other IT platform(s) to meets several requirements which facilitate intervention services (for example, integrated medical/behavioral health record, ability to track patients, ability to report agency-level performance metrics, RHIO/SHIN-NY connectivity, alerts and secure messaging). CCN PMO to coordinate review and approval of IT solutions with the IT Committee (and the associated review processes) and align vendor solutions with project needs as well as the broader IT Vision of the PPS.										
Task 8h. The PPS will execute a contract with the selected vendor for the delivery of services. The CCN PMO/Provider Relations to oversee roll out of EHR or other IT platform to contracted agencies, providers, and CBOs offering crisis stabilization services. Rollout includes readiness assessment, training, workflow optimization, and go live. (Risk #3) As part of the implementation process, PPS Partners will be required to submit documentation such as certifications, training attestations/rosters, or system reports to confirm achievement of key implementation/integration milestones.										
Milestone #9 Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task PPS has implemented central triage service among psychiatrists and behavioral health providers.										
Task 9b. The PPS (through collaboration by the project team as well as stakeholders) will identify potential providers of a central triage service crisis stabilization services, as outlined by the PPS and/or by the respective regional performance unit. As part of this process, the 3aii Project Team will perform an assessment to align project requirements with the availability and needs of the community (e.g., central triage service). A strategy will be developed to connect triage service provider(s) identified with participating providers of behavioral health services, mobile intervention, inpatient observation, and community respite services. The finalized plans will serve as a baseline for operating/contractual agreements with PPS members participating in project 3aii.										
Task 9c. As part of the Care Compass Network contract, the centralized phone triage provider(s) will be required to use a standard assessment tool, approved by the Clinical Governance Committee and recertified annually.										
Milestone #10 Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.										
Task PPS has created an active quality subcommittee that reports to PPS quality committee that is representative of medical and behavioral health staff and is specifically focused on integration of primary care and behavioral health services within practice sites and other behavioral health project initiatives. Note: Only one quality sub-committee is required for medical and behavioral health integration projects in Domain 3a.										
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics listed in Attachment J Domain 3 Behavioral Health Metrics.										
Task PPS quality subcommittee conducts and/or reviews self-audits to ensure compliance with processes and procedures developed for this project.										

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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 Service and quality outcome measures are reported to all stakeholders including PPS quality committee.										
Task 10f. CCN to seat Regional Performance Unit Behavioral Health Subcommittees. Each committee will be comprised of local medical and behavioral health experts who can evaluate the crisis stabilization program and integration of primary care and behavioral health services.										
Task 10g. CCN PMO regularly reports key quality metrics (including Appendix J metrics Domain 3 Behavioral Health metrics) to RPU Behavioral Health Subcommittees. Behavioral Health Subcommittees identifies opportunities for quality improvement; PMO develops implementation plans, committee and PMO evaluate results of quality improvement initiatives. CCN to distribute service and quality outcome measures to Care Compass Network quality committee(s) as well as to the stakeholders through platforms such as the Stakeholders meeting and/or website.										
Milestone #11 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 11b. 3aii Team to identify EHR or other IT platform(s) for behavioral health screening/assessment tool, collection, sharing and storage of data. EHR or other IT platform(s) to meets several requirements which facilitate intervention services (for example, integrated medical/behavioral health record, ability to track patients, ability to report agency-level performance metrics, RHIO/SHIN-NY connectivity, alerts and secure messaging). CCN PMO to execute a contract with the selected vendor.										
Task 11c. CCN PMO/Provider Relations to oversee roll out of EHR or other IT platform to contracted agencies, providers, and CBOs offering crisis stabilization services. Rollout includes readiness assessment, training, workflow optimization, and go live. (Risk #3)										
Task 11d. The IT Project Manager and 3aii Project Team will prepare a validation checklist to be used as each partner completes implementation and related connectivity requirements. After the initial assessment, the PPS Population Health team 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
feedback regarding the accuracy/validity of data to PPS partners to promote the accuracy, completion, timeliness, and validity of data transmitted and gathered/reported in the EHR/technical platform and related interfaces.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.	The Care Compass Network (CCN) plan for project 3aii includes a total of 11 Milestones with associated steps for implementation, none of which were targeted for DY1, Q2 completion. Each of the Milestones and tasks are being reported as In Progress for DY1, Q2. CCN has made significant progress on the 3aii Crisis Stabilization project in Q2. The 3aii Project Team is finalizing an assessment of existing resources for each of CCN's nine service counties. With this information, the Project Team will build geographical networks of phone triage service providers, mobile crisis teams, housing providers, and hospitals to implement community-wide a Crisis Stabilization protocol within each Regional Performance Unit (RPU). The Project Team will engage Community Based Organizations (CBO) and hospitals to provide these services under our Crisis Stabilization project, including phone triage for crisis de-escalation, mobile crisis intervention, respite services in the community, and observation services in inpatient settings (as opposed to inpatient psychiatric care). The 3aii Project Team has identified three pilot counties to focus our initial efforts: Tompkins, Cortland, and Broome. Through initial assessment these counties were identified for currently lacking one or more of the identified services and have an existing need for such a program in the community. The 3aii Project Team and CCN's Crisis Stabilization partners will develop a community-wide Crisis Stabilization protocol for each RPU or county to de-escalate crises and employ community-based services in order to divert clients from Emergency Departments and avoid inpatient admissions, as appropriate. CCN has established the governance structure for RPU level oversight of these protocols and monitoring of project performance (RPU Behavioral Health committees). CCN's Clinical Governance Committee will ultimately approve each community-wide Crisis Stabilization protocol. The 3aii Project Team and CCN have identified a potential IT solution which will enable project partners to track actively engaged patients, as well as access and share patient information among relevant clinical partners. The chosen IT solution will facilitate intervention services through the sharing of information in a timely way (including RHIO connectivity, alerts, and secure messaging) and allow for performance reporting. The vendor selection process is part of CCN's overall IT Systems and Processes roadmap. CCN expects the roadmap to be completed by DY1, Q3, including a timeline for the vendor selection process.
Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.	The Care Compass Network (CCN) plan for project 3aii includes a total of 11 Milestones with associated steps for implementation, none of which were targeted for DY1, Q2 completion. Each of the Milestones and tasks are being reported as In Progress for DY1, Q2. CCN has made significant progress on the 3aii Crisis Stabilization project in Q2. The 3aii Project Team is finalizing an assessment of existing resources for each of CCN's nine service counties. With this information, the Project Team will build geographical networks of phone triage service providers, mobile crisis teams, housing providers, and hospitals to implement community-wide a Crisis Stabilization protocol within each Regional Performance Unit (RPU). The Project Team will engage Community Based Organizations (CBO) and hospitals to provide these services under our Crisis Stabilization project, including phone triage for crisis de-escalation, mobile crisis intervention, respite services in the community, and observation services in inpatient settings (as opposed to inpatient psychiatric care). The 3aii Project Team has identified three pilot counties to focus our initial efforts: Tompkins, Cortland, and Broome. Through initial assessment these counties were identified for currently lacking one or more of the identified services and have an existing need for such a program in the community.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	The 3aii Project Team and CCN's Crisis Stabilization partners will develop a community-wide Crisis Stabilization protocol for each RPU or county to de-escalate crises and employ community-based services in order to divert clients from Emergency Departments and avoid inpatient admissions, as appropriate. CCN has established the governance structure for RPU level oversight of these protocols and monitoring of project performance (RPU Behavioral Health committees). CCN's Clinical Governance Committee will ultimately approve each community-wide Crisis Stabilization protocol. The 3aii Project Team and CCN have identified a potential IT solution which will enable project partners to track actively engaged patients, as well as access and share patient information among relevant clinical partners. The chosen IT solution will facilitate intervention services through the sharing of information in a timely way (including RHIO connectivity, alerts, and secure messaging) and allow for performance reporting. The vendor selection process is part of CCN's overall IT Systems and Processes roadmap. CCN expects the roadmap to be completed by DY1, Q3, including a timeline for the vendor selection process.
Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.	The Care Compass Network (CCN) plan for project 3aii includes a total of 11 Milestones with associated steps for implementation, none of which were targeted for DY1, Q2 completion. Each of the Milestones and tasks are being reported as In Progress for DY1, Q2. CCN has made significant progress on the 3aii Crisis Stabilization project in Q2. The 3aii Project Team is finalizing an assessment of existing resources for each of CCN's nine service counties. With this information, the Project Team will build geographical networks of phone triage service providers, mobile crisis teams, housing providers, and hospitals to implement community-wide a Crisis Stabilization protocol within each Regional Performance Unit (RPU). The Project Team will engage Community Based Organizations (CBO) and hospitals to provide these services under our Crisis Stabilization project, including phone triage for crisis de-escalation, mobile crisis intervention, respite services in the community, and observation services in inpatient settings (as opposed to inpatient psychiatric care). The 3aii Project Team has identified three pilot counties to focus our initial efforts: Tompkins, Cortland, and Broome. Through initial assessment these counties were identified for currently lacking one or more of the identified services and have an existing need for such a program in the community. The 3aii Project Team and CCN's Crisis Stabilization partners will develop a community-wide Crisis Stabilization protocol for each RPU or county to de-escalate crises and employ community-based services in order to divert clients from Emergency Departments and avoid inpatient admissions, as appropriate. CCN has established the governance structure for RPU level oversight of these protocols and monitoring of project performance (RPU Behavioral Health committees). CCN's Clinical Governance Committee will ultimately approve each community-wide Crisis Stabilization protocol. The 3aii Project Team and CCN have identified a potential IT solution which will enable project partners to track actively engaged patients, as well as access and share patient information among relevant clinical partners. The chosen IT solution will facilitate intervention services through the sharing of information in a timely way (including RHIO connectivity, alerts, and secure messaging) and allow for performance reporting. The vendor selection process is part of CCN's overall IT Systems and Processes roadmap. CCN expects the roadmap to be completed by DY1, Q3, including a timeline for the vendor selection process.
Develop written treatment protocols with consensus from participating providers and facilities.	The Care Compass Network (CCN) plan for project 3aii includes a total of 11 Milestones with associated steps for implementation, none of which were targeted for DY1, Q2 completion. Each of the Milestones and tasks are being reported as In Progress for DY1, Q2. CCN has made significant progress on the 3aii Crisis Stabilization project in Q2. The 3aii Project Team is finalizing an assessment of existing resources for each of CCN's nine service counties. With this information, the Project Team will build geographical networks of phone triage service providers, mobile crisis teams, housing providers, and hospitals to implement community-wide a Crisis Stabilization protocol within each Regional Performance Unit (RPU). The Project Team will engage Community Based Organizations (CBO) and hospitals to provide these services under our Crisis Stabilization project, including phone triage for crisis de-escalation, mobile crisis intervention, respite services in the community, and observation services in inpatient settings (as opposed to inpatient psychiatric care). The 3aii Project Team has identified three pilot counties to focus our initial efforts: Tompkins, Cortland, and Broome. Through initial assessment these counties were identified for currently lacking one or more of the identified services and have an existing need for such a program in the community. The 3aii Project Team and CCN's Crisis Stabilization partners will develop a community-wide Crisis Stabilization protocol for each RPU or county to de-escalate crises and employ community-based services in order to divert clients from Emergency Departments and avoid inpatient admissions, as appropriate. CCN has established the governance structure for RPU level oversight of these protocols and monitoring of project performance (RPU Behavioral Health committees). CCN's Clinical Governance Committee will ultimately approve each community-wide Crisis Stabilization protocol. The 3aii Project Team and CCN have identified a potential IT solution which will enable project partners to track actively engaged patients, as well as access

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Milestone Name	Narrative Text
	and share patient information among relevant clinical partners. The chosen IT solution will facilitate intervention services through the sharing of information in a timely way (including RHIO connectivity, alerts, and secure messaging) and allow for performance reporting. The vendor selection process is part of CCN's overall IT Systems and Processes roadmap. CCN expects the roadmap to be completed by DY1, Q3, including a timeline for the vendor selection process.
Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.	The Care Compass Network (CCN) plan for project 3aii includes a total of 11 Milestones with associated steps for implementation, none of which were targeted for DY1, Q2 completion. Each of the Milestones and tasks are being reported as In Progress for DY1, Q2. CCN has made significant progress on the 3aii Crisis Stabilization project in Q2. The 3aii Project Team is finalizing an assessment of existing resources for each of CCN's nine service counties. With this information, the Project Team will build geographical networks of phone triage service providers, mobile crisis teams, housing providers, and hospitals to implement community-wide a Crisis Stabilization protocol within each Regional Performance Unit (RPU). The Project Team will engage Community Based Organizations (CBO) and hospitals to provide these services under our Crisis Stabilization project, including phone triage for crisis de-escalation, mobile crisis intervention, respite services in the community, and observation services in inpatient settings (as opposed to inpatient psychiatric care). The 3aii Project Team has identified three pilot counties to focus our initial efforts: Tompkins, Cortland, and Broome. Through initial assessment these counties were identified for currently lacking one or more of the identified services and have an existing need for such a program in the community. The 3aii Project Team and CCN's Crisis Stabilization partners will develop a community-wide Crisis Stabilization protocol for each RPU or county to de-escalate crises and employ community-based services in order to divert clients from Emergency Departments and avoid inpatient admissions, as appropriate. CCN has established the governance structure for RPU level oversight of these protocols and monitoring of project performance (RPU Behavioral Health committees). CCN's Clinical Governance Committee will ultimately approve each community-wide Crisis Stabilization protocol. The 3aii Project Team and CCN have identified a potential IT solution which will enable project partners to track actively engaged patients, as well as access and share patient information among relevant clinical partners. The chosen IT solution will facilitate intervention services through the sharing of information in a timely way (including RHIO connectivity, alerts, and secure messaging) and allow for performance reporting. The vendor selection process is part of CCN's overall IT Systems and Processes roadmap. CCN expects the roadmap to be completed by DY1, Q3, including a timeline for the vendor selection process.
Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).	The Care Compass Network (CCN) plan for project 3aii includes a total of 11 Milestones with associated steps for implementation, none of which were targeted for DY1, Q2 completion. Each of the Milestones and tasks are being reported as In Progress for DY1, Q2. CCN has made significant progress on the 3aii Crisis Stabilization project in Q2. The 3aii Project Team is finalizing an assessment of existing resources for each of CCN's nine service counties. With this information, the Project Team will build geographical networks of phone triage service providers, mobile crisis teams, housing providers, and hospitals to implement community-wide a Crisis Stabilization protocol within each Regional Performance Unit (RPU). The Project Team will engage Community Based Organizations (CBO) and hospitals to provide these services under our Crisis Stabilization project, including phone triage for crisis de-escalation, mobile crisis intervention, respite services in the community, and observation services in inpatient settings (as opposed to inpatient psychiatric care). The 3aii Project Team has identified three pilot counties to focus our initial efforts: Tompkins, Cortland, and Broome. Through initial assessment these counties were identified for currently lacking one or more of the identified services and have an existing need for such a program in the community. The 3aii Project Team and CCN's Crisis Stabilization partners will develop a community-wide Crisis Stabilization protocol for each RPU or county to de-escalate crises and employ community-based services in order to divert clients from Emergency Departments and avoid inpatient admissions, as appropriate. CCN has established the governance structure for RPU level oversight of these protocols and monitoring of project performance (RPU Behavioral Health committees). CCN's Clinical Governance Committee will ultimately approve each community-wide Crisis Stabilization protocol. The 3aii Project Team and CCN have identified a potential IT solution which will enable project partners to track actively engaged patients, as well as access and share patient information among relevant clinical partners. The chosen IT solution will facilitate intervention services through the sharing of information in a timely way (including RHIO connectivity, alerts, and secure messaging) and allow for performance reporting. The vendor selection process is part of CCN's overall IT Systems and Processes roadmap. CCN expects the roadmap to be completed by DY1, Q3, including a timeline for the vendor selection process.
Deploy mobile crisis team(s) to provide crisis stabilization services	The Care Compass Network (CCN) plan for project 3aii includes a total of 11 Milestones with associated steps for implementation, none of which were

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using evidence-based protocols developed by medical staff.	targeted for DY1, Q2 completion. Each of the Milestones and tasks are being reported as In Progress for DY1, Q2. CCN has made significant progress on the 3aii Crisis Stabilization project in Q2. The 3aii Project Team is finalizing an assessment of existing resources for each of CCN's nine service counties. With this information, the Project Team will build geographical networks of phone triage service providers, mobile crisis teams, housing providers, and hospitals to implement community-wide a Crisis Stabilization protocol within each Regional Performance Unit (RPU). The Project Team will engage Community Based Organizations (CBO) and hospitals to provide these services under our Crisis Stabilization project, including phone triage for crisis de-escalation, mobile crisis intervention, respite services in the community, and observation services in inpatient settings (as opposed to inpatient psychiatric care). The 3aii Project Team has identified three pilot counties to focus our initial efforts: Tompkins, Cortland, and Broome. Through initial assessment these counties were identified for currently lacking one or more of the identified services and have an existing need for such a program in the community. The 3aii Project Team and CCN's Crisis Stabilization partners will develop a community-wide Crisis Stabilization protocol for each RPU or county to de-escalate crises and employ community-based services in order to divert clients from Emergency Departments and avoid inpatient admissions, as appropriate. CCN has established the governance structure for RPU level oversight of these protocols and monitoring of project performance (RPU Behavioral Health committees). CCN's Clinical Governance Committee will ultimately approve each community-wide Crisis Stabilization protocol. The 3aii Project Team and CCN have identified a potential IT solution which will enable project partners to track actively engaged patients, as well as access and share patient information among relevant clinical partners. The chosen IT solution will facilitate intervention services through the sharing of information in a timely way (including RHIO connectivity, alerts, and secure messaging) and allow for performance reporting. The vendor selection process is part of CCN's overall IT Systems and Processes roadmap. CCN expects the roadmap to be completed by DY1, Q3, including a timeline for the vendor selection process.
Ensure that all PPS safety net providers have actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.	The Care Compass Network (CCN) plan for project 3aii includes a total of 11 Milestones with associated steps for implementation, none of which were targeted for DY1, Q2 completion. Each of the Milestones and tasks are being reported as In Progress for DY1, Q2. CCN has made significant progress on the 3aii Crisis Stabilization project in Q2. The 3aii Project Team is finalizing an assessment of existing resources for each of CCN's nine service counties. With this information, the Project Team will build geographical networks of phone triage service providers, mobile crisis teams, housing providers, and hospitals to implement community-wide a Crisis Stabilization protocol within each Regional Performance Unit (RPU). The Project Team will engage Community Based Organizations (CBO) and hospitals to provide these services under our Crisis Stabilization project, including phone triage for crisis de-escalation, mobile crisis intervention, respite services in the community, and observation services in inpatient settings (as opposed to inpatient psychiatric care). The 3aii Project Team has identified three pilot counties to focus our initial efforts: Tompkins, Cortland, and Broome. Through initial assessment these counties were identified for currently lacking one or more of the identified services and have an existing need for such a program in the community. The 3aii Project Team and CCN's Crisis Stabilization partners will develop a community-wide Crisis Stabilization protocol for each RPU or county to de-escalate crises and employ community-based services in order to divert clients from Emergency Departments and avoid inpatient admissions, as appropriate. CCN has established the governance structure for RPU level oversight of these protocols and monitoring of project performance (RPU Behavioral Health committees). CCN's Clinical Governance Committee will ultimately approve each community-wide Crisis Stabilization protocol. The 3aii Project Team and CCN have identified a potential IT solution which will enable project partners to track actively engaged patients, as well as access and share patient information among relevant clinical partners. The chosen IT solution will facilitate intervention services through the sharing of information in a timely way (including RHIO connectivity, alerts, and secure messaging) and allow for performance reporting. The vendor selection process is part of CCN's overall IT Systems and Processes roadmap. CCN expects the roadmap to be completed by DY1, Q3, including a timeline for the vendor selection process.
Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.	The Care Compass Network (CCN) plan for project 3aii includes a total of 11 Milestones with associated steps for implementation, none of which were targeted for DY1, Q2 completion. Each of the Milestones and tasks are being reported as In Progress for DY1, Q2. CCN has made significant progress on the 3aii Crisis Stabilization project in Q2. The 3aii Project Team is finalizing an assessment of existing resources for each of CCN's nine service counties. With this information, the Project Team will build geographical networks of phone triage service providers, mobile crisis teams, housing providers, and hospitals to implement community-wide a Crisis Stabilization protocol within each Regional Performance Unit (RPU). The Project Team will engage Community Based Organizations (CBO) and hospitals to provide these services under our Crisis Stabilization project, including phone triage for crisis de-

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	escalation, mobile crisis intervention, respite services in the community, and observation services in inpatient settings (as opposed to inpatient psychiatric care). The 3aii Project Team has identified three pilot counties to focus our initial efforts: Tompkins, Cortland, and Broome. Through initial assessment these counties were identified for currently lacking one or more of the identified services and have an existing need for such a program in the community. The 3aii Project Team and CCN's Crisis Stabilization partners will develop a community-wide Crisis Stabilization protocol for each RPU or county to de-escalate crises and employ community-based services in order to divert clients from Emergency Departments and avoid inpatient admissions, as appropriate. CCN has established the governance structure for RPU level oversight of these protocols and monitoring of project performance (RPU Behavioral Health committees). CCN's Clinical Governance Committee will ultimately approve each community-wide Crisis Stabilization protocol. The 3aii Project Team and CCN have identified a potential IT solution which will enable project partners to track actively engaged patients, as well as access and share patient information among relevant clinical partners. The chosen IT solution will facilitate intervention services through the sharing of information in a timely way (including RHIO connectivity, alerts, and secure messaging) and allow for performance reporting. The vendor selection process is part of CCN's overall IT Systems and Processes roadmap. CCN expects the roadmap to be completed by DY1, Q3, including a timeline for the vendor selection process.
Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.	The Care Compass Network (CCN) plan for project 3aii includes a total of 11 Milestones with associated steps for implementation, none of which were targeted for DY1, Q2 completion. Each of the Milestones and tasks are being reported as In Progress for DY1, Q2. CCN has made significant progress on the 3aii Crisis Stabilization project in Q2. The 3aii Project Team is finalizing an assessment of existing resources for each of CCN's nine service counties. With this information, the Project Team will build geographical networks of phone triage service providers, mobile crisis teams, housing providers, and hospitals to implement community-wide a Crisis Stabilization protocol within each Regional Performance Unit (RPU). The Project Team will engage Community Based Organizations (CBO) and hospitals to provide these services under our Crisis Stabilization project, including phone triage for crisis de-escalation, mobile crisis intervention, respite services in the community, and observation services in inpatient settings (as opposed to inpatient psychiatric care). The 3aii Project Team has identified three pilot counties to focus our initial efforts: Tompkins, Cortland, and Broome. Through initial assessment these counties were identified for currently lacking one or more of the identified services and have an existing need for such a program in the community. The 3aii Project Team and CCN's Crisis Stabilization partners will develop a community-wide Crisis Stabilization protocol for each RPU or county to de-escalate crises and employ community-based services in order to divert clients from Emergency Departments and avoid inpatient admissions, as appropriate. CCN has established the governance structure for RPU level oversight of these protocols and monitoring of project performance (RPU Behavioral Health committees). CCN's Clinical Governance Committee will ultimately approve each community-wide Crisis Stabilization protocol. The 3aii Project Team and CCN have identified a potential IT solution which will enable project partners to track actively engaged patients, as well as access and share patient information among relevant clinical partners. The chosen IT solution will facilitate intervention services through the sharing of information in a timely way (including RHIO connectivity, alerts, and secure messaging) and allow for performance reporting. The vendor selection process is part of CCN's overall IT Systems and Processes roadmap. CCN expects the roadmap to be completed by DY1, Q3, including a timeline for the vendor selection process.
Use EHRs or other technical platforms to track all patients engaged in this project.	The Care Compass Network (CCN) plan for project 3aii includes a total of 11 Milestones with associated steps for implementation, none of which were targeted for DY1, Q2 completion. Each of the Milestones and tasks are being reported as In Progress for DY1, Q2. CCN has made significant progress on the 3aii Crisis Stabilization project in Q2. The 3aii Project Team is finalizing an assessment of existing resources for each of CCN's nine service counties. With this information, the Project Team will build geographical networks of phone triage service providers, mobile crisis teams, housing providers, and hospitals to implement community-wide a Crisis Stabilization protocol within each Regional Performance Unit (RPU). The Project Team will engage Community Based Organizations (CBO) and hospitals to provide these services under our Crisis Stabilization project, including phone triage for crisis de-escalation, mobile crisis intervention, respite services in the community, and observation services in inpatient settings (as opposed to inpatient psychiatric care). The 3aii Project Team has identified three pilot counties to focus our initial efforts: Tompkins, Cortland, and Broome. Through initial assessment these counties were identified for currently lacking one or more of the identified services and have an existing need for such a program in the community. The 3aii Project Team and CCN's Crisis Stabilization partners will develop a community-wide Crisis Stabilization protocol for each RPU or county to de-escalate crises and employ community-based services in order to divert clients from Emergency Departments and avoid inpatient admissions, as appropriate.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	CCN has established the governance structure for RPU level oversight of these protocols and monitoring of project performance (RPU Behavioral Health committees). CCN's Clinical Governance Committee will ultimately approve each community-wide Crisis Stabilization protocol. The 3aii Project Team and CCN have identified a potential IT solution which will enable project partners to track actively engaged patients, as well as access and share patient information among relevant clinical partners. The chosen IT solution will facilitate intervention services through the sharing of information in a timely way (including RHIO connectivity, alerts, and secure messaging) and allow for performance reporting. The vendor selection process is part of CCN's overall IT Systems and Processes roadmap. CCN expects the roadmap to be completed by DY1, Q3, including a timeline for the vendor selection process.

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	

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

1. Our first risk is the difficulty in the establishment of Electronic medical records (EMR) at all safety net provider settings. This will impact our project in that an integrated EMR infrastructure will improve the ability of providers to coordinate care across the continuum and ensure appropriate utilization of resources. A lack of this will hinder the interconnectivity of providers touching Medicaid beneficiaries. Our strategy to manage this risk is the PPS through project 2ai will assess the EMR status for each provider and identify the barriers for attaining EMRs. Funds have been budgeted to build the IT infrastructure, and onsite IT staff will need to be available to support implementation and training. Providers currently without EMRs could consider joining groups with EMRs already in place.
2. Our second identified risk is the inability of all Safety net providers to meet Meaningful Use and PCMH requirements by DY3. This will impact our project in that the burden on primary care providers to meet the requirements of MU, PCMH and the multiple requirements for project 3bi may have a negative impact on their ability to provide open access to patients in primary care, which is essential to managing chronic disease and avoiding unnecessary acute care visits. In order to mitigate this risk providers will need ongoing education on MU and PCMH requirements. Support through realignment of office staff duties and EMR functionality will need to be considered to fulfill all the requirements. Pre-visit planning, use of laptops in the waiting room and "top of license" roles and responsibilities have been concepts used by other systems to manage the increasing demands in the primary care setting. The PPS will develop a structure through project 2ai to support these transitions and monitor, troubleshoot barriers and provide feedback on attainment of MU and PCMH requirements.
3. Our third risk is the difficulty in obtaining provider buy-in to standard treatment protocols. This will impact our project in that the implementation of standard treatment protocols for cardiovascular disease management will provide beneficiaries and providers throughout the continuum with a consistent medical plan and thereby allow all to be active participants in meeting optimal clinical outcomes. Our mitigating strategy centers on the Clinical Governance Committee being established to identify the standard treatment protocols throughout the PPS. Once established provider education will be needed along with identification of ways to integrate these standards in EMRs to make it easy to comply. "Click count" and the ability to readily schedule follow-up visits should be considerations. Processes to make referrals user friendly for community supports along with the development of feedback loops from these referrals will be established.

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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**
DY4,Q4	4,137

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
0	0		0	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1b. Assess system readiness for population health providers, IT infrastructure, and CBOs through the PPS' Pre-Engagement Assessment to be disseminated by the CBO Engagement Council as well as each respective Regional Perfomance Unit (RPU) Operating Group.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1c. Data Analytics - The PPS Salient team will work in conjunction with the Population Health workgroup in order to identify patients with cardiovascular disease within our PPS region. The associated methodologies, assumptions, and results will be presented to the respective Disease Management subcommittees of the Clinical Governance Committee for review and identification of potential gaps in the analysis.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1d. Interventions - The PPS will adopt and/or develop evidence based strategies - such as the Million Hearts Campaign, JNC-8, AHA 2013, ACC - for implementation based on benficiary risk in conjunction with the 3bi Project Team and the Clinical Governance Committee. These interventions will be used in tandem with other industry standards such as blood pressure checks, lipids, smoking and other health assessment screenings at primary care provider visits to determine criteria for patient risk	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
stratification.									
Task 1e. Identify process to risk stratify beneficiaries with cardiovascular disease for intervention. An acuity score will be developed by the Project 3bi Team working with the Project Management Office. This acuity score will determine a level of risk and the subsequent health management interventions needed, i.e. preventive services, lifestyle coaching, transitional care, complex care management, and/or palliative care. The acuity score and subsequent interventions will be presented to the Disease Management subcommittee and Clinical Governance Committee for review, alterations, and approval. Reassessment of acuity score and interventions will occur annually at a minimum.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1f. Patient Supports - The Project Leaders and PMO representation from Projects 3bi and Project 2ci will work together to identify community-based organizations (e.g., Social Services) offering the necessary patient supports for medicaid beneficiaries with cardiovascular disease. The PPS Community Navigation Team will leverage the Community Health Advocates (CHAs) and defined care management protocols to further promote navigation of cardiovascular disease patients through the healthcare system.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1g. Metrics - The PPS will leverage population health data at the organizational/office level as well as the PPS level in order to review quality of the program and patient activation levels (e.g., through PAM survey results and trends). Blood pressure and smoking cessation will be the initial focus for year one, after which the efficacy will be reviewed to determine if either additional metrics should be isolated or if remediation efforts need to be addressed related to blood pressure and smoking cessation efforts. Identified gaps and alterations to plan will be identified, remediation or plan ammendments drafted by the project team, and presented to the Disease Management Quality Committee for oversight and approval.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1h. Each participating provider shall determine a Project 3bi	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Champion. This Champion will participate in Cardiovascular Disease Management-related training created by and provided by the Workforce team collaborating with the Project Management Office. The Project Chamption will then conduct training at their respective facility to the related support staff, including topics such as care coordination processes, blood pressure measurement, protocol regarding patients with repeated elevated blood pressure, patient self-management, follow-up procedures, home blood pressure monitoring, and Million Lives Campaign strategies. As required by partner contract agreements the champion will also be responsible for the provision of training date(s), attendees, and written materials (as well as Q/A items) to the PMO.									
Task 1i. IT Tools and Support - The Project 3bi Team will collaborate with the IT Workgroup to develop necessary IT Tools and support such as provider alerts and patient reminders as per defined care management goals within EHRs. These metrics will be created to align with 2014 PCMH Level 3 standards and/or Meaningful Use requirements.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 2e. Assess connectivity of PPS providers in all settings- to RHIO,	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
secure messaging capability, etc through the PPS' Pre-Engagement Assessment to be disseminated by the CBO Engagement Council as well as each respective Regional Perfomance Unit (RPU) Operating Group.									
Task 2f. Develop plan to connect all providers- begin with high volume / well engaged providers.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 2g. Develop outreach plans and a PPS consent for patients to participate in the exchange.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 2h. Develop standards for provider alerts in the EMR in conjunction with the Clinical Governance and IT & Data Governance Committees .	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 3c. Conduct a readiness assessment including MU and PCMH status of participating safety net providers.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 3d. Develop plan to support providers in the attainment of MU.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 3e. Develop plan to support providers in the attainment of PCMH level 3 - 2014 standards.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
4b. Develop a methodology and requirements to identify the data elements to collect on the population for reporting in order to establish a baseline in conjunction with the IT & Data Governance Committee as well as the Analytics Team.									
Task 4c. The Project Management Office will work with partners and/or alongside EHR vendors to acquire required validation of EHR connectivity and capabilities, including formal documentation/retention of certification related documents and EHR reminder functionality. The PPS IT Project Manager will review and monitor the IT environment to confirm EHR system capabilities are in place and used and functioning as designed, ensuring access to real-time data to improve interoperability. Periodic reviews will be performed and include evidence of alerts/secure messaging, availability of training materials, and status of prior review remediation status. The status of these reviews will be reported to the IT & Data Governance Committee and/or Clinical Governance Committee as appropriate.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4d. As required and appropriate, partners will be contracted with for achievement of specific tasks (e.g., build and maintenance of EMR modification to provide reminders), which will be monitored for completion as reported to the project team and PMO. Upon completion, validity of system enhancements will be reviewed and validated as described in step 4c.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate tobacco control protocols.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5c. Educate providers and office staff on the "5A's" - Ask, Assess, Advise, Assist, and Arrange.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5d. Develop 5As assessment tool in the EMRs including hard	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
stop prompts.									
Task 5e. Develop process for smoking cessation referrals through EMR secure messaging .	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5f. Develop process for provider feedback.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 6b. Obtain PPS approval for hypertension protocol from the Clinical Governance Committee - suggest existing guidance such as "JNC8".	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 6c. Obtain PPS approval for cholesterol protocol from the Clinical Governance Committee- suggest existing guidance such as "AHA 2013" guidelines.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 6d. Educate providers on these protocols .	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination processes are in place.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7d. The 3bi Project Team and PMO will develop care	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
coordination teams by achieving four core foundational requirements: assessing available resources, assessing the patient demographics, providing education where required, and adopting applicable standards.									
Task 7e. Assess Resources - The 3bi Project Team and PMO will work in tandem with the Population Health workgroup to assess availability of current care coordination and disease management resources in the PPS. Assess Patients - The 3bi Project Team, in conjunction with the PPS Analytics Team will develop a process to risk stratify beneficiaries for connection with care coordination based on the results of the Population Health data results and risk stratification review.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7f. Education - The Workforce team along with the Project Management Office will create Care Coordination teams within each office/practice and will include nurses, pharmacists, dieticians, community health workers, health home care managers, and others where applicable. Once established, the Workforce team will oversee the education to providers on these resources and create referral processes through the EMR to connect with providers of care coordination.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7g. Standards - Adopt/develop standards for cardiovascular disease management / care coordination in conjunction with the Clinical Governance Committee and, more specificly, disease management subcommittees.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	Project	N/A	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 8b. Assess availability of current practice for blood pressure checks with no copay or appointment required .	Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 8c. Develop PPS protocol for the provision of this service as a	Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
standard of care in conjunction with the Clinical Governance Committee.									
Task 8d. Identify the support needed for practices to offer this service and document in the EMRs.	Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
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	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 9b. Identify evidence based practice for blood pressure measurement in conjunction with the Clinical Governance Committee and, more specifically, the disease management subcommittees.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 9c. Create the competency for staff training and annual assessment.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 9d. Create PPS protocol to require all staff taking blood pressures take/pass an annual competency test.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
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	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.	Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.	Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.	Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 10d. Create risk stratification tool to identify beneficiaries in need of follow-up appointments for BP management.	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 10e. Develop alert in the EMR for beneficiaries with repeat elevated blood pressure readings.	Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 10f. Utilize "measure up, pressure down" for BP management (Million Hearts Campaign).	Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11b. Establish alert in the EMRs as reminders for once daily regimens.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11c. Engage pharmacists in recommending once daily regimens as substitutions for other regimens.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11d. Engage managed care payers in offering once daily regimens as formulary options.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Self-management goals are documented in the clinical record.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 12c. The education of staff on the development of self management goals with beneficiaries will be done by the collaborative efforts of the Project Management Office, the Provider Relations team, and the Communications Team. Forums will be held within each RPU for the participating providers.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 12d. The 3bi Project Team will collaborate with the PPS IT Committee and/or Clinical Governance Committee to develop	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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standards of data elements to identify partner EMR capability of reaching the required elements of the standard of care (e.g., documentation of benficiary self management goals.)									
Task 12e. Once approved, the 3bi Project Team and PMO will conduct a survey/assessment with partners to understand current system capabilities. As identified, system functionality deficiencies or gaps will be reported to the IT Committee and PPS partner 3bi Project Champion for identification of remediation solutions.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 12f. The IT Workgroup will identify EMR reporting requirements to document and verify utilization and implementation of standards of care within the EMR which are in place to document patient driven self-management goals in the medical record and review of said goals.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 12g. PPS Partner status reports will be reported to the PPS Disease Management Quality Committee for review and any necessary improvements to be pursued as appropriate.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	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	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task PPS has developed referral and follow-up process and adheres to process.	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task PPS provides periodic training to staff on warm referral and follow-up process.	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
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	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 13d. Identify resources to provide beneficiary support for lifestyle changes- CDSMP.	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 13e. Develop a 2 way referral process from the EMR: provider to CBO and CBO feedback to provider.	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3

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Task 13f. Train staff on the referral process including appropriate beneficiaries for referral.	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS has developed and implemented protocols for home blood pressure monitoring.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
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	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS provides periodic training to staff on warm referral and follow-up process.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 14d. Develop protocols for home BP monitoring based on risk (self monitor vs telehealth) in conjunction with the Clinical Governance Committee and, more specifically, the disease management subcommittees.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 14e. Identify resource for home BP cuffs if needed to support compliance .	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 14f. Develop method for beneficiary follow up reporting- phone, web program, telehealth, etc.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
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	03/31/2017	04/01/2015	03/31/2017	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	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 15b. Identify benficiaries through EMR functionality and/or claims data.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 15c. Develop process for scheduling patients for office visit.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 15d. Develop process for BP screening outside of office setting	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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in a community "hot spot".									
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed referral and follow-up process and adheres to process.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 16b. Develop process for referral to quitline preferably through EMR.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 16c. Develop process for provider feedback on referral.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 16d. Educate providers and office staff on referral process and beneficiary education.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	Project	N/A	In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
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	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task If applicable, PPS has established linkages to health homes for targeted patient populations.	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 17d. Identification of high risk neighborhoods and development of strategies to engage beneficiaries.	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 17e. Develop processes to link with patients through Medicaid health home relationships.	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 17f. Utilize CDSMP for beneficiary engagement in lifestyle changes .	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Milestone #18	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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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.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 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	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Mental Health	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 18d. Develop methods to risk stratify the population with CV or potential CV disease.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 18e. Create processes to screen BPs with beneficiary health care contact and in the community in conjunction with the Clinical Governance Committee and, more specifically, the disease management subcommittees.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 18f. Utilize "measure up, pressure down" planks as the standards for BP management by providers.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 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	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 19b. Define Population - As defined in the 3bi project plan the affected population includes cardiovascular patients. As such, the first step towards achievement of this milestone will involve the PMO and Population Health team performing a defined population review to understand the affected cardiovascular disease population in the PPS by associated MCO.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Task 19c. Risk Statify - Following the affected patient review, the population will be risk stratified to identify high risk versus rising risk cardiovascular populations.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 19d. Organize - Organize a PPS approach for care coordation efforts by the affeted population. For each, arrange an associated provider network comprised of primary care physicians and medical cardiologists who are willing to serve this high risk population. The provider network should isolate (as possible) a narrow high performance network of providers (e.g., low cost/high volume) based on available metrics.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 19e. Meet with MCOs to discuss the utilization of narrow high performing network for the definted affected population based on the PPS allocation of rising versus high risk populations. Note that this will need to be performed in for each Managed Care Organizations network.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS has engaged at least 80% of their PCPs in this activity.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 20b. Identify PCPs and evaluate their ability to meet the project requirements.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 20c. Educate providers on the projects and seek their input on implementation.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	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 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.										

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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 1b. Assess system readiness for population health providers, IT infrastructure, and CBOs through the PPS' Pre-Engagement Assessment to be disseminated by the CBO Engagement Council as well as each respective Regional Perfomance Unit (RPU) Operating Group.										
Task 1c. Data Analytics - The PPS Salient team will work in conjunction with the Population Health workgroup in order to identify patients with cardiovascular disease within our PPS region. The associated methodologies, assumptions, and results will be presented to the respective Disease Management subcommittees of the Clinical Governance Committee for review and identification of potential gaps in the analysis.										
Task 1d. Interventions - The PPS will adopt and/or develop evidence based strategies - such as the Million Hearts Campaign, JNC-8, AHA 2013, ACC - for implementation based on benficiary risk in conjunction with the 3bi Project Team and the Clinical Governance Committee. These interventions will be used in tandem with other industry standards such as blood pressure checks, lipids, smoking and other health assessment screenings at primary care provider visits to determine criteria for patient risk stratification.										
Task 1e. Identify process to risk stratify beneficiaries with cardiovascular disease for intervention. An acuity score will be developed by the Project 3bi Team working with the Project Management Office. This acuity score will determine a level of risk and the subsequent health management interventions needed, i.e. preventive services, lifestyle coaching, transitional care, complex care management, and/or palliative care. The acuity score and subsequent interventions will be presented to the Disease Management subcommittee and Clinical Governance Committee for review, alterations, and approval. Reassessment of acuity score and interventions will occur annually at a minimum.										
Task 1f. Patient Supports - The Project Leaders and PMO representation from Projects 3bi and Project 2ci will work together to identify community-based organizations (e.g., Social Services) offering the necessary patient supports for medicaid beneficiaries with cardiovascular disease. The PPS Community Navigation Team will leverage the Community Health Advocates (CHAs) and defined care management protocols to further promote navigation of cardiovascular disease patients through										

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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 healthcare system.										
Task 1g. Metrics - The PPS will leverage population health data at the organizational/office level as well as the PPS level in order to review quality of the program and patient activation levels (e.g., through PAM survey results and trends). Blood pressure and smoking cessation will be the initial focus for year one, after which the efficacy will be reviewed to determine if either additional metrics should be isolated or if remediation efforts need to be addressed related to blood pressure and smoking cessation efforts. Identified gaps and alterations to plan will be identified, remediation or plan ammendments drafted by the project team, and presented to the Disease Management Quality Committee for oversight and approval.										
Task 1h. Each participating provider shall determine a Project 3bi Champion. This Champion will participate in Cardiovascular Disease Management-related training created by and provided by the Workforce team collaborating with the Project Management Office. The Project Chamption will then conduct training at their respective facility to the related support staff, including topics such as care coordination processes, blood pressure measurement, protocol regarding patients with repeated elevated blood pressure, patient self-management, follow-up procedures, home blood pressure monitoring, and Million Lives Campaign strategies. As required by partner contract agreements the champion will also be responsible for the provision of training date(s), attendees, and written materials (as well as Q/A items) to the PMO.										
Task 1i. IT Tools and Support - The Project 3bi Team will collaborate with the IT Workgroup to develop necessary IT Tools and support such as provider alerts and patient reminders as per defined care management goals within EHRs. These metrics will be created to align with 2014 PCMH Level 3 standards and/or Meaningful Use requirements.										
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0

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Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR 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.										
Task 2e. Assess connectivity of PPS providers in all settings- to RHIO, secure messaging capability, etc through the PPS' Pre-Engagement Assessment to be disseminated by the CBO Engagement Council as well as each respective Regional Perfomance Unit (RPU) Operating Group.										
Task 2f. Develop plan to connect all providers- begin with high volume / well engaged providers.										
Task 2g. Develop outreach plans and a PPS consent for patients to participate in the exchange.										
Task 2h. Develop standards for provider alerts in the EMR in conjunction with the Clinical Governance and IT & Data Governance Committees .										
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	0	0	0	0	0	0	0	0	0
Task 3c. Conduct a readiness assessment including MU and PCMH status of participating safety net providers.										
Task 3d. Develop plan to support providers in the attainment of MU.										
Task 3e. Develop plan to support providers in the attainment of PCMH level 3 - 2014 standards.										
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.										

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Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 4b. Develop a methodology and requirements to identify the data elements to collect on the population for reporting in order to establish a baseline in conjunction with the IT & Data Governance Committee as well as the Analytics Team.										
Task 4c. The Project Management Office will work with partners and/or alongside EHR vendors to acquire required validation of EHR connectivity and capabilities, including formal documentation/retention of certification related documents and EHR reminder functionality. The PPS IT Project Manager will review and monitor the IT environment to confirm EHR system capabilities are in place and used and functioning as designed, ensuring access to real-time data to improve interoperability. Periodic reviews will be performed and include evidence of alerts/secure messaging, availability of training materials, and status of prior review remediation status. The status of these reviews will be reported to the IT & Data Governance Committee and/or Clinical Governance Committee as appropriate.										
Task 4d. As required and appropriate, partners will be contracted with for achievement of specific tasks (e.g., build and maintenance of EMR modification to provide reminders), which will be monitored for completion as reported to the project team and PMO. Upon completion, validity of system enhancements will be reviewed and validated as described in step 4c.										
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 5c. Educate providers and office staff on the "5A's" - Ask, Assess, Advise, Assist, and Arrange.										
Task 5d. Develop 5As assessment tool in the EMRs including hard stop prompts.										
Task 5e. Develop process for smoking cessation referrals through										

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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
EMR secure messaging .										
Task 5f. Develop process for provider feedback.										
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 6b. Obtain PPS approval for hypertension protocol from the Clinical Governance Committee - suggest existing guidance such as "JNC8".										
Task 6c. Obtain PPS approval for cholesterol protocol from the Clinical Governance Committee- suggest existing guidance such as "AHA 2013" guidelines.										
Task 6d. Educate providers on these protocols .										
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 7d. The 3bi Project Team and PMO will develop care coordination teams by achieving four core foundational requirements: assessing available resources, assessing the patient demographics, providing education where required, and adopting applicable standards.										
Task 7e. Assess Resources - The 3bi Project Team and PMO will work in tandem with the Population Health workgroup to assess availability of current care coordination and disease management resources in the PPS.										

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Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Assess Patients - The 3bi Project Team, in conjunction with the PPS Analytics Team will develop a process to risk stratify beneficiaries for connection with care coordination based on the results of the Population Health data results and risk stratification review.										
Task 7f. Education - The Workforce team along with the Project Management Office will create Care Coordination teams within each office/practice and will include nurses, pharmacists, dieticians, community health workers, health home care managers, and others where applicable. Once established, the Workforce team will oversee the education to providers on these resources and create referral processes through the EMR to connect with providers of care coordination.										
Task 7g. Standards - Adopt/develop standards for cardiovascular disease management / care coordination in conjunction with the Clinical Governance Committee and, more specificly, disease management subcommittees.										
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.										
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	0	0	0	0	0	0	0	0	0	241
Task 8b. Assess availability of current practice for blood pressure checks with no copay or appointment required .										
Task 8c. Develop PPS protocol for the provision of this service as a standard of care in conjunction with the Clinical Governance Committee.										
Task 8d. Identify the support needed for practices to offer this service and document in the EMRs.										
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 9b. Identify evidence based practice for blood pressure measurement in conjunction with the Clinical Governance Committee and, more specifically, the disease management										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
subcommittees.										
Task 9c. Create the competency for staff training and annual assessment.										
Task 9d. Create PPS protocol to require all staff taking blood pressures take/pass an annual competency test.										
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 10d. Create risk stratification tool to identify beneficiaries in need of follow-up appointments for BP management.										
Task 10e. Develop alert in the EMR for beneficiaries with repeat elevated blood pressure readings.										
Task 10f. Utilize "measure up, pressure down" for BP management (Million Hearts Campaign).										
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 11b. Establish alert in the EMRs as reminders for once daily regimens.										
Task 11c. Engage pharmacists in recommending once daily regimens as substitutions for other regimens.										
Task 11d. Engage managed care payers in offering once daily										

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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 12c. The education of staff on the development of self management goals with beneficiaries will be done by the collaborative efforts of the Project Management Office, the Provider Relations team, and the Communications Team. Forums will be held within each RPU for the participating providers.										
Task 12d. The 3bi Project Team will collaborate with the PPS IT Committee and/or Clinical Governance Committee to develop standards of data elements to identify partner EMR capability of reaching the required elements of the standard of care (e.g., documentation of benficiary self management goals.)										
Task 12e. Once approved, the 3bi Project Team and PMO will conduct a survey/assessment with partners to understand current system capabilities. As identified, system functionality deficiencies or gaps will be reported to the IT Committee and PPS partner 3bi Project Champion for identification of remediation solutions.										
Task 12f. The IT Workgroup will identify EMR reporting requirements to document and verify utilization and implementation of standards of care within the EMR which are in place to document patient driven self-management goals in the medical record and review of said goals.										
Task 12g. PPS Partner status reports will be reported to the PPS Disease Management Quality Committee for review and any necessary improvements to be pursued as appropriate.										
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.										

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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 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 13d. Identify resources to provide beneficiary support for lifestyle changes- CDSMP.										
Task 13e. Develop a 2 way referral process from the EMR: provider to CBO and CBO feedback to provider.										
Task 13f. Train staff on the referral process including appropriate beneficiaries for referral.										
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 14d. Develop protocols for home BP monitoring based on risk (self monitor vs telehealth) in conjunction with the Clinical Governance Committee and, more specifically, the disease management subcommittees.										
Task 14e. Identify resource for home BP cuffs if needed to support compliance .										
Task 14f. Develop method for beneficiary follow up reporting- phone, web program, telehealth, etc.										
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.										

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Task 15b. Identify benficiaries through EMR functionality and/or claims data.										
Task 15c. Develop process for scheduling patients for office visit.										
Task 15d. Develop process for BP screening outside of office setting in a community "hot spot".										
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task 16b. Develop process for referral to quitline preferably through EMR.										
Task 16c. Develop process for provider feedback on referral.										
Task 16d. Educate providers and office staff on referral process and beneficiary education.										
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 17d. Identification of high risk neighborhoods and development of strategies to engage beneficiaries.										
Task 17e. Develop processes to link with patients through Medicaid health home relationships.										
Task 17f. Utilize CDSMP for beneficiary engagement in lifestyle changes .										

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Milestone #18 Adopt strategies from the Million Hearts Campaign.										
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	0	0	0	241	241	241	241	241	241
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	0	0	0	28	28	28	28	28	28
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	0	0	0	0	0	0	0	0	0
Task 18d. Develop methods to risk stratify the population with CV or potential CV disease.										
Task 18e. Create processes to screen BPs with beneficiary health care contact and in the community in conjunction with the Clinical Governance Committee and, more specifically, the disease management subcommittees.										
Task 18f. Utilize "measure up, pressure down" planks as the standards for BP management by providers.										
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 19b. Define Population - As defined in the 3bi project plan the affected population includes cardiovascular patients. As such, the first step towards achievement of this milestone will involve the PMO and Population Health team performing a defined population review to understand the affected cardiovascular disease population in the PPS by associated MCO.										
Task 19c. Risk Statify - Following the affected patient review, the population will be risk stratified to identify high risk versus rising risk cardiovascular populations.										

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Task 19d. Organize - Organize a PPS approach for care coordation efforts by the affeted population. For each, arrange an associated provider network comprised of primary care physicians and medical cardiologists who are willing to serve this high risk population. The provider network should isolate (as possible) a narrow high performance network of providers (e.g., low cost/high volume) based on available metrics.										
Task 19e. Meet with MCOs to discuss the utilization of narrow high performing network for the definted affected population based on the PPS allocation of rising versus high risk populations. Note that this will need to be performed in for each Managed Care Organizations network.										
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.										
Task PPS has engaged at least 80% of their PCPs in this activity.	0	0	0	0	0	0	241	241	241	241
Task 20b. Identify PCPs and evaluate their ability to meet the project requirements.										
Task 20c. Educate providers on the projects and seek their input on implementation.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task 1b. Assess system readiness for population health providers, IT infrastructure, and CBOs through the PPS' Pre-Engagement Assessment to be disseminated by the CBO Engagement Council as well as each respective Regional Perfomance Unit (RPU) Operating Group.										
Task 1c. Data Analytics - The PPS Salient team will work in conjunction with the Population Health workgroup in order to										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
identify patients with cardiovascular disease within our PPS region. The associated methodologies, assumptions, and results will be presented to the respective Disease Management subcommittees of the Clinical Governance Committee for review and identification of potential gaps in the analysis.										
Task 1d. Interventions - The PPS will adopt and/or develop evidence based strategies - such as the Million Hearts Campaign, JNC-8, AHA 2013, ACC - for implementation based on benficiary risk in conjunction with the 3bi Project Team and the Clinical Governance Committee. These interventions will be used in tandem with other industry standards such as blood pressure checks, lipids, smoking and other health assessment screenings at primary care provider visits to determine criteria for patient risk stratification.										
Task 1e. Identify process to risk stratify beneficiaries with cardiovascular disease for intervention. An acuity score will be developed by the Project 3bi Team working with the Project Management Office. This acuity score will determine a level of risk and the subsequent health management interventions needed, i.e. preventive services, lifestyle coaching, transitional care, complex care management, and/or palliative care. The acuity score and subsequent interventions will be presented to the Disease Management subcommittee and Clinical Governance Committee for review, alterations, and approval. Reassessment of acuity score and interventions will occur annually at a minimum.										
Task 1f. Patient Supports - The Project Leaders and PMO representation from Projects 3bi and Project 2ci will work together to identify community-based organizations (e.g., Social Services) offering the necessary patient supports for medicaid beneficiaries with cardiovascular disease. The PPS Community Navigation Team will leverage the Community Health Advocates (CHAs) and defined care management protocols to further promote navigation of cardiovascular disease patients through the healthcare system.										
Task 1g. Metrics - The PPS will leverage population health data at the organizational/office level as well as the PPS level in order to review quality of the program and patient activation levels (e.g., through PAM survey results and trends). Blood pressure and smoking cessation will be the initial focus for year one, after which the efficacy will be reviewed to determine if either additional metrics should be isolated or if remediation efforts										

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need to be addressed related to blood pressure and smoking cessation efforts. Identified gaps and alterations to plan will be identified, remediation or plan ammendments drafted by the project team, and presented to the Disease Management Quality Committee for oversight and approval.										
Task 1h. Each participating provider shall determine a Project 3bi Champion. This Champion will participate in Cardiovascular Disease Management-related training created by and provided by the Workforce team collaborating with the Project Management Office. The Project Chamption will then conduct training at their respective facility to the related support staff, including topics such as care coordination processes, blood pressure measurement, protocol regarding patients with repeated elevated blood pressure, patient self-management, follow-up procedures, home blood pressure monitoring, and Million Lives Campaign strategies. As required by partner contract agreements the champion will also be responsible for the provision of training date(s), attendees, and written materials (as well as Q/A items) to the PMO.										
Task 1i. IT Tools and Support - The Project 3bi Team will collaborate with the IT Workgroup to develop necessary IT Tools and support such as provider alerts and patient reminders as per defined care management goals within EHRs. These metrics will be created to align with 2014 PCMH Level 3 standards and/or Meaningful Use requirements.										
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	136	136	136	136	136	136	136	136	136
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	8	8	8	8	8	8	8	8	8
Task EHR 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.										
Task 2e. Assess connectivity of PPS providers in all settings- to RHIO,										

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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
secure messaging capability, etc through the PPS' Pre-Engagement Assessment to be disseminated by the CBO Engagement Council as well as each respective Regional Perfomance Unit (RPU) Operating Group.										
Task 2f. Develop plan to connect all providers- begin with high volume / well engaged providers.										
Task 2g. Develop outreach plans and a PPS consent for patients to participate in the exchange.										
Task 2h. Develop standards for provider alerts in the EMR in conjunction with the Clinical Governance and IT & Data Governance Committees .										
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	241	241	241	241	241	241	241	241	241
Task 3c. Conduct a readiness assessment including MU and PCMH status of participating safety net providers.										
Task 3d. Develop plan to support providers in the attainment of MU.										
Task 3e. Develop plan to support providers in the attainment of PCMH level 3 - 2014 standards.										
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 4b. Develop a methodology and requirements to identify the data elements to collect on the population for reporting in order to establish a baseline in conjunction with the IT & Data Governance Committee as well as the Analytics Team.										
Task 4c. The Project Management Office will work with partners and/or										

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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
alongside EHR vendors to acquire required validation of EHR connectivity and capabilities, including formal documentation/retention of certification related documents and EHR reminder functionality. The PPS IT Project Manager will review and monitor the IT environment to confirm EHR system capabilities are in place and used and functioning as designed, ensuring access to real-time data to improve interoperability. Periodic reviews will be performed and include evidence of alerts/secure messaging, availability of training materials, and status of prior review remediation status. The status of these reviews will be reported to the IT & Data Governance Committee and/or Clinical Governance Committee as appropriate.										
Task 4d. As required and appropriate, partners will be contracted with for achievement of specific tasks (e.g., build and maintenance of EMR modification to provide reminders), which will be monitored for completion as reported to the project team and PMO. Upon completion, validity of system enhancements will be reviewed and validated as described in step 4c.										
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 5c. Educate providers and office staff on the "5A's" - Ask, Assess, Advise, Assist, and Arrange.										
Task 5d. Develop 5As assessment tool in the EMRs including hard stop prompts.										
Task 5e. Develop process for smoking cessation referrals through EMR secure messaging .										
Task 5f. Develop process for provider feedback.										
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).										

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Task 6b. Obtain PPS approval for hypertension protocol from the Clinical Governance Committee - suggest existing guidance such as "JNC8".										
Task 6c. Obtain PPS approval for cholesterol protocol from the Clinical Governance Committee- suggest existing guidance such as "AHA 2013" guidelines.										
Task 6d. Educate providers on these protocols .										
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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 7d. The 3bi Project Team and PMO will develop care coordination teams by achieving four core foundational requirements: assessing available resources, assessing the patient demographics, providing education where required, and adopting applicable standards.										
Task 7e. Assess Resources - The 3bi Project Team and PMO will work in tandem with the Population Health workgroup to assess availability of current care coordination and disease management resources in the PPS. Assess Patients - The 3bi Project Team, in conjunction with the PPS Analytics Team will develop a process to risk stratify beneficiaries for connection with care coordination based on the results of the Population Health data results and risk stratification review.										
Task 7f. Education - The Workforce team along with the Project Management Office will create Care Coordination teams within each office/practice and will include nurses, pharmacists, dieticians, community health workers, health home care managers, and others where applicable. Once established, the										

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Workforce team will oversee the education to providers on these resources and create referral processes through the EMR to connect with providers of care coordination.										
Task 7g. Standards - Adopt/develop standards for cardiovascular disease management / care coordination in conjunction with the Clinical Governance Committee and, more specificly, disease management subcommittees.										
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.	241	241	241	241	241	241	241	241	241	241
Task 8b. Assess availability of current practice for blood pressure checks with no copay or appointment required .										
Task 8c. Develop PPS protocol for the provision of this service as a standard of care in conjunction with the Clinical Governance Committee.										
Task 8d. Identify the support needed for practices to offer this service and document in the EMRs.										
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.										
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Task 9c. Create the competency for staff training and annual assessment.										
Task 9d. Create PPS protocol to require all staff taking blood pressures take/pass an annual competency test.										
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.										

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Task 10f. Utilize "measure up, pressure down" for BP management (Million Hearts Campaign).										
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.										
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Task 11b. Establish alert in the EMRs as reminders for once daily regimens.										
Task 11c. Engage pharmacists in recommending once daily regimens as substitutions for other regimens.										
Task 11d. Engage managed care payers in offering once daily regimens as formulary options.										
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Task Self-management goals are documented in the clinical record.										
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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
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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 13d. Identify resources to provide beneficiary support for lifestyle changes- CDSMP.										
Task 13e. Develop a 2 way referral process from the EMR: provider to CBO and CBO feedback to provider.										

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project 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 13f. Train staff on the referral process including appropriate beneficiaries for referral.										
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 14d. Develop protocols for home BP monitoring based on risk (self monitor vs telehealth) in conjunction with the Clinical Governance Committee and, more specifically, the disease management subcommittees.										
Task 14e. Identify resource for home BP cuffs if needed to support compliance .										
Task 14f. Develop method for beneficiary follow up reporting- phone, web program, telehealth, etc.										
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 15b. Identify benficiaries through EMR functionality and/or claims data.										
Task 15c. Develop process for scheduling patients for office visit.										
Task 15d. Develop process for BP screening outside of office setting in a community "hot spot".										
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.										
Task PPS has developed referral and follow-up process and adheres to process.										

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project 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 16b. Develop process for referral to quitline preferably through EMR.										
Task 16c. Develop process for provider feedback on referral.										
Task 16d. Educate providers and office staff on referral process and beneficiary education.										
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 17d. Identification of high risk neighborhoods and development of strategies to engage beneficiaries.										
Task 17e. Develop processes to link with patients through Medicaid health home relationships.										
Task 17f. Utilize CDSMP for beneficiary engagement in lifestyle changes .										
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.	241	241	241	241	241	241	241	241	241	241
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	28	28	28	28	28	28	28	28	28	28
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million	0	0	0	0	0	0	0	0	0	0

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Hearts Campaign.										
Task 18d. Develop methods to risk stratify the population with CV or potential CV disease.										
Task 18e. Create processes to screen BPs with beneficiary health care contact and in the community in conjunction with the Clinical Governance Committee and, more specifically, the disease management subcommittees.										
Task 18f. Utilize "measure up, pressure down" planks as the standards for BP management by providers.										
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 19b. Define Population - As defined in the 3bi project plan the affected population includes cardiovascular patients. As such, the first step towards achievement of this milestone will involve the PMO and Population Health team performing a defined population review to understand the affected cardiovascular disease population in the PPS by associated MCO.										
Task 19c. Risk Statify - Following the affected patient review, the population will be risk stratified to identify high risk versus rising risk cardiovascular populations.										
Task 19d. Organize - Organize a PPS approach for care coordation efforts by the affeted population. For each, arrange an associated provider network comprised of primary care physicians and medical cardiologists who are willing to serve this high risk population. The provider network should isolate (as possible) a narrow high performance network of providers (e.g., low cost/high volume) based on available metrics.										
Task 19e. Meet with MCOs to discuss the utilization of narrow high performing network for the definted affected population based on the PPS allocation of rising versus high risk populations. Note that this will need to be performed in for each Managed Care										

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Organizations network.										
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.	241	241	241	241	241	241	241	241	241	241
Task 20b. Identify PCPs and evaluate their ability to meet the project requirements.										
Task 20c. Educate providers on the projects and seek their input on implementation.										

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.	There are 20 milestones for project 3bi with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 3bi and 4bii. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.
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.	There are 20 milestones for project 3bi with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 3bi and 4bii. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.

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Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	There are 20 milestones for project 3bi with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 3bi and 4bii. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.
Use EHRs or other technical platforms to track all patients engaged in this project.	There are 20 milestones for project 3bi with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 3bi and 4bii. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.
Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	There are 20 milestones for project 3bi with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 3bi and 4bii. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.
Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	There are 20 milestones for project 3bi with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 3bi and 4bii. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.
Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address	There are 20 milestones for project 3bi with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the

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

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Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 3bi and 4bii. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.
Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	There are 20 milestones for project 3bi with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 3bi and 4bii. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.
Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	There are 20 milestones for project 3bi with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 3bi and 4bii. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.
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.	There are 20 milestones for project 3bi with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 3bi and 4bii. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.
Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	There are 20 milestones for project 3bi with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 3bi and 4bii. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.
Document patient driven self-management goals in the medical record and review with patients at each visit.	There are 20 milestones for project 3bi with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 3bi and 4bii. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.
Follow up with referrals to community based programs to document participation and behavioral and health status changes.	There are 20 milestones for project 3bi with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 3bi and 4bii. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.
Develop and implement protocols for home blood pressure monitoring with follow up support.	There are 20 milestones for project 3bi with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 3bi and 4bii. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.
Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	There are 20 milestones for project 3bi with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 3bi and 4bii. During Q2 a Population Health model for 3bi

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.
Facilitate referrals to NYS Smoker's Quitline.	There are 20 milestones for project 3bi with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 3bi and 4bii. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.
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.	There are 20 milestones for project 3bi with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 3bi and 4bii. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.
Adopt strategies from the Million Hearts Campaign.	There are 20 milestones for project 3bi with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 3bi and 4bii. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.
Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	There are 20 milestones for project 3bi with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 3bi and 4bii. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN

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Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	partners.
Engage a majority (at least 80%) of primary care providers in this project.	There are 20 milestones for project 3bi with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 3bi and 4bii. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.

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	

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Care Compass Network (PPS ID:44)

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
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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Care Compass Network (PPS ID:44)

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

Instructions :

Care Compass Network (PPS ID:44)

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.

The first risk within Project 3.g.i centers on the training of physicians, nurses, and other staff within PCMH sites and on referrals. Insufficient training runs the risk of impacting our project by potentially resulting in fewer referrals to palliative care, along with in appropriate referrals. These could be potentially inappropriate by referring people who do not truly need palliative care and not referring those who do. A strategy to mitigate this risk is to provide intensive initial training followed by subsequent retraining throughout the five year DSRIP period.
A second risk for our project is an inability to follow through on referrals to Medicaid beneficiaries due to their lack of engagement. Whether they are unwilling to or unable to make appointments, we run the risk of not providing palliative care. This will impact our project by not allowing palliative care providers to provide the appropriate services. A strategy to mitigate this risk is through the inclusion of palliative care into the PAM survey. This would allow for the activation of patients and their awareness of available palliative care. Furthermore, the development of processes that ensure both appropriate referrals from PCMH sites and the follow through on said referrals would mitigate this risk. The need for knowledge of and inclusion of transportation services is a must to ensure Medicaid beneficiaries' participation.
A third risk to our project is inconsistent and non-uniform functionality of clinical and non-clinical staff within palliative care providers across the PPS. The lack of consistent training results in deficiencies and gaps between providers and thus their patients. Inconsistent results and incoherent data are the two main impacts this would have on our project. A mitigating strategy would be the standardization of specific protocols on a prescribed basis for all participating sites. This is possible with the aid of Clinical Governance Committee and the general strategy PPS-wide to standardize clinical protocols to ensure quality of care. There would need to be initial training and subsequent training on a regular basis throughout the DSRIP period.
The fourth and final risk to our project is the uptake of eMOLST technology. Both the training and technology components could impact our project. This impact would be felt in the potential risk of insufficient funding for the technology and, moreover, the lack of appropriate extant technology within our sites, limiting the implementation of eMOLST. The impact this would have on our project is the lower amounts of advance directives for patients, which would generate more admissions to emergency departments and ICUs. Functionality would be drastically impacted resulting in more admissions and higher cost services being utilized. To mitigate this risk, there would need to be an inclusion of eMOLST within the larger, PPS-wide IT implementation plan. This would need to be coordinated and systematized by the PPS IT team.

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Care Compass Network (PPS ID:44)

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	1,950

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
0	0	0.00%	30	0.00%

Warning: Please note that your patients engaged to date does not meet your committed amount (30)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its actively engaged commitments for DY1, Q2.

New York State Department Of Health
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Care Compass Network (PPS ID:44)

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	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 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	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1b. Develop Pre-Engagement Assessment and disperse among potential partners within PPS.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 1c. Analyze data from Pre-Engagement Assessment to ascertain what Primary Care Providers (PCPs) are currently PCMH certified and those who are in the process of obtaining certification.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 1d. Develop agreements with PCPs committing to integrate palliative care into their practice model.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
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	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2b. Develop Pre-Engagement Assessment and disperse among	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2

Care Compass Network (PPS ID:44)

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
potential partners within PPS.									
Task 2c. Analyze data from Pre-Engagement Assessment to ascertain what hospice providers already exist within the PPS.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2d. Include available hospice providers in community resources developed by Project 2.c.i.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form. PPS has trained staff addressing role-appropriate competence in palliative care skills.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3b. The 3gi Project Team is compromised of key palliative care and hospicare entities from throughout the Care Compass Network nine county community. The Project 3gi Team will convene to determine clinical guidelines which serve as palliative care triggers, using existing standards where applicable. Special consideration will be given to the guidelines, services, and implementation of the MOLST (Medical Orders for Life Sustaining Treatment) and electronic based "e-MOLST" forms, as well as CAPC (Center for the Advancement of Palliative Care) guidance. Once the comprehensive project plan and requirements has been drafted by the Project 3gi Team they will be presented to the PPS Clinical Governance Committee for review. The Clinical Governance Committee is comprised of PPS regional as well as specialty representation. The Clinical Governance Committee will review, revise (where necessary), and endorse the project 3gi clinical guidelines. Lastly, the Clinical Governance Committee will present the PPS Board of Directors with the proposed project 3gi clinical standards and related guidance's for formal review and approval.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3c. The CCN Provider Relations team along with the Project	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Management Office and Project 3gi Team will develop provider education/training forums where the clinical guidelines will be discussed. Clarity, transparency, and accountability to the clinical guidelines (among other topics) will be discussed as agreement from all partners is met. Re-assessment of clinical guidelines will formally occur annually by the Clinical Governance Committee, or more frequently as identified by the project team and/or regional PPS 3gi quality committees (e.g., Disease Management).									
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 4b. Train PCP staff to identify established "clinical triggers" in patients and how to refer these to appropriate PCMH.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4c. Develop PPS care protocols in conjunction with the Clinical Governance Committee.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4d. Train PCMH staff on PPS care protocols.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.	Project	N/A	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5b. Identify MCOs within the Care Compass Network nine county region.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5c. Initiate discussions with MCOs, legal counsel, compliance, and/or the Department of Health (as required) to identify approaches and solutions relative to palliative care supports and offerings provided by MCOs as aligned with DSRIP goals.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5d. Engage with MCOs to understand, for palliative care services	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 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
not currently covered, how to build associated rates into existing programs.									
Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 6b. Partner the 3gi Project Team with IT consultants and the PPS IT Project Manager in order to develop appropriate platforms for tracking 3gi patients in conjunction with the IT & Data Governance Committee and overall infrastructure/IT Vision developed by the PPS.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6c. Identify feasible, complete, and appropriate use of e-MOLST system to satisfactorily meet core IT requirements, including the need to monitor partner performance and track actively engaged patients.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6d. Implement eMOLST, or other supporting applications as needed, where appropriate.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.										
Task PPS has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH and/or APCM have been included. The PPS has received agreement from those PCPs not PCMH and/or APCM certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3.	0	0	0	86	86	86	86	86	86	86
Task 1b. Develop Pre-Engagement Assessment and disperse among potential partners within PPS.										
Task 1c. Analyze data from Pre-Engagement Assessment to ascertain										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
what Primary Care Providers (PCPs) are currently PCMH certified and those who are in the process of obtaining certification.										
Task 1d. Develop agreements with PCPs committing to integrate palliative care into their practice model.										
Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.										
Task The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice.										
Task 2b. Develop Pre-Engagement Assessment and disperse among potential partners within PPS.										
Task 2c. Analyze data from Pre-Engagement Assessment to ascertain what hospice providers already exist within the PPS.										
Task 2d. Include available hospice providers in community resources developed by Project 2.c.i.										
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 3b. The 3gi Project Team is compromised of key palliative care and hospicare entities from throughout the Care Compass Network nine county community. The Project 3gi Team will convene to determine clinical guidelines which serve as palliative care triggers, using existing standards where applicable. Special consideration will be given to the guidelines, services, and implementation of the MOLST (Medical Orders for Life Sustaining Treatment) and electronic based "e-MOLST" forms, as well as CAPC (Center for the Advancement of Palliative Care) guidance. Once the comprehensive project plan and requirements has been drafted by the Project 3gi Team they will be presented to the PPS Clinical Governance Committee for										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
review. The Clinical Governance Committee is comprised of PPS regional as well as specialty representation. The Clinical Governance Committee will review, revise (where necessary), and endorse the project 3gi clinical guidelines. Lastly, the Clinical Governance Committee will present the PPS Board of Directors with the proposed project 3gi clinical standards and related guidance's for formal review and approval.										
Task 3c. The CCN Provider Relations team along with the Project Management Office and Project 3gi Team will develop provider education/training forums where the clinical guidelines will be discussed. Clarity, transparency, and accountability to the clinical guidelines (among other topics) will be discussed as agreement from all partners is met. Re-assessment of clinical guidelines will formally occur annually by the Clinical Governance Committee, or more frequently as identified by the project team and/or regional PPS 3gi quality committees (e.g., Disease Management).										
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 4b. Train PCP staff to identify established "clinical triggers" in patients and how to refer these to appropriate PCMH.										
Task 4c. Develop PPS care protocols in conjunction with the Clinical Governance Committee.										
Task 4d. Train PCMH staff on PPS care protocols.										
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 5b. Identify MCOs within the Care Compass Network nine county region.										
Task 5c. Initiate discussions with MCOs, legal counsel, compliance, and/or the Department of Health (as required) to identify approaches and solutions relative to palliative care supports 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
offerings provided by MCOs as aligned with DSRIP goals.										
Task 5d. Engage with MCOs to understand, for palliative care services not currently covered, how to build associated rates into existing programs.										
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 6b. Partner the 3gi Project Team with IT consultants and the PPS IT Project Manager in order to develop appropriate platforms for tracking 3gi patients in conjunction with the IT & Data Governance Committee and overall infrastructure/IT Vision developed by the PPS.										
Task 6c. Identify feasible, complete, and appropriate use of e-MOLST system to satisfactorily meet core IT requirements, including the need to monitor partner performance and track actively engaged patients.										
Task 6d. Implement eMOLST, or other supporting applications as needed, where appropriate.										

Project 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.	86	86	86	86	86	86	86	86	86	86
Task 1b. Develop Pre-Engagement Assessment and disperse among potential partners within PPS.										
Task 1c. Analyze data from Pre-Engagement Assessment to ascertain										

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
what Primary Care Providers (PCPs) are currently PCMH certified and those who are in the process of obtaining certification.										
Task 1d. Develop agreements with PCPs committing to integrate palliative care into their practice model.										
Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.										
Task The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice.										
Task 2b. Develop Pre-Engagement Assessment and disperse among potential partners within PPS.										
Task 2c. Analyze data from Pre-Engagement Assessment to ascertain what hospice providers already exist within the PPS.										
Task 2d. Include available hospice providers in community resources developed by Project 2.c.i.										
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 3b. The 3gi Project Team is compromised of key palliative care and hospicare entities from throughout the Care Compass Network nine county community. The Project 3gi Team will convene to determine clinical guidelines which serve as palliative care triggers, using existing standards where applicable. Special consideration will be given to the guidelines, services, and implementation of the MOLST (Medical Orders for Life Sustaining Treatment) and electronic based "e-MOLST" forms, as well as CAPC (Center for the Advancement of Palliative Care) guidance. Once the comprehensive project plan and requirements has been drafted by the Project 3gi Team they will be presented to the PPS Clinical Governance Committee for										

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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
review. The Clinical Governance Committee is comprised of PPS regional as well as specialty representation. The Clinical Governance Committee will review, revise (where necessary), and endorse the project 3gi clinical guidelines. Lastly, the Clinical Governance Committee will present the PPS Board of Directors with the proposed project 3gi clinical standards and related guidance's for formal review and approval.										
Task 3c. The CCN Provider Relations team along with the Project Management Office and Project 3gi Team will develop provider education/training forums where the clinical guidelines will be discussed. Clarity, transparency, and accountability to the clinical guidelines (among other topics) will be discussed as agreement from all partners is met. Re-assessment of clinical guidelines will formally occur annually by the Clinical Governance Committee, or more frequently as identified by the project team and/or regional PPS 3gi quality committees (e.g., Disease Management).										
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 4b. Train PCP staff to identify established "clinical triggers" in patients and how to refer these to appropriate PCMH.										
Task 4c. Develop PPS care protocols in conjunction with the Clinical Governance Committee.										
Task 4d. Train PCMH staff on PPS care protocols.										
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 5b. Identify MCOs within the Care Compass Network nine county region.										
Task 5c. Initiate discussions with MCOs, legal counsel, compliance, and/or the Department of Health (as required) to identify approaches and solutions relative to palliative care supports 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
offerings provided by MCOs as aligned with DSRIP goals.										
Task 5d. Engage with MCOs to understand, for palliative care services not currently covered, how to build associated rates into existing programs.										
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 6b. Partner the 3gi Project Team with IT consultants and the PPS IT Project Manager in order to develop appropriate platforms for tracking 3gi patients in conjunction with the IT & Data Governance Committee and overall infrastructure/IT Vision developed by the PPS.										
Task 6c. Identify feasible, complete, and appropriate use of e-MOLST system to satisfactorily meet core IT requirements, including the need to monitor partner performance and track actively engaged patients.										
Task 6d. Implement eMOLST, or other supporting applications as needed, where appropriate.										

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.	Complete – In the 3gi Milestone 1 project plan there are four steps to implementation, two of which are due and being reported as complete in the DY1, Q2 report. In June 2015, Care Compass Network (CCN) developed its Pre-Engagement Assessment through its Community-Based Organization Engagement Council. It was distributed to the PPS Stakeholders at the bi-monthly Stakeholders meeting on both 6/12/15 and again on 6/26/15 (Step 1b). Therein, CCN sought to understand the level of readiness, predominant county served, IT development, and number of paid staff, among other inquiries. The goal of this assessment was to acquire a map of the services providers throughout the PPS and determine where gaps needed to be filled, who to contract with, and what projects providers would fit into. This information also served to allocate partners to their respective Regional Performing Unit (RPU) based on the geographic region their organization served, leading to the development of RPU Operations and PAC meetings. Regional needs have been identified and addressed

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	within each Regional Performing Unit's meetings. By the end of September 2015, the Pre-Engagement Assessment had been completed by 92 organizations, including information regarding PCMH status. The results of the survey were subsequently made available to and analyzed by the CBO Engagement Council and RPU Leads (Step 1c). Per the Assessment, there were no organizations that self-indicated as being in the process of obtaining PCMH certification. The PPS remains on track for completion of the remaining steps to implementation by the associated due dates.
Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	In Progress - In the 3gi Milestone 2 project plan there are four steps to implementation, one of which is due in DY1, Q2, however two are being reported as complete. In June 2015, Care Compass Network (CCN) developed its Pre-Engagement Assessment through its Community-Based Organization Engagement Council. The survey was distributed to the PPS Stakeholders at the bi-monthly Stakeholders meeting on both 6/12/15 and again on 6/26/15 (Step 2b). Therein, CCN sought to understand the level of readiness, predominant county served, IT development, and number of paid staff, among other inquiries. The goal of this assessment was to acquire a map of the services providers throughout the PPS and determine where gaps needed to be filled, who to contract with, and what projects providers would fit into. This information also served to allocate partners to their respective Regional Performing Unit (RPU) based on the geographic region their organization served, leading to the development of RPU Operations and PAC meetings. Through review of initial survey and analysis we noted 12 organizations self-indicating that they provide hospice services (Step 2c). This analysis took place on 9/1/15 and was reviewed by the 3gi project leads on 9/11/15. Supplemented by relational knowledge within the PPS, 4 specific hospices were identified within the responses.
Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	
Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	
Engage with Medicaid Managed Care to address coverage of services.	
Use EHRs or other IT platforms to track all patients engaged in this project.	

Milestone Review Status

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

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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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

Instructions :

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project 4.a.iii – Strengthen Mental Health and Substance Abuse Infrastructure across Systems

IPQR Module 4.a.iii.1 - Major Risks to Implementation and Mitigation Strategies

Instructions :

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

#1 Risk – There is a risk is that patients are too spread out within PPS. If too spread out, community organizations conducting screening may find it difficult to offer this service for small numbers of eligible clients. CCN will address this risk by continually reaching out to organizations whose clientele are predominantly Medicaid eligibile and by seeking out additional "hot spots" in order to bring new organizations into the program to maximize our outreach to Medicaid patients.
#2 Risk - A second risk is that Medicaid patients may access behavioral health services on their own following a screening at a community location and won't self-identify as having been screened and prompted to seek services. Project success will be measured by our success in conducting screenings as well as connecting beneficiaries to behavioral health services when appropriate. We will engage with the various behavioral health providers to help identify beneficiaries who are seeking services as a result of these community-based screening services.
#3 Risk – A third risk is the expected limited resources for community based management. To mitigate this risk we will collaborate with other projects, as well as within the PPS RPU infrastructure to identify overlap in resources to consolidate where possible (for example, using population health resources to identify the most effective services for patients).

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Milestone 1 - Participate in MEB health promotion and MEB disorder prevention partnerships.	In Progress	Participate in MEB health promotion and MEB disorder prevention partnerships.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1a. Leveraging the 4aiii MEB project team, identify evidence-based screening tools which can meet DSRIP goals of strengthening mental health and substance abuse infrastructure of the PPS. Identified tools should be validated by the PPS Clinical Governance Committee and approved for PPS adoption by the Board of Directors.	In Progress	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1b. Identify those primary and specialty care providers in each of the four regions of the PPS with whom the PPS can engage in the screening process and the associated staff education.	In Progress	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1c. Identify and procure the evidence based targeted intervention services, for approval by CCN Clinical Governance Committee and Board of Directors.	In Progress	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1d. Engage with partner agencies across the PPS region to provide the targeted intervention services and associated training requirements.	In Progress	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone Milestone 2 - Expand efforts with DOH and	In Progress	2. Expand efforts with DOH and OMH to implement 'Collaborative Care' in primary care settings throughout NYS.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

Care Compass Network (PPS ID:44)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
OMH to implement 'Collaborative Care' in primary care settings throughout NYS.								
Task 2a. On an as needed basis, engage DOH / OMH/ OASAS for feedback and recommendations on best practice documents developed by the PPS as a result of this project.	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2b. RPU Leads, Behavioral Health Subcommittees, and CCN Provider Relations to identify opportunities to enhance coordination of care across the MEB system (BH providers, PC providers, CBOs providing ancillary social services). Collaborative efforts will be in conjunction with collaborative care development for PC and BH integration (project 3ai).	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone Milestone 3 - Share data and information on MEB health promotion and MEB disorder prevention and treatment.	In Progress	Share data and information on MEB health promotion and MEB disorder prevention and treatment.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3a. Leveraging the 4aiii MEB project team, develop the mechanism for collection and aggregation of all data as the project components are implemented, informed by the IT & Data Governance Committee for alignment (where appropriate) with other behavioral health initiatives and/or PPS integrated delivery system roadmaps.	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3b. Behavioral Health quality subcommittee in place at each Regional Performance Unit (RPU) will evaluate program function and efficacy and report results to the PPS level Clinical Governance Committee. Identified quality improvement metrics, if any, as	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	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
identified by the quality subcommittees will be presented to the Clinical Governance Committee and implemented with the associated providers facilitated by PPS Provider Relations, Project Champion(s), Behavioral Health Project Managers, and/or Workforce Transition Project Manager.								

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Milestone 1 - Participate in MEB health promotion and MEB disorder prevention partnerships.	The Care Compass Network (CCN) plan for project 4aiii includes a total of three Milestones none of which were targeted for DY1, Q2 completion. Each of the Milestones and tasks are on track and are being reported as In Progress for DY1, Q2. CCN has made significant progress on the 4aiii Mental Health and Substance Abuse Infrastructure project. The 4aiii Project Team has identified two evidence-based screening tools (the Patient Health Questionnaire (PHQ) for adolescents and screening tools available within the Behavioral Works software application) for use in community to help strengthen the Mental Health and Substance Abuse infrastructure. These screening tools were identified and prepared by the Project Team in DY1, Q2 and subsequently approved by both the Clinical Governance Committee and the CCN Board of Directors in early October. The 4aiii Project Team and CCN have identified a potential IT solution which will enable project partners to track all actively engaged patients, as well as access and share patient information among relevant clinical partners. The chosen IT solution will facilitate intervention services through the sharing of information in a timely way (including RHIO connectivity, alerts, and secure messaging) and allow for performance reporting capabilities. The vendor selection process is part of CCN's overall IT Systems and Processes roadmap. CCN expects the roadmap to be completed by DY1, Q3, including a timeline for the vendor selection process.
Milestone 2 - Expand efforts with DOH and OMH to implement 'Collaborative Care' in primary care settings throughout NYS.	The Care Compass Network (CCN) plan for project 4aiii includes a total of three Milestones none of which were targeted for DY1, Q2 completion. Each of the Milestones and tasks are on track and are being reported as In Progress for DY1, Q2. CCN has made significant progress on the 4aiii Mental Health and Substance Abuse Infrastructure project. The 4aiii Project Team has identified two evidence-based screening tools (the Patient Health Questionnaire (PHQ) for adolescents and screening tools available within the Behavioral Works software application) for use in community to help strengthen the Mental Health and Substance Abuse infrastructure. These screening tools were identified and prepared by the Project Team in DY1, Q2 and subsequently approved by both the Clinical Governance Committee and the CCN Board of Directors in early October. The 4aiii Project Team and CCN have identified a potential IT solution which will enable project partners to track all actively engaged patients, as well as access and share patient information among relevant clinical partners. The chosen IT solution will facilitate intervention services through the sharing of information in a timely way (including RHIO connectivity, alerts, and secure messaging) and allow for performance reporting capabilities. The vendor selection process is part of CCN's overall IT Systems and Processes roadmap. CCN expects the roadmap to be completed by DY1, Q3, including a timeline for the vendor selection process.

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Milestone 3 - Share data and information on MEB health promotion and MEB disorder prevention and treatment.	The Care Compass Network (CCN) plan for project 4aiii includes a total of three Milestones none of which were targeted for DY1, Q2 completion. Each of the Milestones and tasks are on track and are being reported as In Progress for DY1, Q2. CCN has made significant progress on the 4aiii Mental Health and Substance Abuse Infrastructure project. The 4aiii Project Team has identified two evidence-based screening tools (the Patient Health Questionnaire (PHQ) for adolescents and screening tools available within the Behavioral Works software application) for use in community to help strengthen the Mental Health and Substance Abuse infrastructure. These screening tools were identified and prepared by the Project Team in DY1, Q2 and subsequently approved by both the Clinical Governance Committee and the CCN Board of Directors in early October. The 4aiii Project Team and CCN have identified a potential IT solution which will enable project partners to track all actively engaged patients, as well as access and share patient information among relevant clinical partners. The chosen IT solution will facilitate intervention services through the sharing of information in a timely way (including RHIO connectivity, alerts, and secure messaging) and allow for performance reporting capabilities. The vendor selection process is part of CCN's overall IT Systems and Processes roadmap. CCN expects the roadmap to be completed by DY1, Q3, including a timeline for the vendor selection process.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 4.a.iii.3 - IA Monitoring

Instructions :

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Delivery System Reform Incentive Payment Project

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Project 4.b.ii – Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer

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

Instructions :

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

1. The first identified risk is the lack of IT infrastructure & connectivity (EMR/EHR) to support COPD prevention & chronic disease management across all safety net provider settings. This will have an impact on the project in that establishing and integrating EMR/EHR, connectivity, and infrastructure will improve coordination of COPD care across settings, impact patient access to education, supports and positive respiratory outcomes. A mitigating strategy is to assess EMR status of safety net providers via project 2ai and identify challenges and solutions to reaching meaningful use for PCMH Level 3 standards by DY3Q4. Capital improvement funds will be allocated and PPS IT staff available for infrastructure build, onsite support in implementation and training. PCMH Level 3 provider champions will be identified to share best practices, office work flow strategies and mentoring. Provider alerts will be integrated into EMRs throughout the PPS to assess and manage COPD patients and make appropriate referrals.
2. Our second risk is the inability to consent and engage COPD patients and those at risk as active self –managers. This will impact the project in that PPS success in reaching targets on time requires COPD patients to be identified by disease or risk, geographic location, and PCP. Outreach to gain written patient consent to PPS and RHIO requires trusted entities in a variety of settings overtime to gain trust and onboard patients efficiently and effectively with few transitions. Skilled staff cross trained in cultural competency, health literacy and motivational interviewing in addition to completing multiple screenings will be keys to project success.
To mitigate this risk we plan to collaborate with the PPS IT team to develop use of a central data base and standardized tracking tools for process and performance reporting. Also, a reliance on Project 2ci to standardize Medicaid patient intake and onboarding protocols will be needed. The success of project 4bii is contingent upon ability of projects 2ai, 2ci, 2di, 3bi, Cultural Competency/Health Literacy.
3. Our third risk is the failure to engage providers in following standardized treatment protocols and care coordination. The potential impact this will have is that consistency in both practice and data collection will not be possible. Our mitigating strategy for this risk is to leverage the PPS Clinical Governance Committee to develop PPS-wide Disease Management standardized protocols. In addition, we will leverage the Regional Performance Unit (RPU) Disease Management Sub-Committees to further seek provider input and monitor compliance with standards. This will likely include PFT standardized protocols, GOLD standards and smoking cessation 5 As. We will ask for provider feedback on office work flow efficiency, receptiveness to COPD nurse care manager and care coordination supports. When possible we will create COPD patient registries and provide follow up in EMR for PCP on referrals made to determine patient outcomes to support documenting self -management goal of beneficiary.

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Milestone 1 - Increase community partner participation in COPD prevention and management.	In Progress	Increase community partner participation in COPD prevention and management.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1a. The CBO Engagement Council will produce and disseminate a Pre-Engagement Assessment wherein providers' scope of services will be gathered. The Provider Relations team will engage community partners in planning for PPS wide COPD prevention and management activities.	In Progress	See narrative	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1b. The 4bii Project Team, Project Management Office, Providers Relations team, and CCN Communications team will work collaboratively with tobacco free coalitions to establish consistent messaging for smoking cessation for patients and smoke free environments for facilities participating in the project. This will include COPD specific materials and disease management materials in related agendas with focused review on at least an annual basis for QA/QI opportunities.	In Progress	See narrative	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1c. Educate COPD patients and smokers about available options for Chronic Disease Self Management (CDSMP) evidence based interventions.	In Progress	See narrative	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone Milestone 2 - Establish PPS wide COPD	In Progress	Establish PPS wide COPD screening protocols and clinical practice guidelines.	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
screening protocols and clinical practice guidelines.								
Task 2a. Engage clinical and community based providers in the establishment of PPS wide screening protocols and clinical practice guidelines for COPD in conjunction with the Clinical Governance Committee and, more specifically, the Disease Management Subcommittees within each Regional Performance Unit (RPU). Established protocols, particularly GOLD Standards, will be taken into consideration as PPS wide protocols are adopted and/or developed by the Clinical Governance Committee and Board of Directors. Review and alteration to said protocols will occur annually at a minimum for effectiveness and relevance.	In Progress	See narrative	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 2b. The 4bii project team will pursue the standardized utilization of the 5As (Ask, Assess, Advise, Assist, and Arrange) for tobacco cessation and appropriate referrals to NYS Quit line. The PMO and the IT & Data Governance Committee will work in conjunction to locate the 5As within providers' EMRs and implement strategies to fill identified gaps. Smoking history, willingness to self-manage goals, and other pertinent clinical interventions will be sought to be included in EMR.	In Progress	See narrative	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 2c. As part of the engagement of clinical and community based partners, the PPS will include a focused effort for increased adult immunization rates (influenza, pneumococcal, pertussis). Measured and monitored success of this effort to be measured by reported	In Progress	See narrative	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
numbers provided by NYS DOH.								
Milestone Milestone 3 - Increase pulmonary function testing (PFT)for COPD at risk adults.	In Progress	Increase pulmonary function testing (PFT)for COPD at risk adults.	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 3a. The IT & Data Governance Committee work group will establish a PPS wide approach for provider alerts of patients requiring PFT screening in conjunction with the Clinical Governance Committee and, more specifically, the Disease Management Subcommittees within each Regional Performance Unit (RPU). Patients will be assessed for their COPD-related health conditions, risk stratified via screening protocols and guidelines (i.e. GOLD Standards and/or PAM Survey), and then receive appropriate health management interventions. This framework will be reviewed, altered if need be, and approved by the Disease Management Subcommittee to then be fully adopted by the Clinical Governance Committee annually at a minimum.	In Progress	See narrative	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 3b. Utilize the population health management screening model to identify opportunities for distribution of patient reminders PFT screening needed, as applicable, such as text message reminders for spyrometry in the office or pulmonary function screening.	In Progress	See narrative	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone Milestone 4 - Improve adherence to timely follow up of abnormal PFT screening results.	In Progress	Improve adherence to timely follow up of abnormal PFT screening results.	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 4a. The IT & Data Governance Committee will establish a PPS wide approach for provider alerts to conduct follow up appointments with patients with abnormal PFT screening results. Care coordination teams will be utilized and/or	In Progress	See narrative	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
patients with abnormal PFT screening results will be assigned to a COPD care coordinator.								
Task 4b. Establish PPS-wide approach for patient reminders of need for follow up on abnormal PFT screening results.	In Progress	See narrative	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Milestone 1 - Increase community partner participation in COPD prevention and management.	There are five milestones for project 4bii with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 4bii and 3bi. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.
Milestone 2 - Establish PPS wide COPD screening protocols and clinical practice guidelines.	There are five milestones for project 4bii with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 4bii and 3bi. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.
Milestone 3 - Increase pulmonary function testing (PFT)for COPD at risk adults.	There are five milestones for project 4bii with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
	and plans for integration of the 5A's of Tobacco cessation with regards to projects 4bii and 3bi. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.
Milestone 4 - Improve adherence to timely follow up of abnormal PFT screening results.	There are five milestones for project 4bii with no tasks due for the Q2 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. For other project plan updates, in June 2015 one of the project co-leaders met with Population Health Improvement Coordinators & Tobacco Free Coalition Coordinators (Broome & Tioga Counties) & CNY Regional Center for Tobacco Health Systems to discuss integration of strategies across counties, systems and DSRIP/PHIP/Tobacco Control programs. Following this meeting the CCN PMO Director also met with the CNY Regional Center for Tobacco Health Systems team (9/10/15) to specifically review project requirements and plans for integration of the 5A's of Tobacco cessation with regards to projects 4bii and 3bi. During Q2 a Population Health model for 3bi Cardiovascular and 4bii COPD patient risk stratification and interventions was created and distributed to the Disease Management workgroup. This framework is being finalized for presentation to the Clinical Governance Committee in Q3 and will serve as a baseline for contracting discussions with CCN partners.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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Attestation

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

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

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

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

☐ **I here by attest, as the Lead Representative of the 'Care Compass Network', 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:	UNITED HEALTH SERV HOSP INC
Secondary Lead PPS Provider:	
Lead Representative:	Robin Marie Kinslow-Evans
Submission Date:	12/15/2015 03:36 PM

Comments:

New York State Department Of Health
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Status Log				
Quarterly Report (DY,Q)	**Status**	**Lead Representative Name**	**User ID**	**Date Timestamp**
DY1, Q2	Adjudicated	Robin Marie Kinslow-Evans	sv590918	12/31/2015 09:22 PM
DY1, Q2	Submitted	Robin Marie Kinslow-Evans	rk442298	12/15/2015 03:36 PM
DY1, Q2	Returned	Robin Marie Kinslow-Evans	emcgill	12/01/2015 12:26 PM
DY1, Q2	Submitted	Robin Marie Kinslow-Evans	rk442298	10/30/2015 04:31 PM
DY1, Q2	In Process		ETL	10/01/2015 12:14 AM

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Comments Log			
Status	**Comments**	**User ID**	**Date Timestamp**
Returned	DY1 Q2 Quarterly Report has been returned for remediation.	emcgill	12/01/2015 12:26 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
	IPQR Module 4.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed

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Section	Module Name	Status
	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
	IPQR Module 7.6 - Key Stakeholders	Completed

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Section	Module Name	Status
	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
	IPQR Module 10.8 - IA Monitoring	

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

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Project ID	Module Name	Status
	IPQR Module 3.a.i.5 - IA Monitoring	
3.a.ii	IPQR Module 3.a.ii.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 3.a.ii.2 - Patient Engagement Speed	Completed
	IPQR Module 3.a.ii.3 - Prescribed Milestones	Completed
	IPQR Module 3.a.ii.4 - PPS Defined Milestones	Completed
	IPQR Module 3.a.ii.5 - IA Monitoring	
3.b.i	IPQR Module 3.b.i.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 3.b.i.2 - Patient Engagement Speed	Completed
	IPQR Module 3.b.i.3 - Prescribed Milestones	Completed
	IPQR Module 3.b.i.4 - PPS Defined Milestones	Completed
	IPQR Module 3.b.i.5 - IA Monitoring	
3.g.i	IPQR Module 3.g.i.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 3.g.i.2 - Patient Engagement Speed	Completed
	IPQR Module 3.g.i.3 - Prescribed Milestones	Completed
	IPQR Module 3.g.i.4 - PPS Defined Milestones	Completed
	IPQR Module 3.g.i.5 - IA Monitoring	
4.a.iii	IPQR Module 4.a.iii.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 4.a.iii.2 - PPS Defined Milestones	Completed
	IPQR Module 4.a.iii.3 - IA Monitoring	
4.b.ii	IPQR Module 4.b.ii.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 4.b.ii.2 - PPS Defined Milestones	Completed
	IPQR Module 4.b.ii.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 & Ongoing	
	Module 1.5 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
Section 02	Module 2.1 - Prescribed Milestones		
	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	
	Milestone #9	Pass & Ongoing	
Section 03	Module 3.1 - Prescribed Milestones		
	Milestone #1	Pass & Complete	
	Milestone #2	Pass & Ongoing	
	Milestone #3	Pass & Ongoing	
	Milestone #4	Pass & Ongoing	
	Milestone #5	Pass & Ongoing	
	Milestone #6	Pass & Ongoing	

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Section	Module Name / Milestone #	Review Status	
	Milestone #7	Pass & Ongoing	
	Milestone #8	Pass & Ongoing	
Section 04	Module 4.1 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
Section 05	Module 5.1 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
	Milestone #3	Pass & Ongoing	
	Milestone #4	Pass & Ongoing	
	Milestone #5	Pass & Ongoing	
Section 06	Module 6.1 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
Section 07	Module 7.1 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
Section 08	Module 8.1 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
Section 09	Module 9.1 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
Section 11	Module 11.2 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	

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Section	Module Name / Milestone #	Review Status	
	Milestone #2	Pass & Ongoing	
	Milestone #3	Pass & Ongoing	
	Milestone #4	Pass & Ongoing	
	Milestone #5	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	Pass & Ongoing	
	Milestone #2	Pass & Complete	
	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	
2.b.iv	Module 2.b.iv.2 - Patient Engagement Speed	Fail	
	Module 2.b.iv.3 - Prescribed Milestones		
	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	
2.b.vii	Module 2.b.vii.2 - Patient Engagement Speed	Fail	
	Module 2.b.vii.3 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	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	
2.c.i	Module 2.c.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.c.i.3 - Prescribed Milestones		
	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	
2.d.i	Module 2.d.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.d.i.3 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
	Milestone #3	Pass & Ongoing	
	Milestone #4	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	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	
3.a.i	Module 3.a.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.a.i.3 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
	Milestone #3	Pass & Ongoing	
	Milestone #4	Pass & Ongoing	
	Milestone #5	Pass & Ongoing	
	Milestone #6	Pass & Ongoing	
	Milestone #7	Pass & Ongoing	
	Milestone #8	Pass & Ongoing	
	Milestone #9	Pass & Ongoing	
	Milestone #10	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #11	Pass & Ongoing	
	Milestone #12	Pass & Ongoing	
	Milestone #13	Pass & Ongoing	
	Milestone #14	Pass & Ongoing	
	Milestone #15	Pass & Ongoing	
3.a.ii	Module 3.a.ii.2 - Patient Engagement Speed	Fail	IA
	Module 3.a.ii.3 - Prescribed Milestones		
	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	
3.b.i	Module 3.b.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.b.i.3 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
	Milestone #3	Pass & Ongoing	
	Milestone #4	Pass & Ongoing	
	Milestone #5	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	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	
3.g.i	Module 3.g.i.2 - Patient Engagement Speed	Fail	IA
	Module 3.g.i.3 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
	Milestone #3	Pass & Ongoing	
	Milestone #4	Pass & Ongoing	
	Milestone #5	Pass & Ongoing	
	Milestone #6	Pass & Ongoing	
4.a.iii	Module 4.a.iii.2 - PPS Defined Milestones	Pass & Ongoing	
4.b.ii	Module 4.b.ii.2 - PPS Defined Milestones	Pass & Ongoing	