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

DSRIP Implementation Plan Project

SBH Health System (PPS ID:36)

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Quarterly Report - Implementation Plan for SBH Health System

Year and Quarter: DY2, Q1 **Quarterly Report Status:** Adjudicated

Status By Section

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

Status By Project

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

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Section 01 – Budget

IPQR Module 1.1 - PPS Budget - Waiver Revenue (Baseline) - READ ONLY

Instructions :

READ ONLY - The Baseline Budget table was left for ease of reference during reporting.

Budget Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	26,930,696	28,699,271	46,410,322	41,096,163	26,930,696	170,067,148
Cost of Project Implementation & Administration	**12,926,734**	**13,775,650**	**22,276,955**	**19,726,158**	**12,926,734**	**81,632,231**
Administration	10,876,612	7,060,285	6,279,660	6,468,050	6,662,091	37,346,698
Project Implementation	2,050,122	6,715,365	15,997,295	13,258,108	6,264,643	44,285,533
Revenue Loss	**4,039,604**	**4,304,891**	**6,961,548**	**6,164,425**	**4,039,604**	**25,510,072**
Internal PPS Provider Bonus Payments	**5,924,753**	**6,313,840**	**10,210,271**	**9,041,156**	**5,924,753**	**37,414,773**
Cost of non-covered services	**1,346,535**	**1,434,964**	**2,320,516**	**2,054,808**	**1,346,535**	**8,503,358**
Other	**2,693,070**	**2,869,927**	**4,641,032**	**4,109,616**	**2,693,070**	**17,006,715**
Contingency	2,693,070	2,869,927	4,641,032	4,109,616	2,693,070	17,006,715
Total Expenditures	**26,930,696**	**28,699,272**	**46,410,322**	**41,096,163**	**26,930,696**	**170,067,149**
Undistributed Revenue	**0**	**0**	**0**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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Delivery System Reform Incentive Payment Project

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IPQR Module 1.2 - PPS Budget - Waiver Revenue (Quarterly)

Instructions :

Please include updates on waiver revenue 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 DY2	Total Waiver Revenue	Undistributed Revenue YTD	Undistributed Revenue Total
28,699,271	170,067,148	22,740,263	151,534,834

Budget Items	DY2 Q1 Quarterly Amount - Update	Cumulative Spending to Date (DY1 - DY5)	Remaining Balance in Current DY	Percent Remaining in Current DY	Cumulative Remaining Balance	Percent Remaining of Cumulative Balance
Cost of Project Implementation & Administration	**5,959,008**	**18,532,314**	**7,816,642**	**56.74%**	**63,099,917**	**77.30%**
Administration	1,566,796					
Project Implementation	4,392,212					
Revenue Loss	**0**	**0**	**4,304,891**	**100.00%**	**25,510,072**	**100.00%**
Internal PPS Provider Bonus Payments	**0**	**0**	**6,313,840**	**100.00%**	**37,414,773**	**100.00%**
Cost of non-covered services	**0**	**0**	**1,434,964**	**100.00%**	**8,503,358**	**100.00%**
Other	**0**	**0**	**2,869,927**	**100.00%**	**17,006,715**	**100.00%**
Contingency	0					
Total Expenditures	**5,959,008**	**18,532,314**				

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Narrative Text :

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

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IPQR Module 1.3 - PPS Flow of Funds - Waiver Revenue (Baseline) - READ ONLY

Instructions :

READ ONLY - The Baseline Funds Flow table was left for ease of reference during reporting.

Funds Flow Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	26,930,696	28,699,271	46,410,322	41,096,163	26,930,696	170,067,148
Practitioner - Primary Care Provider (PCP)	1,553,901	1,607,159	3,420,441	2,784,265	1,386,931	10,752,697
Practitioner - Non-Primary Care Provider (PCP)	675,960	717,482	1,327,335	1,160,967	693,465	4,575,209
Hospital	4,263,129	5,639,407	9,690,475	10,541,166	9,594,060	39,728,237
Clinic	1,553,901	2,673,226	4,873,850	2,977,914	1,386,931	13,465,822
Case Management / Health Home	2,738,852	5,083,903	8,312,658	4,845,979	2,433,862	23,415,254
Mental Health	810,614	1,408,217	2,982,505	2,065,860	1,151,287	8,418,483
Substance Abuse	371,105	347,262	936,560	918,499	528,515	3,101,941
Nursing Home	1,268,436	1,334,516	2,441,183	2,321,933	1,528,317	8,894,385
Pharmacy	202,519	198,025	539,288	663,703	504,951	2,108,486
Hospice	1,012,594	932,726	1,675,413	1,469,188	693,465	5,783,386
Community Based Organizations	1,621,228	1,678,908	3,930,954	3,400,707	1,844,753	12,476,550
All Other	0	0	0	0	0	0
Uncategorized						0
PPS PMO	10,858,457	7,078,440	6,279,660	7,945,982	5,184,159	37,346,698
Total Funds Distributed	**26,930,696**	**28,699,271**	**46,410,322**	**41,096,163**	**26,930,696**	**170,067,148**
Undistributed Revenue	**0**	**0**	**0**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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IPQR Module 1.4 - PPS Flow of Funds - Waiver Revenue (Quarterly)

Instructions :

Please include updates on waiver revenue flow of funds for this quarterly reporting period by importing the PIT file and filling out the PPS PMO line manually. 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 DY2	Total Waiver Revenue	Undistributed Revenue YTD	Undistributed Revenue Total
28,699,271.00	170,067,148.00	22,739,747.00	151,534,498.00

Funds Flow Items	DY2 Q1 Quarterly Amount - Update	Percentage of Safety Net Funds - DY2 Q1 Quarterly Amount - Update	Safety Net Funds Flowed YTD	Safety Net Funds Percentage YTD	Total Amount Disbursed to Date (DY1-DY5)	Percent Spent By Project											DY Adjusted Difference	Cumulative Difference
						Projects Selected By PPS												
						2.a.i	2.a.iii	2.b.iii	2.b.iv	3.a.i	3.b.i	3.c.i	3.d.ii	4.a.iii	4.c.ii			
Practitioner - Primary Care Provider (PCP)	0	0.00%	0	0.00%	0	0	0	0	0	0	0	0	0	0	0		1,607,159	10,752,697
Practitioner - Non-Primary Care Provider (PCP)	0	0.00%	0	0.00%	0	0	0	0	0	0	0	0	0	0	0		717,482	4,575,209
Hospital	2,736,400	100.00%	2,736,400	100.00%	8,637,906	74.1	.81	11.76	11.76	0	.19	1	.19	.19	0		2,903,007	31,090,331
Clinic	1,403,718	100.00%	1,403,718	100.00%	1,744,854	91.2	1.33	1.33	1.33	1.33	.64	1.16	1.33	0	.33		1,269,508	11,720,968
Case Management / Health Home	0	0.00%	0	0.00%	0	0	0	0	0	0	0	0	0	0	0		5,083,903	23,415,254
Mental Health	0	0.00%	0	0.00%	188,606	0	0	0	0	0	0	0	0	0	0		1,408,217	8,229,877
Substance Abuse	0	0.00%	0	0.00%	0	0	0	0	0	0	0	0	0	0	0		347,262	3,101,941
Nursing Home	0	0.00%	0	0.00%	0	0	0	0	0	0	0	0	0	0	0		1,334,516	8,894,385
Pharmacy	0	0.00%	0	0.00%	0	0	0	0	0	0	0	0	0	0	0		198,025	2,108,486
Hospice	0	0.00%	0	0.00%	0	0	0	0	0	0	0	0	0	0	0		932,726	5,783,386
Community Based Organizations	50,000	0.00%	0	0.00%	429,727	0	0	0	0	0	0	100	0	0	0		1,628,908	12,046,823
All Other	0	0.00%	0	0.00%	0	0	0	0	0	0	0	0	0	0	0		0	0
Uncategorized	0	0.00%	0	0.00%	0	0	0	0	0	0	0	0	0	0	0		0	0
Additional Providers	37,500	0.00%	0	0.00%	37,500													
PPS PMO	1,731,906	100.00%	1,731,906	100.00%	7,494,057												5,346,534	29,852,641
Total	**5,959,524**	**98.53%**	**5,872,024**	**98.53%**	**18,532,650**													

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Narrative Text :

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

Bronx Partners for Healthy Communities (BPHC) PPS distributed waiver level-one funds to 7 organizations ranging in size based on number of Primary Care Providers and the complexity with which the organization was categorized. Since these were level-one funds, they were distributed to the organizations' primary category. Montefiore Medical Center (MMC) has 703 PCPs and is categorized by Hospital, All Other, Case Management/Health Home, Clinic, Community-Based Organization (CBO), Mental Health, Nursing Home, Pharmacy, Substance Abuse and Uncategorized. SBH Health System (SBH) has 65 PCPs and is included in Hospital, All Other, Clinic, Mental Health, Nursing Home, Pharmacy, Substance Abuse and Uncategorized categories. MMC and SBH were distributed funds to their primary category, Hospital. Acacia Network has 18 PCPs and is categorized by Clinic, All Other, CBO, Mental Health, Substance Abuse and Uncategorized. Institute for Family Health has 80 PCPs and is categorized by Clinic, All Other, Case Management/Health Home and Mental Health. Morris Heights Health Center has 42 PCPs and is categorized as Clinic, All Other and Mental Health. Union Community Health Center has 13 PCPs and is included in Clinic, All Other, CBO and Uncategorized categories. Acacia Network, Institute for Family Health, Morris Heights Health Center and Union Community Health Center were distributed funds to their primary category, which is Clinic. Health People was distributed funds as a CBO. PPS PMO funds were dedicated to PCMH and Operational Costs.

Bronx Partners for Healthy Communities (BPHC) PPS also distributed non-waiver funds for the Demonstration Year 1 period to 1199 SEIU United Healthcare Workers East (TEF funds) in the amount of $895,388 for workforce implementation. These funds were classified as waiver funds during the periods of payment in DY1. For Demonstration Year 2 BPHC has distributed funds to 1199 SEIU United Healthcare Workers East (TEF funds) and to Bronx RHIO. These two entities are classified under the category of CBO's non-safety net.

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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	Completed	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.	05/01/2015	03/31/2016	05/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task Obtain final attribution and valuation	Completed	Receive final PPS attribution and valuation from the state.	05/12/2015	12/31/2015	05/12/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish schedule for flow of funds	Completed	Define PPS baseline funding schedule and distribution plan. Present for review and approval by the Executive Committee.	06/01/2015	07/31/2015	06/01/2015	07/31/2015	09/30/2015	DY1 Q2	
Task Share flow of funds information with PPS members	Completed	Conduct All PPS meeting describing the baseline funding schedule and approach for the development of project and provider specific funding schedules to be included as an attachment in the Master DSRIP Service Agreement (MDSA) as a rolling statement of work. .	08/01/2015	10/31/2015	08/01/2015	10/31/2015	12/31/2015	DY1 Q3	
Task Develop budgets	Completed	Develop initial project specific budgets based on specific clinical project implementation requirements and performance expectations using the baseline funding schedule as a guidepost. Present for review and approval to the Executive Committee.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Finalize funding schedules	Completed	Finalize the initial project and partner specific funding schedules with PPS partners to be included as an attachment in the MDSA as a rolling statement of work.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Initiate reporting process	Completed	Initiate quarterly reporting process for earned waiver revenue and partner payments.	08/15/2015	09/30/2015	08/15/2015	09/30/2015	09/30/2015	DY1 Q2	
Task	Completed	Define annual review and update process for the PPS	10/01/2015	11/30/2015	10/01/2015	11/30/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Establish annual review and update process		baseline funding schedule and distribution plan. Present for review and approval by the Executive Committee.							
Task Establish criteria for bonus payments and revenue loss funds	Completed	Engage PPS Committees and stakeholders to develop criteria and processes for administering DSRIP internal PPS provider bonus payments and revenue loss funds.	10/15/2015	01/31/2016	10/15/2015	01/31/2016	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
Complete funds flow budget and distribution plan and communicate with network	

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IPQR Module 1.6 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 1.7 - PPS Budget - Non-Waiver Revenue (Baseline)

Instructions :

This table contains five budget categories for non-waiver revenue baseline budget reporting . Please add rows to this table as necessary in order to identify sub-categories.

Budget Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Non-Waiver Revenue	35,214,291	35,214,291	35,214,291	35,214,291	35,214,291	176,071,455
Cost of Project Implementation & Administration	**16,902,860**	**16,902,860**	**16,902,860**	**16,902,860**	**16,902,860**	**84,514,300**
Administration	7,747,144	7,747,144	7,747,144	7,747,144	7,747,144	38,735,720
Implementation	9,155,716	9,155,716	9,155,716	9,155,716	9,155,716	45,778,580
Revenue Loss	**5,282,144**	**5,282,144**	**5,282,144**	**5,282,144**	**5,282,144**	**26,410,720**
Internal PPS Provider Bonus Payments	**7,747,144**	**7,747,144**	**7,747,144**	**7,747,144**	**7,747,144**	**38,735,720**
Cost of non-covered services	**1,760,715**	**1,760,715**	**1,760,715**	**1,760,715**	**1,760,715**	**8,803,575**
Other	**3,521,429**	**3,521,429**	**3,521,429**	**3,521,429**	**3,521,429**	**17,607,145**
Contingency	3,521,429	3,521,429	3,521,429	3,521,429	3,521,429	17,607,145
Total Expenditures	**35,214,292**	**35,214,292**	**35,214,292**	**35,214,292**	**35,214,292**	**176,071,460**
Undistributed Revenue	**0**	**0**	**0**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

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IPQR Module 1.8 - PPS Budget - Non-Waiver Revenue (Quarterly)

Instructions :

Please include updates on non-waiver revenue 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

Non-Waiver Revenue DY2	Total Non-Waiver Revenue	Undistributed Non-Waiver Revenue YTD	Undistributed Non-Waiver Revenue Total
35,214,291	176,071,455	34,713,073	174,601,110

Budget Items	DY1 Amount - Update	DY2 Q1 Quarterly Amount - Update	Cumulative Spending to Date (DY1 - DY5)	Remaining Balance in Current DY	Percent Remaining in Current DY	Cumulative Remaining Balance	Percent Remaining of Cumulative Balance
Cost of Project Implementation & Administration	**969,127**	**501,218**	**1,470,345**	**16,401,642**	**97.03%**	**83,043,955**	**98.26%**
Administration	0	516					
Implementation	969,127	500,702					
Revenue Loss	**0**	**0**	**0**	**5,282,144**	**100.00%**	**26,410,720**	**100.00%**
Internal PPS Provider Bonus Payments	**0**	**0**	**0**	**7,747,144**	**100.00%**	**38,735,720**	**100.00%**
Cost of non-covered services	**0**	**0**	**0**	**1,760,715**	**100.00%**	**8,803,575**	**100.00%**
Other	**0**	**0**	**0**	**3,521,429**	**100.00%**	**17,607,145**	**100.00%**
Contingency	0	0					
Total Expenditures	**969,127**	**501,218**	**1,470,345**				

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

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IPQR Module 1.9 - PPS Flow of Funds - Non-Waiver Revenue (Baseline)

Instructions :

In the table below, please detail your PPS's projected flow of non-waiver funds by provider type.

Funds Flow Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Non-Waiver Revenue	35,214,291	35,214,291	35,214,291	35,214,291	35,214,291	176,071,455
Practitioner - Primary Care Provider (PCP)	2,226,465	2,226,465	2,226,465	2,226,465	2,226,465	11,132,325
Practitioner - Non-Primary Care Provider (PCP)	947,348	947,348	947,348	947,348	947,348	4,736,740
Hospital	8,226,173	8,226,173	8,226,173	8,226,173	8,226,173	41,130,865
Clinic	2,788,248	2,788,248	2,788,248	2,788,248	2,788,248	13,941,240
Case Management / Health Home	4,848,388	4,848,388	4,848,388	4,848,388	4,848,388	24,241,940
Mental Health	1,743,140	1,743,140	1,743,140	1,743,140	1,743,140	8,715,700
Substance Abuse	642,291	642,291	642,291	642,291	642,291	3,211,455
Nursing Home	1,841,681	1,841,681	1,841,681	1,841,681	1,841,681	9,208,405
Pharmacy	436,585	436,585	436,585	436,585	436,585	2,182,925
Hospice	1,197,514	1,197,514	1,197,514	1,197,514	1,197,514	5,987,570
Community Based Organizations	2,583,408	2,583,408	2,583,408	2,583,408	2,583,408	12,917,040
All Other	0	0	0	0	0	0
Uncategorized	0	0	0	0	0	0
PPS PMO	7,733,048	7,733,048	7,733,048	7,733,048	7,733,048	38,665,240
Total Funds Distributed	**35,214,289**	**35,214,289**	**35,214,289**	**35,214,289**	**35,214,289**	**176,071,445**
Undistributed Non-Waiver Revenue	**2**	**2**	**2**	**2**	**2**	**10**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

New York State Department Of Health
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IPQR Module 1.10 - PPS Flow of Funds - Non-Waiver Revenue (Quarterly)

Instructions :

Please include updates on flow of funds for this quarterly reporting period by importing the PIT file and filling out the PPS PMO line manually. 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

Non-Waiver Revenue DY2	Total Non-Waiver Revenue	Undistributed Non-Waiver Revenue YTD	Undistributed Non-Waiver Revenue Total
35,214,291.00	176,071,455.00	26,980,541.00	166,773,578.00

Funds Flow Items	DY1 Amount - Update	DY2 Q1 Quarterly Amount - Update	Percentage of Safety Net Funds - DY2 Q1 Quarterly Amount - Update	Safety Net Funds Flowed YTD	Safety Net Funds Percentage YTD	Total Amount Disbursed to Date (DY1-DY5)	DY Adjusted Difference	Cumulative Difference
Practitioner - Primary Care Provider (PCP)	0	0	0.00%	0	0.00%	0	2,226,465	11,132,325
Practitioner - Non-Primary Care Provider (PCP)	0	0	0.00%	0	0.00%	0	947,348	4,736,740
Hospital	0	0	0.00%	0	0.00%	0	8,226,173	41,130,865
Clinic	0	0	0.00%	0	0.00%	0	2,788,248	13,941,240
Case Management / Health Home	0	0	0.00%	0	0.00%	0	4,848,388	24,241,940
Mental Health	0	0	0.00%	0	0.00%	0	1,743,140	8,715,700
Substance Abuse	0	0	0.00%	0	0.00%	0	642,291	3,211,455
Nursing Home	0	0	0.00%	0	0.00%	0	1,841,681	9,208,405
Pharmacy	0	0	0.00%	0	0.00%	0	436,585	2,182,925
Hospice	0	0	0.00%	0	0.00%	0	1,197,514	5,987,570
Community Based Organizations	895,388	500,702	0.00%	0	0.00%	1,396,090	2,082,706	11,520,950
All Other	0	0	0.00%	0	0.00%	0	0	0
Uncategorized	0	0	0.00%	0	0.00%	0	0	0

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Funds Flow Items	DY1 Amount - Update	DY2 Q1 Quarterly Amount - Update	Percentage of Safety Net Funds - DY2 Q1 Quarterly Amount - Update	Safety Net Funds Flowed YTD	Safety Net Funds Percentage YTD	Total Amount Disbursed to Date (DY1-DY5)	DY Adjusted Difference	Cumulative Difference
Additional Providers	0	0	0.00%	0	0.00%	0		
PPS PMO	168,739	7,733,048	100.00%	7,733,048	100.00%	7,901,787	0	30,763,453
Total	**1,064,127**	**8,233,750**	**93.92%**	**7,733,048**	**93.92%**	**9,297,877**		

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Bronx Partners for Healthy Communities (BPHC) PPS distributed non-waiver funds for the Demonstration Year 1 period to 1199 SEIU United Healthcare Workers East (TEF funds) in the amount of $895,388 for workforce implementation. These funds were classified as waiver funds during the periods of payment in DY1. For Demonstration Year 2 BPHC has distributed funds to 1199 SEIU United Healthcare Workers East (TEF funds) and to Bronx RHIO. These two entities are classified under the category of CBO's non-safety net.

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IPQR Module 1.11 - IA Monitoring

Instructions :

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Section 02 – Governance

IPQR Module 2.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize governance structure and sub-committee structure	Completed	This milestone must be completed by 9/30/2015. Governance and committee structure, signed off by PPS Board.	04/01/2015	05/01/2015	04/01/2015	05/01/2015	06/30/2015	DY1 Q1	YES
Task Establish committee charters	Completed	Develop and finalize charters for Executive Committee, Nominating Committee, Quality and Care Innovation Sub-Committee, Finance and Sustainability Sub-Committee, Workforce Sub-Committee and Information Technology Sub-Committee (collectively, the "Governance Charters"). The Governance Charters will describe the responsibilities of each committee, the process for appointing members to each committee, meeting frequency and the consensus-based decision making process of each committee.	04/01/2015	05/01/2015	04/01/2015	05/01/2015	06/30/2015	DY1 Q1	
Task Appoint EC members	Completed	Appoint members of the Executive Committee.	04/23/2015	05/01/2015	04/23/2015	05/01/2015	06/30/2015	DY1 Q1	
Task Initiate EC work	Completed	Convene Executive Committee, provide orientation to Executive Committee on roles and responsibilities, and initiate Committee work.	04/23/2015	04/23/2015	04/23/2015	04/23/2015	06/30/2015	DY1 Q1	
Task Appoint Sub-Committee members	Completed	Appoint members of the Quality and Care Innovation Sub-Committee, Finance and Sustainability Sub-Committee, Workforce Sub-Committee and Information Technology Sub-Committee (collectively, the "Sub-Committees").	04/23/2015	05/01/2015	04/23/2015	05/01/2015	06/30/2015	DY1 Q1	
Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Completed	This milestone must be completed by 12/31/2015. Clinical Quality Committee charter and committee structure chart	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task	Completed	Develop and finalize charter for Quality and Care Innovation	04/01/2015	05/01/2015	04/01/2015	05/01/2015	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
Establish QCIS charter		Sub-Committee. The charter will describe the responsibilities of the Quality and Care Innovation Sub-Committee, the process for appointing members to the Quality and Care Innovation Sub-Committee, meeting frequency and the consensus-based decision making process of the Quality and Care Innovation Sub-Committee.							
Task Establish QCIS membership	Completed	Solicit and appoint members of the Quality and Care Innovation Sub-Committee. The Sub-Committee is composed of PPS Members with clinical experience relevant to the selected projects, including (but not limited to) participation of members with expertise in primary care, emergency medicine, intellectual and developmental disabilities, behavioral and mental health, long-term care, housing services and substance abuse services.	04/01/2015	05/01/2015	04/01/2015	05/01/2015	06/30/2015	DY1 Q1	
Task Initiate QCIS work	Completed	Convene Quality and Care Innovation Sub-Committee, review charter, and initiate Quality and Care Innovation Sub-Committee work.	06/05/2015	06/05/2015	06/05/2015	06/05/2015	06/30/2015	DY1 Q1	
Task Create work groups	Completed	Establish project-specific work groups comprised of partner providers and CBOs (e.g., primary care physicians, subspecialists, nurses, mental health professionals and social workers) to develop detailed clinical operational plans for deployment of the clinical projects under the oversight of the Quality and Care Innovation Sub-Committee.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Select membership for rapid deployment collaboratives	Completed	Work with key PPS organizations and CBOs to select thought leaders from among the major practitioner groups/CBOs (including primary care physicians, subspecialists, nurses, mental health professionals, social workers, and peers) who will form rapid deployment colloaboratives that will develop engagement strategies specific to the PPS quality improvement agenda and DSRIP projects. These workgroups will also serve as project clinical quality councils.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish reporting format and schedule	Completed	Develop a Quality and Care Innovation Sub-Committee and rapid deployment collaboratives reporting format and schedule to track progress and metrics.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #3	Completed	This milestone must be completed by 9/30/2015. Upload of	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	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
Finalize bylaws and policies or Committee Guidelines where applicable		bylaws and policies document or committee guidelines.							
Task Establish PPS governance by-laws	Completed	Develop and finalize approval of Governance Charters, which are the functional equivalent of by-laws for the PPS governance structure.	04/01/2015	04/01/2015	04/01/2015	04/01/2015	06/30/2015	DY1 Q1	
Task Establish PPS polices and procedures	Completed	Develop and finalize PPS policies and procedures, including dispute resolution policy, conflicts of interest policy, anti-trust policy, data sharing policies, and policies regarding non- or under-performing partners. The Executive Committee and SBH will approve policies and procedures.	07/23/2015	09/30/2015	07/23/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Share policies and procedures	Completed	Share policies and procedures with other Sub-Committees and partner organizations.	07/23/2015	09/30/2015	07/23/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Establish process for review of policies and procedures	Completed	Develop a process and schedule for reviewing, revising and updating policies and procedures.	07/23/2015	09/30/2015	07/23/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #4 Establish governance structure reporting and monitoring processes	Completed	This milestone must be completed by 12/31/2015. Governance and committee structure document, including description of two-way reporting processes and governance monitoring processes.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Establish reporting framework across PPS governance	Completed	Designate reporting oversight responsibilities to Executive Committee, Quality and Care Innovation Sub-Committee and Finance and Sustainability Sub-Committee. BPHC Senior Director for Quality Management and Analytics will be responsible for working with the Quality and Care Innovation Sub-Committee on performance reporting activities.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Establish procedures for meeting minutes	Completed	Draft procedures by which the Executive Committee and Committees will (a) keep minutes and (b) send minutes to the Executive Committee, other Sub-Committees and SBH, as applicable.	07/23/2015	09/30/2015	07/23/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Establish governance section in online portal for report and information sharing purposes.	Completed	Establish governance section on an online document-sharing portal to post minutes, reports and other key documents from Executive Committee and Sub-Committees.	04/01/2015	04/23/2015	04/01/2015	04/23/2015	06/30/2015	DY1 Q1	
Task Develop project tracking dashboard	Completed	Create a dashboard to track quarterly progress of each DSRIP project.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop MSAs with schedules	Completed	Create Master Service Agreements with schedules to be executed with each PPS member receiving DSRIP funds that	06/01/2015	12/31/2015	06/01/2015	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
		will hold each member responsible for tracking their progress toward achieving identified milestones, performance on metrics and reporting to the BPHC Central Services Organization (CSO).							
Task Compile performance data for review	Completed	Compile performance data into reports highlighting trends and gaps and submit to the appropriate subcommittee(s) for review.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop feedback mechanisms	Completed	Create mechanisms for feedback to members on their performance.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish response mechanisms for underperformance	Completed	Develop policy and procedure on how to address underperformance by member organizations.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish milestones and metrics for organizational work streams	Completed	Identify key milestones and metrics quarterly for organizational workstreams (finance, IT, workforce, governance and clinical).	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish CSO Planning Team	Completed	Establish CSO Planning Team to coordinate the work of all the governance committees/subcommittees.	06/01/2015	06/15/2015	06/01/2015	06/15/2015	06/30/2015	DY1 Q1	
Task Develop DSRIP planning calendars	Completed	Develop DSRIP planning calendars for each committee/subcommittee to ensure that overlapping and interdependent tasks and responsibilities vis-a-vis quarterly DSRIP milestones and metrics are met.	06/01/2015	06/15/2015	06/01/2015	06/15/2015	06/30/2015	DY1 Q1	
Task Establish regular cross-committee conference calls	Completed	Establish monthly conference calls of the subcommittee chairs/co-chairs to review their respective DSRIP planning calendars and meeting minutes and identify action items for the coming month.	07/01/2015	07/17/2015	07/01/2015	07/17/2015	09/30/2015	DY1 Q2	
Task Create and disseminate tools for quarterly reporting by partners	Completed	Identify, develop and deploy tools for collecting and reporting quarterly data for all partner organizations. Theese tools will be used by our CSO clinical projects management staff, as well as DSRIP Liaisons/Senior Program Managers located at PPS Partner sites , to track each DSRIP project and communicate in real-time to monitor progress.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	Completed	Community engagement plan, including plans for two-way communication with stakeholders.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	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 Create an inventory of CBO services.	Completed	Finalize and administer survey to create an inventory of services offered by CBOs within the PPS area that participate in activities that impact population health. The PPS area covers all the neighborhoods and communities of the Bronx. The CSO implemented a survey of current CBO members of our PPS to profile their services, interest and capacity to participate as partner organizations in our DSRIP projects. Our current CBO members encompass a wide array of service providers, including services for intellectual and development disabilities(IDD); food banks, community gardens and farmer's markets; foster children agencies; HIV prevention/outreach and social services; housing services, including advocacy groups, housing providers and homeless services; individual employment support services; financial assistance and support, including clothing and furniture banks; not-for profit health and welfare agencies; nutrition and exercise programs; peer, family support, training and self advocacy organizations; reentry organizations and alternatives to incarceration; transportation services; youth development programs; syringe access programs; and services for special populations, including immigrants, LGBT, seniors, uninsured and women.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Recruit CBO representatives for engagement in committee work	Completed	Director of Collaboration to recruit representatives from CBOs to participate in patient engagement groups, Sub-Committees and the Executive Committee, as appropriate.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop community engagement strategy	Completed	Identify strategies to facilitate connections with the community and develop associated time line.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Establish community engagement plan	Completed	Draft community engagement plan and obtain feedback from patient engagement group and Executive Committee.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop budget for community engagement	Completed	Review community engagement plan with Director of Collaboration to determine costs associated with outreach and the development and production of communication and marketing materials.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Finalize community engagement budget	Completed	Obtain approval from Finance and Sustainability Subcommittee for community engagement budget.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #6	Completed	Signed CBO partnership agreements or contracts.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Finalize partnership agreements or contracts with CBOs									
Task Identify partner CBOs for DY1 contracts	Completed	Identify CBOs to contract with in DY1, via: 1) project-specific work groups identifying CBOs to target and engage based on the services they provide and how those services address the predominant social determinants of health in the Bronx by primary condition (diabetes, CVD, asthma, etc), based on the initial Bronx CNA (November 2014); 2) CSO implement a survey of current CBO members of our PPS to profile their services and their interest and capacity to participate as partner organizations in our DSRIP projects; 3) hosting forums with groups of CBOs designed to inform them about the CBO role as member organizations and to facilitate their participation in our DSRIP projects.	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Draft MSA for CBOs	Completed	Draft Master Services Agreement (MSA) and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure.	04/01/2015	05/21/2015	04/01/2015	05/21/2015	06/30/2015	DY1 Q1	
Task Obtain feedback on MSA	Completed	Solicit comments on MSA from PPS members through distribution to members, opportunity for submission of written comments, and review in Committee and Sub-Committee meetings.	05/21/2015	06/08/2015	05/21/2015	06/08/2015	06/30/2015	DY1 Q1	
Task Finalize MSA	Completed	Finalize MSA.	07/01/2015	07/23/2015	07/01/2015	07/23/2015	09/30/2015	DY1 Q2	
Task Finalize CBO project schedules	Completed	Develop and finalize CBO project schedules in concert with Clinical Operational Plans.	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Review schedules with CBO partners	Completed	Review and negotiate project schedules with CBOs.	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Execute agreements with CBOs	Completed	Execute agreements and project schedules for CBOs.	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1	
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.	07/01/2015	06/30/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task Identify state and local agencies	Completed	Identify all state and local agencies in the PPS area. Initiate contacts with various agencies and programs of the New York	07/01/2015	09/30/2015	07/01/2015	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
		City Department of Health and Mental Hygiene, including Healthy Homes Program (for asthma services); Primary Care Information Project (health IT); NYC Reach (practice transformation support services to receive PCMH recognition under 2014 standard); Center for Health Equity; Bronx District Public Health Office; Correctional Health Services and services for HIV and treating tobacco use.							
Task Identify additional agencies for engagement and participation	Completed	Director of Collaboration will work with existing partners to identify additional agencies for engagement and participation in DSRIP implementation	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Recruit agency representatives for engagement in committee work	Completed	Director of Collaboration to recruit staff from state and local agencies to serve as liaisons to PPS.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish agency coordination plan	Completed	Develop a plan for coordinating agency activities and obtain feedback from agencies on draft plan.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #8 Finalize workforce communication and engagement plan	Completed	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).	05/22/2015	02/28/2016	05/22/2015	02/28/2016	03/31/2016	DY1 Q4	NO
Task Establish and convene Workforce Project Team	Completed	Establish and convene Workforce Project Team (including Workforce Sub-Committee, Workforce Workgroups, Director of Workforce Innovation and other supportive staff from the CSO, 1199 SEIU Training and Employment Funds (TEF), subject matter experts and stakeholders) responsible for implementing and executing workforce activities.	05/22/2015	08/30/2015	05/22/2015	08/30/2015	09/30/2015	DY1 Q2	
Task Identify workforce engagement needs	Completed	Identify all levels of the workforce that will need to be engaged to ensure the successful implementation of DSRIP projects, by identifying the requirements for each DSRIP project, the new services that will be delivered, the types and estimated numbers of workers needed for each DSRIP project and the competencies, skills, training and roles required for each DSRIP project.	07/17/2015	12/31/2015	07/17/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Convene Workforce Communications Workgroup	Completed	Convene Workforce Communications Workgroup (under the Workforce Committee) to recommend strategies to identify communication needs, key messages, and communication channels to ensure frontline workers are informed of and	05/22/2015	07/31/2015	05/22/2015	07/31/2015	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
		engaged in the deployment of DSRIP projects.							
Task Obtain input on workforce communication and engagement plan	Completed	Develop workforce communication and engagement plan goals, objectives and potential barriers and obtain feedback from Workforce Communications Workgroup.	07/31/2015	10/30/2015	07/31/2015	10/30/2015	12/31/2015	DY1 Q3	
Task Draft workforce communication and engagement plan	Completed	Draft workforce communication plan, including channels to be used/audiences/ milestones to measure effectiveness, and obtain feedback from all levels of the workforce and the Workforce Communications Workgroup.	07/31/2015	12/31/2015	07/31/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Finalize workforce communication and engagement plan	Completed	Obtain sign-off on workforce communication and engagement plan from Workforce Sub-Committee and Executive Committee.	11/09/2015	02/28/2016	11/09/2015	02/28/2016	03/31/2016	DY1 Q4	
Milestone #9 Inclusion of CBOs in PPS Implementation.	Completed	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 Draft MSA for CBOs	Completed	Draft Master Services Agreement (MSA) and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure.	04/01/2015	05/21/2015	04/01/2015	05/21/2015	06/30/2015	DY1 Q1	
Task Obtain feedback on MSA	Completed	Solicit comments on MSA from PPS members through distribution to members, opportunity for submission of written comments, and review in Committee and Sub-Committee meetings.	05/21/2015	06/08/2015	05/21/2015	06/08/2015	06/30/2015	DY1 Q1	
Task Finalize MSA	Completed	Finalize MSA	07/01/2015	07/23/2015	07/01/2015	07/23/2015	09/30/2015	DY1 Q2	
Task Finalize CBO project schedules	Completed	Develop and finalize CBO project schedules in concert with Clinical Operational Plans.	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Review schedules with CBO partners	Completed	Review and negotiate project schedules with CBOs.	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Execute MSA with a.i.r. nyc	Completed	Execute agreement and project schedules with a.i.r. nyc	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Execute MSA with Health People	Completed	Execute agreement and project schedules with Health People	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	

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IA Instructions / Quarterly Update

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

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize governance structure and sub-committee structure	6338	Templates	36_DY2Q1_GOV_MDL21_PRES1_TEMPL_Gov_M1_Meeting_Schedule_DY2Q1_3716.xlsx	Meeting Schedule Template	07/15/2016 10:35 AM
	6338	Other	36_DY2Q1_GOV_MDL21_PRES1_OTH_Gov_M1_Governance_Committee_DY2Q1_3715.xlsx	Governance Committee Template	07/15/2016 10:34 AM
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	6338	Templates	36_DY2Q1_GOV_MDL21_PRES2_TEMPL_Gov_M2_Meeting_Schedule_DY2Q1_3718.xlsx	Meeting Schedule Template	07/15/2016 10:39 AM
	6338	Templates	36_DY2Q1_GOV_MDL21_PRES2_TEMPL_Gov_M2_Clinical_Governance_Committees_DY2Q1_3717.xlsx	Clinical Governance Committee Template	07/15/2016 10:38 AM
Finalize bylaws and policies or Committee Guidelines where applicable	6338	Other	36_DY2Q1_GOV_MDL21_PRES3_OTH_Gov_M3_Revised_BPHC_WF_Subcommittee_Charter_3719.pdf	Revised Workforce Subcommittee Charter	07/15/2016 10:41 AM
Establish governance structure reporting and monitoring processes	6338	Other	36_DY2Q1_GOV_MDL21_PRES4_OTH_Governance_M4_BPHC_Performance_Reporting_and_Monitoring_Structure_3720.pdf	BPHC Performance Reporting and Monitoring Structure	07/15/2016 10:43 AM
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	6338	Templates	36_DY2Q1_GOV_MDL21_PRES5_TEMPL_Gov_M5_Community_Engagement_Template__DY2Q1_3721.xlsx	Community Engagement Template	07/15/2016 10:46 AM
Finalize partnership agreements or contracts with CBOs	6338	Templates	36_DY2Q1_GOV_MDL21_PRES6_TEMPL_Meeting_Schedule_Template_DY2Q1_3723.xlsx	Meeting Schedule Template	07/15/2016 10:49 AM
	6338	Templates	36_DY2Q1_GOV_MDL21_PRES6_TEMPL_Community_Based_Organizations_Template_DY2Q1_3722.xlsx	Community-Based Organization Template	07/15/2016 10:47 AM
Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services,	zstopak	Documentation/Certification	36_DY2Q1_GOV_MDL21_PRES7_DOC_Gov_M7_Agency_Coordination_Plan_5950.docx	Agency Coordination Plan - for reference	09/19/2016 10:33 AM
	zstopak	Report(s)	36_DY2Q1_GOV_MDL21_PRES7_RPT_Gov_M7_Remediation_Narrative_5949.docx	Remediation narrative	09/19/2016 10:30 AM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Corrections, etc.)	6338	Templates	36_DY2Q1_GOV_MDL21_PRES7_TEMPL_Gov_M7_Public_Sector_Agency_Template_DY2Q1_3724.xlsx	Public Sector Agency Template	07/15/2016 10:51 AM
Finalize workforce communication and engagement plan	6338	Templates	36_DY2Q1_GOV_MDL21_PRES8_TEMPL_Gov_M8_Workforce_Communication_&_Engagement_Meeting_Schedule_DY2Q1_3727.xlsx	Workforce Communication & Engagement Meeting Schedule Template	07/15/2016 10:54 AM
	6338	Templates	36_DY2Q1_GOV_MDL21_PRES8_TEMPL_Gov_M8_Workforce_Committee_DY2Q1_3725.xlsx	Workforce Committee Template	07/15/2016 10:52 AM
Inclusion of CBOs in PPS Implementation.	zstopak	Documentation/Certification	36_DY2Q1_GOV_MDL21_PRES9_DOC_Remediation_Gov_M9_PCG_email_5866.pdf	email evidence	09/15/2016 05:21 PM
	zstopak	Report(s)	36_DY2Q1_GOV_MDL21_PRES9_RPT_Remediation_Gov_M9_Narrative_Explanation_5865.docx	narrative explanation	09/15/2016 05:20 PM
	6338	Other	36_DY2Q1_GOV_MDL21_PRES9_OTH_Governance_M9_BPHC_Strategy_for_CBO_Engagement_and_Contracting_3737.docx	BPHC Strategy for CBO Engagement and Contracting	07/15/2016 11:39 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize governance structure and sub-committee structure	Milestone completed DY1Q1. Templates updated per supporting documentation requirements.
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Milestone completed DY1Q3. Templates updated per supporting documentation requirements.
Finalize bylaws and policies or Committee Guidelines where applicable	Milestone completed DY1Q2. The Workforce Subcommittee charter has been amended and approved by the Executive Committee. The revised document can be found in the attached supporting documentation.
Establish governance structure reporting and monitoring processes	Milestone completed DY1Q3. The BPHC Performance Reporting and Monitoring Structure was approved by the Executive Committee. The document can be found in the attached supporting documentation.
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	Milestone completed DY1Q2. The Community Engagement Work Group (CEWG) played a key role in development of the BPHC Resource Directory for the community, which is now available on the BPHC website. The CEWG also participated in the development of a Letter of Interest to use to begin the Request for Proposal (RFP) for our new Community Health Literacy initiative to improve health literacy in the community; the RFP will also serve as a vehicle for contracting with selected CBOs to support their work on this initiative with DSRIP funds. Community Engagement Template updated per supporting documentation requirements.
Finalize partnership agreements or contracts with CBOs	A Master Services Agreement (MSA) and Schedule A have been executed with Health People. This brings the total number of executed partnership agreements with community-based organizations (CBOs) to four, including MSAs and Schedule A agreements with a.i.r. nyc, the Institute for Family Health and Health People, and an executed project management agreement with the Jewish Board of Family and Children's Services. The Jewish Board agreement is for the Mental Health and Substance Abuse Infrastructure Domain IV Project 4.a.iii ("MHSA Project"), in which our PPS, along with three other New York City PPSs, are participating through a collaboration agreement. This milestone is now complete.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.)	The Agency Coordination Plan has been completed. Two major public sector agencies -- New York City Department of Health and Mental Hygiene (NYCDOHMH) and New York State Office of Alcoholism and Substance Abuse Services (OASAS) -- provided feedback on the plan via a questionnaire that we created and distributed during the previous DSRIP quarter. Additionally, NYCDOHMH and New York City Department of Education (NYCDOE) participate in the Mental Health and Substance Use Infrastructure Domain IV Project 4.a.iii ("MHSA Project"), in which our PPS, along with three other New York City PPSs, are participating through a collaboration agreement. A workgroup has been established comprising subject matter experts from the PPSs and advisory members from NYCDOHMH and DOE to design a uniform city MHSA Project. The milestone is now complete.
Finalize workforce communication and engagement plan	Milestone completed DY1Q4. During DY2Q1 the Workforce Communication and Engagement Work Group (WC&EWG) met to develop ideas for communication with the BPHC workforce using new media. This was a recommendation from the Workforce Subcommittee due to the size of the PPS Workforce, originally estimated to be 35,000, and recently adjusted to be more than 70,000 as a result of the current state survey conducted across the PPS. The WC&EWG also made plans for the distribution of DSRIP 101, an online learning module created by our training vendor, 1199 TEF, with major inputs from the PPS. Distribution will occur in DY2Q2 due to delays in installing Health WorkForce apps, or HWapps, a web-based workforce tools application for PPSs, which we plan to use as a Learning Management System, among other purposes at BPHC.
Inclusion of CBOs in PPS Implementation.	BPHC recognizes the important role that CBOs have in developing and guiding our principles for the transformation of in the healthcare delivery system in the Bronx. We have included CBOs in all aspects of planning, governance, and project implementation. Each of our governance committees has CBO representation, including the Executive Committee; Finance & Sustainability, Quality & Care Innovation, Information Technology and Work Force Subcommittees; and Nominating Committee. The membership of our Community Engagement Work Group is comprised entirely of CBOs representatives, and CBOs have representation on six of our seven Implementation Work Groups for our clinical projects. Our plan for distribution of DSRIP funds is structured in five "waves," the fifth of which is funding to support CBOs and is currently underway. Our approach is to use a Request for Proposals (RFP) process to select additional CBOs to contract with in four areas of focus supporting DSRIP goals, including cultural competency, community health literacy, community-based behavioral health and critical time interventions (CTI). We anticipate contracting with a total of 16 to 20 additional CBOs through these four initiatives in the summer and fall of 2016. This milestone is now complete.

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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
Milestone Mid-Point Assessment	Completed	Mid-Point Assessment			06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Mid-Point Assessment	zstopak		36_DY2Q1_GOV_MDL22_PPS1030_TEMPL_3a_Mid-Point_Assessment_Org_Narrative_FINAL_5466.docx	Mid-Point Assessment Organizational Narrative	08/04/2016 04:39 PM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment	

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

Instructions :

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

1. We initially identified three major inter-related challenges: (1) developing and negotiating Master Services Agreements (MSA); (2) the project schedules; (3) funds distribution schedules among such a broad range of partners (type and size). We mitigated these risks by establishing transparent and inclusive processes in these areas: (1) The Executive Committee developed the MSA and established a thorough review and comment process, inviting all members of the PPS to participate. The MSA was finalized through this process in July 2015 and we began executing MSAs at the end of August. (2) The project schedules, which outline each partner's obligations with respect to specific projects and serve as the contractual instruments for the project-specific distribution of funds to partners, are negotiated with each partner. (3) We worked carefully with the Finance & Sustainability Subcommittee and Executive Committee to develop a plan for funds distribution across our broad range of members, which we communicated to PPS members through an All-Members teleconference.

2. It is a challenge to engage members of the Committees/Subcommittees effectively, meaningfully and continuously to achieve the PPS's goals over short timelines. We recognize that to build a strong, working governance structure, the members appointed to the various governance committees, collectively known as the Project Advisory Council (PAC), must prepare for and otherwise be actively involved in the committee meetings (e.g., read materials distributed in advance of meetings). However, committee members also have significant obligations to their organizations outside of the PPS. To mitigate this risk and ensure committee members can stay abreast of PPS developments, we utilize a wide range of online tools to support efficient information sharing. We developed a website to provide information about PPS activities to PPS members and the community; we developed a PAC member portal, where meeting materials are posted and stored and members may vote online; we host PAC webinars quarterly to inform and engage committee members.

3. There is a potential risk in whether the management of partner organizations would be willing to make the investments and changes needed to transform the way care is delivered. Their buy-in is crucial to the success of our PPS. To ensure buy-in at the highest leadership, we designed a highly inclusive governance structure that enables meaningful participation in PPS decision-making by leaders at member organizations. We established member profiles and we have and continue to engage in one-on-one meetings with partner organizations to understand their capacity, priorities and potential barriers to success. These findings have and continue to inform the design and deployment of PPS programs and policies. The Schedule A component of the MSA enables agreements to be tailored to the terms of each member organization, is negotiated with and requires sign-off of partner executive management.

4. The potential exists for the clinical governance structure of ten clinical projects to be burdensome on members supporting the clinical operational planning and implementation activities. To mitigate this risk we created a simple clinical governance structure. We grouped clinical projects that require similar thought leadership and provide care in similar settings. For example, we combined the ED Care Triage and 30-day Care Transitions projects into one Rapid Deployment Collaborative (RDC), also known as Implementation Work Group (IWG), because they are both hospital-based interventions. The other IWGs include Health Home at Risk, Primary Care/Behavioral Health Integration, CVD/Diabetes (combined), Asthma, Mental Health/Substance Use (MHSA) and HIV – totaling to seven IWGs. All these IWGs report up to the Quality & Care Innovations

Subcommittee.

IPQR Module 2.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

The ability to develop the project schedules that are part of the partnership agreements with CBOs depend on partner adoption of the Clinical Operational Plans which detail work plans and partner obligations for each DSRIP project. Creation of the funding schedules is dependent upon outputs of the finance workstream, which will include the funding amount that the BPHC will receive semi-annually, the distribution of Participants among the projects and the allocation of funding to each project-level budget throughout the phases of the DSRIP implementation.

Additionally, BPHC and its partners will need to continuously engage front line workers to ensure the success of each DSRIP project. To achieve this, BPHC will need to, among other things, continue to forge strong relationships with the unions.

Finally, it is critical that the IT systems and processes are capable of collecting key data in a timely fashion so that BPHC can monitor its performance on an ongoing basis and target areas in need of improvement.

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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
SBH COO	Len Walsh	BPHC governance strategy and fiduciary oversight, including policymaking and policy execution
Executive Director, BPHC CSO	Irene Kaufmann	Organize and facilitate committee meetings - Provides committees with relevant data, reports and communications - Records/files meeting minutes - Responsible for policy execution
BPHC Executive Committee	Len Walsh, Chair	Oversight of all aspects of deployment of DSRIP projects and evolution of BPHC into fully integrated delivery network - Responsible for policymaking
BPHC Nominating Committee	Patricia Belair, Chair, SBH Health System	Recommend members of committees and Sub-committees to Executive committee - Responsible for policymaking
BPHC Finance & Sustainability Subcommittee	David Menashy, Co-Chair, Montefiore Medical Center Todd Gorlewski, Co-Chair, SBH Health System	Make recommendations on distribution of project Partner implementation funds - Monitor budget and compliance - Review financial Oversight structure - Oversee provision of assistance to financially frail Partners - Advise on development and implementation of sustainability and financial compliance plans - Responsible for policymaking
BPHC Information Technology Sub-Committee	Dr. Jitendra Barmecha, Chair, SBH Health System	Create and update processes and protocols for adoption and use of information technology that will be applicable to all members -Responsible for policymaking
BPHC Quality & Care Innovation Sub-Committee	Co-Chairs, Quality & Care Innovation Sub-Committee, David Collymore & Debbie Pantin	Establish evidence-based practice and quality standards and metrics - Oversee clinical management processes - Hold providers and PPS accountable for achieving targeted metrics and clinical outcomes - Responsible for policymaking
Workforce Sub-Committee	Mary Morris, Co-Chair, SBH Health System	Develop and implement comprehensive workforce strategy to

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
	Rosa Mejias, Co-Chair, 1199 TEF	ensure BPHC retains, trains and hires staff needed to support implementation of DSRIP projects - Responsible for policymaking
BPHC Compliance Officer	Suzette Gordon	Review and evaluate compliance issues/concerns within BPHC to ensure compliance with the rules and regulations of regulatory agencies and that BPHC's bylaws and policies and procedures are being followed - Responsible for policy execution
CEO of PPS Lead Organization	Dr. David Perlstein	Make final determination of removal of committee members recommended for removal by Executive Committee

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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		
Attributed Patients and Families/Caregivers	Recipients of and partners in care, social and other services delivered by BPHC members	- Interaction sufficient to participate and take limited accountability for health, healthcare and other services activities
BPHC CSO Senior Staff (Irene Kaufmann, Executive Director; Janine Dimitrakakis, Senior Director for Analytics; Robin Moon, Senior Director for Care Delivery and Practice Innovations, Amanda Ascher, Chief Medical Officer; Benny Turner, Director of Capital Projects an Vendor Services, and Mary Morris, Dirctor of Workforce Innovation)	Facilitate evolution of BPHC into Integrated Delivery System	- Conduct operations, communication and coordination with BPHC Partners and other stakeholders to support all DSRIP-related activities
BPHC Member Organizations	Participation in BPHC projects	- Commit resources and provide BPHC project-related data to BPHC - participate in BPHC governance committees and work groups as opportunities exist
SEIU 1199 Labor Union (Tom Cloutier, Teresa Pica, Gladys Wrenick, and Rosa Mejias)	Collaborate with BPHC on workforce strategy and implementation	- 1199 SEIU Labor Management Project will facilitate Workforce Advisory Workgroup of Workforce Sub-Committee - Project Advisory Committee member
External Stakeholders		
Bronx RHIO (Charles Scaglione, Executive Director)	Accountable for integration of Bronx RHIO-supplied HIE functionality for BPHC support	- Oversight and integration of Bronx RHIO HIE technology into BPHC operations - Training staff of BPHC Partners on use of Bronx RHIO system - Executive Committee member - IT Sub-Committee member
SEIU 1199 Training and Employment Fund (TEF) (Rosa Mejias, co-chair of the Workforce Sub-Committee)	Collaborate with BPHC on workforce strategy and implementation	- Work with Workforce Sub-Committee to identify competency and training gaps, provide trainers and training to meet identified training needs, hold joint training sessions and coordinate recruitment strategies
Other Bronx PPS	Collaborate with BPHC to identify commonalities for more effective use of resources	- Collaborate with BPHC on Bronx-wide force and DSRIP communication strategies, e.g., a single tool for communications

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
		and messaging to public and possibly unified workforce recruitment strategies and training initiatives

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.

Shared IT infrastructure will be important because it will enable the Executive Committee and the Sub-Committees to analyze data obtained from all participating providers in order to effectively monitor and improve the PPS's performance.

BPHC has created a public-facing website for the PPS (www.bronxphc.org), on which materials from all-Member meetings, updates from the Rapid Deployment Collaboratives, and other important documents will be posted. The website contains a calendar of key events for stakeholders, and a jobs page to connect community members and frontline workers to DSRIP-related employment opportunities. In addition, BPHC has created a member portal for PAC members through the platform Directors Desk. Materials and minutes from all Committee and Sub-Committee meetings will be posted to the PAC portal unless deemed confidential.

IPQR Module 2.8 - Progress Reporting

Instructions :

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

Success will be measured by (1) the occurrence of meetings of the Executive Committee, Finance and Sustainability Sub-Committee, Workforce Sub-Committee, Quality and Care Innovation Sub-Committee, Information Technology Sub-Committee, and Nominating Committee at a frequency in accordance with the applicable charter, (2) implementation of PPS policies and procedures, and (3) execution of the Base Agreement and project schedules by BPHC and Participants (including CBOs) and performance by BPHC and Participants (including CBOs) of obligations against the Base Agreement. We will also monitor the performance reporting dashboard in order to track the progress of each DSRIP project against key quarterly milestones and metrics and produce progress reports that summarize the status for review by the Executive Committee and the Sub-Committees. A subset of key indicators will be posted to the BPHC website to ensure all PPS members and the community are kept up to speed on PPS progress.

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	12/31/2015	12/31/2015	DY1 Q3	YES
Task Develop Finance and Sustainability Sub-Committee charter	Completed	Develop Finance and Sustainability Sub-Committee charter and present to Executive Committee for review and approval.	04/01/2015	04/16/2015	04/01/2015	04/16/2015	06/30/2015	DY1 Q1	
Task Appoint Sub-Committee members	Completed	Identify and appoint Finance and Sustainability (F&S) Sub-Committee members with financial leaders from PPS member organizations. Appoint SBH's CFO and a finance executive from Montefiore as the initial co-chairpersons.	04/01/2015	04/29/2015	04/01/2015	04/29/2015	06/30/2015	DY1 Q1	
Task Initiate Sub-Committee and report to EC	Completed	Conduct initial meeting of the F&S Sub-Committee meeting. Document Finance and Sustainability Sub-Committee actions and provide first report to Executive Committee.	05/01/2015	05/20/2015	05/01/2015	05/20/2015	06/30/2015	DY1 Q1	
Task Create PPS bank account	Completed	Set up a separate bank account and treasury function for PPS that is separate and distinct from SBH.	04/02/2015	06/30/2015	04/02/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Establish policies and procedures	Completed	Develop and finalize financial policies and procedures, reporting structure and roles and responsibilities for the PPS including CSO operation expenses, and expenses of PPS support services related to the DSRIP projects undertaken. Roles and responsibilities will be defined for CSO finance staff, SBH CFO in relationship to PPS, and role of PPS partners.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Obtain EC approval of financial framework	Completed	Obtain Executive Committee sign-off of PPS finance structure, policies and procedures.	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Perform network financial health current state	Completed	This milestone must be completed by 3/31/2016. Network	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
assessment and develop financial sustainability strategy to address key issues.		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							
Task Conduct assessment of financial impact of DSRIP projects	Completed	Assess financial impact of DSRIP projects on participating provider types based on revenue gains or losses associated with achieving required metrics. Present findings to the Finance and Sustainability Sub-Committee and Executive Committee.	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Conduct assessment of current state of financial health	Completed	Conduct financial health current state assessment utilizing assessment tool developed during the DSRIP planning phase for partners added since the first assessment was completed.	09/01/2015	11/15/2015	09/01/2015	11/15/2015	12/31/2015	DY1 Q3	
Task Analyze results of assessments	Completed	Analyze results of financial health current state assessment and the financial impact of projects assessment, and, if applicable, identify financially frail partners. Review with Finance and Sustainability Sub-Committee and Executive Committee.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Establish reporting and monitoring processes	Completed	Establish a process for identifying, monitoring and assisting financially frail partners. Define partner reporting requirements and the role of the CSO Provider Engagement Team and the Finance and Sustainability Sub-Committee. Present to the Executive Committee for review and approval.	11/15/2015	01/31/2016	11/15/2015	01/31/2016	03/31/2016	DY1 Q4	
Task Conduct first annual review	Completed	Perform first annual review of the financial health current state assessment tool and revise as needed to capture key financial health and sustainability indicators. Present to the Executive Committee for review and approval.	01/15/2016	02/28/2016	01/15/2016	02/28/2016	03/31/2016	DY1 Q4	
Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Completed	This milestone must be completed by 12/31/2015. Finalized Compliance Plan (for PPS Lead).	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
Task Appoint Compliance Committee leadership	Completed	Appoint CSO lead as a member of the compliance committee. Appoint SBH's compliance officer as interim compliance officer for the PPS	04/01/2015	07/10/2015	04/01/2015	07/10/2015	09/30/2015	DY1 Q2	
Task Identify Compliance Officer	Completed	Identify a Compliance Officer who has an expertise in NYSSS Law 363-d.	07/01/2015	08/30/2015	07/01/2015	08/30/2015	09/30/2015	DY1 Q2	
Task Hire Compliance Officer	Completed	Hire or designate PPS Compliance Officer who will report to legal affairs department of SBH and its compliance officer. The Compliance Officer will conduct internal control and will develop a Compliance plan consistent with NYS SSL 363-d and OMIG requirements for DSRIP.	06/15/2015	07/31/2015	06/15/2015	07/31/2015	09/30/2015	DY1 Q2	
Task Establish compliance enforcement procedures	Completed	Establish PPS chain-of-command for compliance enforcement including relationship between the compliance function and the PPS governance structure.	07/15/2015	09/30/2015	07/15/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Establish compliance plan	Completed	Customize PPS lead's existing compliance plan and programs (e.g., HIPAA) for the PPS, consistent with NYS Social Services Law 363-d, OMIG requirements and present to the Executive Committee for approval.	07/15/2015	11/10/2015	07/15/2015	11/10/2015	12/31/2015	DY1 Q3	
Task Integrate compliance requirements into MSA	Completed	Incorporate compliance requirements into Master DSRIP Services Agreement as appropriate to ensure participant compliance with NYS Social Services Law 363-d.	07/15/2015	11/15/2015	07/15/2015	11/15/2015	12/31/2015	DY1 Q3	
Task Share compliance plan with partners	Completed	Publish PPS Compliance Plan (including standards of conduct, conflicts of interest, receipt of complaints/no retaliation policies, and monitoring procedures) and share with all partners and post to PPS website.	07/15/2015	11/30/2015	07/15/2015	11/30/2015	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 09/30/2016. Value-based payment plan, signed off by PPS board.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	YES
Task Identify subject matter experts for leadership positions	Completed	Recruit senior Medicaid MCO leadership to serve on Executive Committee. Identify and appoint HMO industry expert to F&S Sub-Committee.	04/01/2015	05/21/2015	04/01/2015	05/21/2015	06/30/2015	DY1 Q1	
Task Review VBP guidelines	Completed	Review final state value-based payment prototype and roadmap upon release.	07/01/2015	08/31/2015	07/01/2015	08/31/2015	09/30/2015	DY1 Q2	
Task Establish VBP payment assessment procedures	Completed	Develop value-based payment assessment and annual assessment process. Present to the Executive Committee for	08/01/2015	09/30/2015	08/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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DSRIP Implementation Plan Project

SBH Health System (PPS ID:36)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		review and approval.							
Task Assess current VBP arrangements	Completed	Develop detailed analysis of PPS partners' existing value-based payment arrangements with Medicaid MCOs and other payers by reviewing claims-level data. A survey will be administered based on the defined VBP assessment procedures. Assessment will likely begin with larger organizations that already have significant VBP contracts and make up the majority of activity within the PPS and are actively participating in PPS leadership.	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Engage MCOs in VBP planning	Completed	Identify MCOs in BPHC PPS catchment area and actively engage them in developing value-based payment arrangements through a structured stakeholder engagement process.	09/01/2015	11/15/2015	09/01/2015	11/15/2015	12/31/2015	DY1 Q3	
Task Develop VBP education and engagement strategy	Completed	Develop provider education and engagement strategy through a structured stakeholder engagement process, which will facilitate participant understanding of and input to value-based payments and potential contracting arrangements.	08/15/2015	11/30/2015	08/15/2015	11/30/2015	12/31/2015	DY1 Q3	
Task Hold regular meetings with MCOs	Completed	Initiate monthly meetings with MCOs and engage in development of MCO strategy framework for BPHC PPS.	08/15/2015	11/30/2015	08/15/2015	11/30/2015	12/31/2015	DY1 Q3	
Task Engage PPS providers in VBP education and planning	Completed	BPHC is working with Montefiore Hospital to leverage their experience and strategy to develop their VBP rates for the PPS. Montefiore Hospital is experienced with Value Based Purchasing contracts for Medicaid Managed Care and for their Accountable Care Organization (ACO) and will play a key role in the development of VBP rates.	12/01/2015	02/15/2016	12/01/2015	02/15/2016	03/31/2016	DY1 Q4	
Task Establish methodology for estimating revenue and determining value	Completed	In coordination with Finance and Sustainability Committee, develop methodology for estimating revenue and determining value. Review and obtain sign-off from Executive Committee.	11/01/2015	01/31/2016	11/01/2015	01/31/2016	03/31/2016	DY1 Q4	
Task Conduct first annual assessment of VBP	Completed	Perform the first annual assessment of the current state of value-based payment and associated revenue across all PPS partners.	11/01/2015	01/31/2016	11/01/2015	01/31/2016	03/31/2016	DY1 Q4	
Task Establish compensation and MCO strategy framework	Completed	Develop preferred compensation and MCO strategy framework. Review and obtain sign-off with Executive Committee.	11/15/2015	01/31/2016	11/15/2015	01/31/2016	03/31/2016	DY1 Q4	
Task Establish methodology for PPS members to	Completed	In coordination with Finance and Sustainability Committee, develop plan to show how PPS members will demonstrate	09/01/2015	10/31/2015	09/01/2015	10/31/2015	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
demonstrate value		value to MCOs.							
Task Establish VBP sub working group within the F&S Subcommittee	Completed	Establish a sub working group of the F&S subcommittee. This sub working group will develop a plan for the best way to assess the current state of VBP that is compliant with BPHC Antitrust policies. Representatives will be able to represent the current state within their own organizations	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
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 3/31/2017. Value-based payment plan, signed off by PPS board.	07/15/2015	03/31/2017	07/15/2015	03/31/2017	03/31/2017	DY2 Q4	YES
Task Review VBP guidelines	Completed	Review final state value-based payment prototype and road map upon release.	07/15/2015	08/31/2015	07/15/2015	08/31/2015	09/30/2015	DY1 Q2	
Task Review baseline assessment of VBP current state	Completed	Review baseline assessment of partners' value-based payment revenue to inform development of PPS value-based payment plan.	02/01/2016	04/30/2016	02/01/2016	04/30/2016	06/30/2016	DY2 Q1	
Task Conduct gap analysis	Completed	Conduct gap assessment between PPS's current volume of value-based revenue and target of 90% across the PPS network.	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Engage MCOs in creation of transition plan	Completed	Engage MCOs in development of value-based purchasing transition plan.	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Engage providers in creation of transition plan	Completed	Engage PPS providers in development of the value-based purchasing transition plan, provider adoption strategy, reporting requirements and procedures.	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Establish reporting requirements and procedures	Completed	Establish partner value-based payment reporting requirements and procedures to enable ongoing monitoring of PPS value-based payment revenue.	03/01/2016	05/31/2016	03/01/2016	05/31/2016	06/30/2016	DY2 Q1	
Task Determine organizational requirements for transition	Completed	Define PPS organizational requirements necessary to support transition to value-based payment.	03/01/2016	04/30/2016	03/01/2016	04/30/2016	06/30/2016	DY2 Q1	
Task Establish VBP transition plan	In Progress	Finalize PPS value-based payment transition plan and provider adoption strategy in the timeframe required by DSRIP guidelines. Present to Executive Committee for approval.	06/01/2016	09/30/2016	06/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Finalize VBP reporting schedule	In Progress	Establish a monthly Executive Committee value based payment reporting schedule that will continue throughout	06/01/2016	09/30/2016	06/01/2016	09/30/2016	09/30/2016	DY2 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		DSRIP years.							
Task Begin expanding existing VBP arrangements	Not Started	SBH and MMC will expand the lives in their existing fully capitated arrangements starting in DY2	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Begin to pursue shared saving arrangements and risk-sharing	Not Started	Introduce partners to value-based contracting arrangements at a lower level of risk by pursuing shared savings arrangements, gradually converting to risk-sharing arrangements over time	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Expand VBP arrangements throughout PPS	Not Started	Expand the level of risk and capitation assumed by BPHC partners as the capabilities of PPS members increase	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Milestone #6 Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Milestone #7 Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Milestone #8 >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description
Finalize PPS finance structure, including reporting structure	If there have been changes, please describe those changes and upload any supporting documentation as necessary.	Please state if there have been any changes during this reporting quarter. Please state yes or no in the corresponding narrative box.

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
Finalize PPS finance structure, including reporting structure	Completed in DY1 Q3. No changes have been made to the finance/reporting structure.
Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	Completed in DY1 Q4. No changes have been made to the financial sustainability strategy.
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Completed in DY1 Q3. No changes have been made to the compliance plan.
Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	BPHC continues to gather and assess all facets of existing and potential value-based payment (VBP) arrangements and the related infrastructure within the PPS. While further guidance is expected from New York State with regard to creating a 5-year plan to achieve 90% VBP across the PPS network, BPHC is taking several steps to corral the various components that will need to be developed and/or enhanced going forward. The components include, but are not limited to, evaluating existing infrastructure and processes, understanding the VBP impact across non-Hospital providers such as FQHCs, Behavior Health (Article 31 and 32) and CBOs and determining which Medicaid Managed Care entities have the ability to administer this type of contracting. In May 2016, BPHC engaged Manatt to assist with VBP planning efforts. The engagement's objective is to assist BPHC with VBP modeling and understanding the various contractual arrangements that may be used. The engagement also focuses on the current structures and capabilities of the Montefiore ACO and analyzing the features of the VBP Innovator Pilot program which Montefiore and SBH Health System are pursuing. Several meetings have taken place between Montefiore's Care Management Organization (CMO) and BPHC leadership to assess capacity, business functions, data support features, contracting options and legal structures. The approach of this engagement recognizes the nuances of certain service providers and physician groups within BPHC where an existing Montefiore ACO may not be suitable. BPHC will analyze which funding methodologies and data platforms are effective and can be leveraged vs. those that may require other needs and financial structures. The results of this engagement will significantly enhance the assessment efforts for this milestone and will serve as a foundation for the overall 5-year plan. As noted in prior milestone reporting, the financial stability survey directed to PPS participants included questions regarding percentage of patient service revenue that is currently being realized through VBP. Only the Hospitals, Montefiore and SBH, have more than 5% of its respective patient service revenue coming from VBP arrangements. Recognizing the broad number of non-Hospital providers within the PPS, BPHC is pro-actively communicating with a variety of PPS participants to understand their book of business, revenue streams and the impact VBP will have on their respective financial operations. Through EIP and EPP discussions and reporting, BPHC is actively engaged with MCOs. In the context of establishing a baseline and determining VBP-readiness at the payer level, however, there is evidence that certain MCOs do not have the personnel or information technology infrastructure to engage in VBP discussion. This gap will be critically reviewed in conjunction with finalizing the 5-year plan by the end of DY2. The VBP assessment efforts have begun at the Finance & Sustainability Subcommittee level. Because of its impact on PPS participants and the presence of Medicaid managed care organizations within BPHC provider network, VBP discussions are also actively discussed at the Executive Committee level. This milestone is on track to be completed by September 30, 2016 with a significant amount of information to come together from the Manatt engagement and ongoing discussions with non-Hospital PPS participants. This milestone is on track for completion by DY2Q2.
Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	BPHC's plan towards achieving 90% VBP across the PPS network by DY5 has evolved from one where the intention was to work directly with Medicaid MCOs to one that follows Montefiore's foundational work with ACO's and now, most recently, with the Innovator program. Through the assessment efforts outlined in Milestone 4, BPHC will evaluate the benefits and resource needs in the context of the BPHC constituency. Montefiore has established its ACO IPA as the contracting entity for current and future value based arrangements. Moreover, the Montefiore ACO IPA is mature and its affiliated IPAs currently have several Level 2 and 3 contracts in place today that may be effective for certain PPS members. This is currently on track and will be addressed as part of the larger plan.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	From a more granular perspective, this milestone has several layers and requires a significant amount of due diligence. BPHC recognizes that all providers are different and that the VBP strategy needs to be tailored for a variety of licensed providers. Because of this, BPHC's objective is to establish and/or leverage a governance structure that allows for broad accommodations and complete transparency. BPHC has also discussed the need to use a VBP analytics vendor such as Aver or COPE Health Solutions to assist with fund flow models for subpopulations such as behavioral health. Before a plan has been crafted, BPHC and SBH leadership are looking to prove out VBP concepts and work closely with community behavioral health providers and care management agencies. Through our VBP Workgroup discussion, provider members also identified potential hurdles or open questions that need to be addressed in conjunction with finalizing a plan before DY2Q4. The F&SS outlined several items that need to be considered in the overall process of developing a plan, some of which could have a negative impact on VBP implementation and its long-term sustainability. Some of the issues that will be discussed in the next several months include the following: • MCOs are not being made whole for VBP readiness and the investment in technology and personnel to administer are not yet established. Some MCOs are significantly more advanced than others in their ability to administer shared savings. • FQHCs are benefited by the 1115 Waiver and Federal wrap-around payment. The plan needs to address the dynamics of VBP contracting and its impact on the existing methodology and federal mandate. • How VBP works in concert with other State programs including, but not limited to, HARP, FIDA, and PACE. • Rebasing may be a major concern. There are lessons learned from Montefiore's Pioneer ACO including a rebasing of the fees that will lower premiums in future years and mitigate the savings opportunities that could be put towards investing in other healthcare costs (i.e., labor union salary increases, capital investments, technology support, etc.). • There are concerns that VBP starting point is "current Medicaid claims payments" which do not cover costs. With high denials and reimbursement at 80% of Medicare rates, the baseline for VBP will be inherently understated. • There is a lack of data from NYS on claims information and how covered lives are assigned is creating concerns about the ability to streamline healthcare services. Also, claims data need to be reconciled to actual costs incurred as claims payments do not always equal cost of care. Overall, VBP discussions have generated a great deal of dialogue as well as uncertainty. Through the BPHC Finance & Sustainability Subcommittee and Executive Committee, VBP planning is being discussed in a granular fashion to ensure transparency and address provider-specific concerns. BPHC will continue to review processes in the context of achieving this milestone and finalizing a plan that is in the interest of the PPS membership as a whole.
Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	
Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	
>=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	

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IPQR Module 3.2 - PPS Defined Milestones

Instructions :

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

Milestone/Task Name	Status	Description	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.

1) If BPHC fails to report on state-established milestones or meet prescribed metrics and measures, we risk having limited availability of funds to distribute to partners. To mitigate this risk, BPHC continues to engage in a thoughtful planning and monitoring process to ensure it achieves DSRIP milestones and metrics efficiently and effectively. Meticulous work plans have been developed to help network partners meet patient engagement targets and pay-for-performance measures benchmarks. In addition, BPHC developed a budget model that assumed underperformance and incomplete target achievement. As a result, we discounted anticipated DSRIP payments and contained the BPHC budget. Furthermore, we included language in each of our MSA schedules and contracts indicating that BPHC would only pay with DSRIP funds once received and discontinue the agreement in the event that DSRIP funds were not available.

2) Failure to be awarded CRFP funds will impact PPS project implementation and performance, as some projects require capital investments not covered by DSRIP waiver funds. SBH/BPHC was not awarded CRFP funds and is moving forward with its own resources to help the PPS achieve its goals and create a healthy community. Unavailability of capital funds may create significant risks, to core IT functionality and interoperability programs. We will work to meet these challenges by identifying additional sources of funding for interconnectivity and capital-intensive projects, and continue to attempt to engage the State in conversation.

3) Initial assessment of the financial health of its partner organizations showed that while a majority were "not immediately fragile," a small number were identified as moderately fragile or fragile. To mitigate this risk, BPHC, through its Finance and Sustainability Sub-Committee and CSO Provider Engagement Team, will develop a process for timely monitoring of financially at risk partners. BPHC will also establish a process to determine and ensure that the PPS, through its member organizations, has the capacity and range of services to address the needs of our attribution in case any of the at risk partners will diminish the services it can provide.

4) The transition to value-based payment (VBP) across the PPS requires engagement and willingness from Medicaid managed care organizations (MCOs) to transform existing contracts into DSRIP-aligned VBP contracts over 5 years. BPHC will continue the effort to ensure MCOs are meaningfully engaged in developing transition plans and have time to prepare for the transition to VBP.

5) Several third-party groups will have a significant impact on patient outcomes and overall success of the PPS, but they depend on extraneous revenue streams. NYC-run social service agencies and CBOs are dependent on city and state funding and charitable support. While MCOs will be supported by NYS in this restructuring, local community and county agencies face a host of outside influences that could impair their ability to support the PPS in a meaningful way. Timely funding of EIP funds and NPV funds from the state will impact the involvement of CBOs that have major effects in the restructure of a VBP system.

6) For the PPS to meet reporting requirements, it needs access to data for financial reporting. This requires appropriate processes and mechanisms to allow providers to perform and provide timely information. The PPS intends to mitigate this risk by engaging its participants to assist in the development and implementation of appropriate reporting requirements and structures.

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IPQR Module 3.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

• Performance Reporting: Identify point-of-contact in each partner organization for finance-related matters (e.g., reporting and policies/procedures); base partner reporting requirements on DSRIP reporting milestones/metrics; performance reporting infrastructure that supports provider, practice, and organization-level reporting and evaluation to drive DSRIP incentive payments (note: performance reporting and incentive payments will be detailed in each Participant's Master Services Agreement).
• Governance: The PPS governance structure must be capable of executing financial responsibilities; the PPS governance structure must evolve to incorporate Medicaid MCOs to support transition to value-based payment.
• IT: The PPS IT systems must support central finance and performance reporting to inform and track PPS and project-level budgets and funds flow; the PPS IT systems must support population health management to enable partners to improve patient outcomes that will drive the transition to value-based payment with Medicaid MCOs and other payers.
• Physician Engagement: The PPS must effectively engage and educate physicians regarding DSRIP's incentive-based funding structure, including contractual obligations associated with project-specific clinical interventions, Domain 1 requirements and their relationship to incentive payments.

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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
BPHC Executive Director	Irene Kaufmann	Overall financial sustainability plan
BPHC Director of Financial Planning	Ronald Sextus	Overall implementation of financial strategy and sustainability plan
SBH CFO	Todd Gorlewski	Oversight of the sustainability plan
BPHC Sr. Accountant	Janneth Gaona	Setting up GL and maintenance of all BPHC revenue and expense accounts. Reconciling and Managing BPHC Bank accounts.
BPHC Compliance Officer	Suzette Gordon	Oversight of the compliance strategy
BPHC External Independent Auditor	Ernst & Young	Independent auditor will audit annually and report to the Finance and Executive Committee that the recording of accounting are done according to GAAP and are in compliance.

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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		
BPHC CSO Business Staff	Accountable for integration and effective financial plan	Oversight and integration of finances into BPHC operations
BPHC Finance and Sustainability Sub-Committee	Governance for effective integration and use of IT, centrally and across partners	Oversight and integration of finance plan into BPHC operations
SBH Management/Leadership	Fiduciary oversight for effective financial plans	Oversight of BPHC financial operations
BPHC Executive Committee	Governance for effective and sustainable financial strategy	Governance structure with PPS-wide representation, makes policy decisions and provides direction for effective and sustainable financial strategy
BPHC Compliance Officer	Oversight and advice on the compliance plan and audits	Oversight and advice on financial compliance and audit
BPHC Senior Director of Quality Management and Analytics	Accountable for providing required quality data in a timely manner	Quality data support
SBH IT team	Support the financial functions with the existing IT infrastructure and data streams	Support with the technical infrastructure
BPHC member organizations	Work within financial models to ensure BPHC success	Provide services according to master contract requirements
External Stakeholders		
External Auditor - Ernyst & Young	Conduct the annual audit	Complete audit documentation and recommendation
Hudson Valley PPS	Align financial models for paying and incenting providers and provider organizations with those developed by BPHC	Financial models and master contract agreements
Bronx Chamber of Commerce	Coordinate with the BCC in order for local businesses to increase employment opportunities for the local community.	Participating in events geared towards employment opportunities that foster local community development.
Bronx Business Improvement Districts	Working with Bronx BIDs and local CBOs to increase their involvement in local economic empowerment of the community.	Meeting with Bronx BIDs such as Fordham BID, Belmont BID and others to identify programs and opportunities that the community can benefit from.
Community Boards	Community Boards will participate in identifying the local community needs and concerns.	BPHC will participate in Local Community Board Meeting, Educate them about DSRIP and learn from them about the community needs and how to improve them.
Bronx Elected Officials	Work with the various Bronx Elected Officials and CBOs to address social determinants of health to improve the overall health of Bronx residents.	Work with Bronx Elected Officials and CBOs to host forums in addressing how to improve the overall health and economics of the community.

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Medicaid Managed Care Health Plans	Monitor performance of financial models and use them to develop value-based contracting	Initiate development of value-based contracting with PPS hospitals and their providers

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IPQR Module 3.7 - IT Expectations

Instructions :

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

The PPS will require appropriate IT systems to support central and PPS-wide reporting capabilities to support performance reporting, track PPS and project-level budgets and funds flow, and monitor financial sustainability. The systems will need to support PPS financial analysis reports, performance metrics reporting, and PPS-specific financial statements. When conducive, BPHC will leverage existing back-office systems within St. Barnabas Hospital and Montefiore. In terms of funds flow, treasury and general ledger, however, SBH has created a separate general ledger platform and banking arrangement to ensure that the restrictive nature and purpose of the intended funds are directed accurately with complete documentation for audit purposes. PPS-wide IT systems and health information exchanges that support care management and population health management will be required to enable partners to improve patient outcomes that will drive the transition to value-based payment with Medicaid MCOs and other payers.

IPQR Module 3.8 - Progress Reporting

Instructions :

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

The success of this workstream will be measured on the financial stability of the participants in the PPS, PPS adherence to a compliance plan consistent with NY State Social Services Law 363-d, and the migration from the current level of VBP across PPS provider participants to 90% of the total MCO-PPS payments captured in at least Level 1 VBPs, with more than 70% in Level 2 VBPs or higher.
The PPS has already done an initial assessment of the financial stability of its lead organization and its partners. It is currently expanding this initial assessment to new partners that have joined the PPS since the first assessment was completed. The assessment itself will be evaluated for potential updates and will be administered to all PPS participants annually. The Finance and Sustainability Sub-Committee will charged with updating the assessment as required, administering the evaluation and analyzing the results of the assessments. It will determine the need for potential interventions and initiate more robust monitoring of any financial fragile partners. The provider engagement team of the CSO and the Finance and Sustainability Sub-Committee will report findings from the assessment and monitoring activities regularly to the Executive Committee.

The PPS will publish its compliance plan and conduct quarterly compliance meetings. There will be quarterly and annual compliance reports as well as an annual review of the compliance plan itself to determine if additional changes are required.
The PPS has good visibility into the VBPs of its lead organization as well as some of the larger provider organizations participating in the PPS. It will develop an initial assessment to develop a complete baseline assessment of revenue linked to VBPs across all participants. The PPS will implement reporting requirements to monitor revenue linked to VBPs to regularly assess our performance against our plan to achieving 90% VBPs.

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Starting in DY1, Q3 the PPS began to engage MCOs and providers to develop the appropriate reporting requirements and procedures to meet the quarterly reporting requirements to the state.

IPQR Module 3.9 - IA Monitoring

Instructions :

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Section 04 – Cultural Competency & Health Literacy

IPQR Module 4.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize cultural competency / health literacy strategy.	Completed	This milestone must be completed by 12/31/2015. Cultural competency / health literacy strategy signed off by PPS Board. The strategy should: -- Identify priority groups experiencing health disparities (based on your CNA and other analyses); -- Identify key factors to improve access to quality primary, behavioral health, and preventive health care -- Define plans for two-way communication with the population and community groups through specific community forums -- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors); and -- Identify community-based interventions to reduce health disparities and improve outcomes.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Initiate QCIS to support CC/HL strategy.	Completed	Establish and convene a Quality and Care Innovation Sub-Committee (QCIS) to support development of a PPS-wide cultural competency and health literacy strategy (CC/HL).	06/05/2015	06/30/2015	06/05/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Inventory existing CC/HL programs in PPS	Completed	Conduct an inventory of existing CC/HL programs across PPS members and identify assets and gaps that should be addressed in CC/HL strategy.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Identify priority populations and locations	Completed	Through CNA and PPS member surveys, identify priority populations and neighborhoods experiencing health disparities and having low literacy. Particular attention to be focused on immigrant populations and populations	05/18/2015	09/30/2015	05/18/2015	09/30/2015	09/30/2015	DY1 Q2	

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		experiencing food and/or housing insecurity. Furthermore the strategy should target neighborhoods designated as Medically Underserved Areas and populations residing along the corridor of concentrated preventable admissions, stretching from Fordham-Bronx Park, down the Grand Concourse, to the South Bronx.							
Task Identify best practices in interventions to reduce health disparities	Completed	Gather information from key stakeholders with expertise on CC/HL to identify PPS and community-based interventions to reduce health disparities and improve outcomes.	05/18/2015	09/30/2015	05/18/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop CC/HL strategy and action plan	Completed	Convene a CC/HL work group including co-chairs of the QCIS and CBO member leadership supported by the Director of Collaboration and the Director of Workforce Innovation. This group will utilize findings from CNA, inventory of providers, best practice experts and stakeholders to develop a CC/HL strategy and action plan. Strategy and action plan will include 1) specific initiatives such as remote simultaneous medical interpretation, 2) identified stigmatized populations such as the mentally ill and SUD, 3) standards for member organizations and 4) requirements and timing for training and re-training staff, in concert with implementation of the clinical projects.	05/18/2015	12/31/2015	05/18/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Partner with CBOs	Completed	In conjunction with the Director of Collaboration, seek partnerships with CBOs with experience and success in cultural competency and health literacy strategies (e.g. Health People, etc) to participate in the implementation of the CC/HL strategy.	05/18/2015	12/31/2015	05/18/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop an evaluation plan	Completed	Develop a plan for evaluating the effectiveness of the CC/HL strategy.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Obtain approval for CC/HL strategy and action plan	Completed	Present CC/HL plan to Quality and Care Innovation Sub-Committee then Executive Committee for approval	10/06/2015	12/17/2015	10/06/2015	12/17/2015	12/31/2015	DY1 Q3	
Milestone #2 Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	Completed	This milestone must be completed by 6/30/2016. Cultural competency training strategy, signed off by PPS Board. The strategy should include: -- Training plans for clinicians, focused on available evidence-based research addressing health disparities for particular	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
		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 Initiate development of health disparities training strategy	Completed	Convene Workforce Sub-Committee and QCIS to support development of health disparities training strategy.	05/22/2015	06/05/2015	05/22/2015	06/05/2015	06/30/2015	DY1 Q1	
Task Inventory training best practices	Completed	Perform inventory of existing training programs within the PPS and identify best practices to leverage (as part of strengths/gaps assessment in Milestone 1).	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Identify key features of training plans	Completed	Based on inventory and research, identify key features of training plans, including scope of providers trained, mechanisms for delivering training services, and frequency of offerings (e.g., semiannual).	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Obtain approval for training plan	Completed	Vet training plan through Workforce Sub-Committee, QCIS and Executive Committee.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Develop a reporting plan for training program	Completed	Develop a plan for conducting ongoing quarterly reports on training program.	06/01/2015	06/30/2016	06/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Communicate training strategy to providers	Completed	Present the training strategy to PPS providers through the rapid deployment collaboratives.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize cultural competency / health literacy strategy.	zstopak	Templates	36_DY2Q1_CCHL_MDL41_PRES1_TEMPL_DY2_Q1_-_CCHL_Meeting_Schedule_4668.xlsx	Meeting schedule template	08/01/2016 01:56 PM
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate	zstopak	Report(s)	36_DY2Q1_CCHL_MDL41_PRES2_RPT_Remediation_Narratives_5869.docx	narrative	09/15/2016 05:28 PM
	zstopak	Templates	36_DY2Q1_CCHL_MDL41_PRES2_TEMPL_Rem	remediation - training schedule	09/15/2016 05:28 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
material).			ediation_CCHL_M2_Cultural_Competency_Training_Schedule_DY2Q1_9.14.16_5868.xlsx		
	zstopak	Documentation/Certification	36_DY2Q1_CCHL_MDL41_PRES2_DOC_Remediation_CCHL_M2_Cultural_Competency_Training_Strategy_Revised_FINAL_5867.DOC	remediation - revised strategy	09/15/2016 05:27 PM
	zstopak	Meeting Materials	36_DY2Q1_CCHL_MDL41_PRES2_MM_Board_Approval_-_EC_Meeting_Minutes_07_21_16_5480.docx	Evidence of Board Approval	08/04/2016 05:09 PM
	sgjevuka	Training Documentation	36_DY2Q1_CCHL_MDL41_PRES2_TRAIN_Cultural_Competency_Training_Strategy_FINAL_7_19_16_4371.doc	Cultural Competency Training Strategy	07/28/2016 11:36 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize cultural competency / health literacy strategy.	The major emphasis during DY2Q1 has been to complete the second Cultural competency milestone, which is the development of a training strategy focused on addressing the drivers of health disparities beyond the availability of language-appropriate materials. Additionally, the BPHC Community Engagement Work Group, composed of representatives from our community-based social and human service organizations, along with members of the Quality and Care Innovation and the Cultural Responsiveness Work Group, have collectively identified some essential areas of health literacy knowledge and healthcare system navigation skills that our community should have. These include subjects such as: seeking and using health insurance, understanding the purpose and importance of primary care and behavioral health, choosing the right care setting at the right time, the role of a care plan and using it to achieve health goals, nutrition, exercise and healthy lifestyle habits and patient consent to sharing information with other providers of care. Because BPHC believes that models in which peer educators and community health workers educate community populations, the PPS has made plans to select community-based organizations to deliver the community health literacy curriculum. These community-based organizations will be trained, funded and incentivized by BPHC to train clients and community residents.
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	BPHC has completed and submitted the cultural competency training strategy this quarter, which reflects the combined efforts of the Cultural responsiveness work group with major inputs from multiple Community Based Organizations, project leads and workgroups. During DY2Q1, the Cultural Responsiveness Work Group held five meetings, attended two full day trainings (including a Poverty Simulation with members of PPSs in the Hudson Valley) held numerous meetings with Subject Matter Experts and sent out an LOI to 183 Community Based Organizations requesting their interest in training for specific populations. BPHC has also collaborated with other PPSs, particularly One City Health, in sharing best practices and resources. Major attention was paid to the target populations identified in the BPHC Cultural Competency Strategy, completed in DY1Q3. The BPHC Executive Committee voted to approve this strategy on July 27, 2016. BPHC has created a strategy that contains an inventory of necessary training for segments of the workforce providing various patient services, from providers to CBOs. The identified courses, explained in more detail in the Training Strategy Document include: Cultural Competency in the Bronx- for front line staff (current RFP for vendor)

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	Program to Identify and Address Healthcare Disparities for Immigrant Seniors- available as part of the BPHC Speaker's Bureau, at no cost to member organizations (CBO led) Cultural Competency Program for Home Health Aides- developed and led by CBOs BPHC Cultural Competency Leadership-led by the Jewish Board to examine and build mission, goals and strategies, values, policies and programs that promote effective, patient centered culturally competent care throughout Bronx Partners for Healthy Communities. Poverty Simulation- for representative teams from BPHC organizations with potential for cross PPS collaboration. Cultural Competency and the Social Determinants of Health for Practitioners- focus on Primary Care and Behavioral Health Practioners, to be delivered by the Center for Immigrant Health and Cancer Services Working with Behavior Health Patients- for primary care team members and care coordinators throughout the PPS, led by The New York Psychiatric Institute, Columbia University, Center for Cultural Competency- collaboration with One City Health PPS. Community Health Literacy Program- CBOs to provide training on basic concepts and strategies for using the transformed care delivery system more effectively. Topics include health insurance, primary care, using health care services effectively, care coordinators, care plans, consent to information sharing Trainings have not yet been conducted; therefore the training schedule template has not been attached.

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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.

Risk #1 - Extremely Diverse Linguistic Requirements and Low Literacy/Health Literacy:
The Bronx is one of the most diverse counties in New York State, and this rich diversity demands a culturally responsive system of care. However, the Community Needs Assessment findings indicate that immigrant and limited English-speaking populations in the Bronx experience barriers to accessing health care, including low quality language services, lack of culturally and linguistically competent providers, low literacy, and distrust of the healthcare system. Together, these issues could undermine the PPS's ability to engage patients in care.

Mitigation:
BPHC has developed mitigation strategies to address patient engagement, including working with our community-based organizations (CBOs) to drive a communication and education campaign focused on health literacy basics: using health services and primary care effectively, working with care coordinators to help manage health, and the reasons to sign consent forms, specifically the Bronx RHIO consent forms. The BPHC Cultural Responsiveness Training Strategy includes components for multiple front line staff roles and providers, and is dedicated to measurably improving the cultural and linguistic competence of the BPHC workforce.

Risk #2 - Recruiting and Workforce Challenges:
Securing a culturally competent workforce is key to patient engagement and the overall success of DSRIP. Yet hiring and recruiting locally-based, bilingual and/or otherwise culturally identifying frontline workers will be challenging, due both to the general shortage of qualified health workers and competition for similar workers among other PPSs.

Mitigation:
BPHC has developed mitigation strategies to address recruiting and workforce issues, including working with local colleges to promote community-based English Speakers of Other Languages (ESOL) and GED training programs for new workers; working with 1199 Training and Education Fund and PPS member organizations that have expertise recruiting local, peer-based, and other frontline staff; and recruiting community members to enroll in healthcare worker training courses. Recruitment of community members, particularly through CBOs, applies particularly to community health workers (CHWs), critical to our cultural competency strategy.

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.)

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BPHC's cultural competency and health literacy strategy has interdependencies with the workforce, IT, and clinical project workstreams.

• Workforce Workstream Dependencies: The provision of culturally competent care will depend on the success of the PPS's Bronx-centric recruitment and training strategy. As discussed, the PPS will work with 1199 TEF, CUNY, and contracted CBOs to develop training curricula that meet cultural competency and health literacy standards and incorporate these trainings into all new hire orientations, refresher courses, and provider agreements.

• Practitioner Engagement Workstream Dependencies: Practitioners play a key role in providing culturally competent care to patients. The importance of providing culturally competent care and best practices for how to do so will be a key part of the practitioner communication and engagement plan, which will include regular webinars, in-person, peer-to-peer learning forums, and participation in project-specific and a Patient Engagement-focused Rapid Deployment Collaborative. It will also be included in the training/education plan targeting practitioners and other professional groups as part of educating them about the DSRIP program and the PPS-specific quality improvement agenda.

• IT and Population Health Management Workstream Dependencies: Connecting patients to culturally competent resources is critical to improving patient outcomes. BPHC's care management technology will include fields to record patients' linguistic and cultural needs so that patients are matched to care managers, providers, and community-based organizations that can appropriately serve them.

• Clinical Workstreams Dependencies: The PPS's success will be heavily reliant on the success of its clinical projects. The PPS's project referral protocols and resources must be able to address the social, linguistic, cultural, behavioral and physical needs of patients. The PPS will make available a Web-based PPS-wide directory of CBOs. These efforts will help to ensure PPS-wide tools and resources meet health literacy/cultural competency standards and address patients' social needs in a culturally competent manner.

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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
Co-Chairs, Quality and Care Innovation Sub-Committee (QCIS)	Debbie Pantin, SAED, VIP Community Services, Dr. David Collymore, Medical Director, Acacia	Development and implementation of cultural competency/health literacy ("CC/HL") strategy
Quality and Care Innovation Sub-Committee	QCIS has 15 members with clinical experience relative to the specific projects. Membership includes: David Collymore, MD Acacia Network Megan Fogarty BronxWorks Pablo Idez, LMSW The Institute for Family Health Kenneth Jones, MD Morris Heights Health Center Loredan Ladogana, MD UCP of NYC Frank Maselli, MD Bronx United IPA Anne Meara, RN Montefiore Medical Center Beverly Mosquera, MD Comunilife Chris Norwood Health People Todd Ostrow CenterLight Health Center Debbie Pantin, LMSW VIP Community Services Rona Shapiro 1199SEIU Ed Telzak, MD SBH Health System Lizica Troneci, MD SBH Health System Dharti Vaghela Essen Medical Associates, P.C. Committee will review recommendations made by CWG, and make final decisions about PPS strategy for cultural competency/health literacy	Strategy for CC/HL, Practitioner Communication & Education, EB practice guidelines/clinical practices & protocols
Senior Director, DSRIP Care Delivery & Practice Innovations, BPHC CSO	Dr. J. Robin Moon	Advisor to the development of the CC/HL strategy
Director of Collaboration, BPHC CSO	Albert Alvarez	Develop outreach to CBOs to identify CC/HL needs for specific sub populations, diseases and locations in the Bronx
Workforce Sub-Committee	Mary Morris, Co-Chair, SBH Health System Rosa Mejias, Co-Chair, 1199 TEF	Training strategy for CC/HL
Cultural Competency/Health Literacy Work Group	Includes key players listed above including: Debbie Pantin, SAED VIP Community Services (co-chair of QCIS), Charmaine Ruddock, Project Director, Bronx REACH, Barbara Hart, Executive Director, The Bronx Health Link, Albert Alvarez, BPHC Director of	CC/HL strategy and standards developed and signed off by Executive Committee

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
	Collaboration, Mary Morris, BPHC Director of Workforce Innovation and Rosa Mejias, TEF (co-chair of the Workforce Subcommittee)	
Project Manager	Venus Goulbourne	Administrative management

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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		
Partner organization Providers and Staff	Participate and contribute to CC/HL PPS initiatives	Comply with identified standards
CBO partner liaisons that represent a range of socioeconomic, cultural and demographic backgrounds	Provide input and feedback to create CC/HL initiatives and strategy	Community stakeholder participation in meetings, town halls, focus groups and BPHC Cultural Competency/Health Literacy Work Group
Dr. Nicole Hollingsworth	Advisor	Best practice guidance
Arlene Allende, SBH	Advisor	Best practice guidance
Leanette Alvarado	Advisor	Best practice guidance
External Stakeholders		
BPHC patients	Provide feedback by participating in surveys and focus groups	Focus groups and patient satisfaction survey responses
Other Bronx PPSs	Potential collaboration in developing Bronx-wide CC/HL strategy	Bronx-wide CC/HL strategy
Bronx Community at large	Greater use of primary care providers, health self-management for chronic conditions & participation in educational programs sponsored by the PPS	Improved health outcomes, more jobs with "living wages"
TEF-Rosa Mejias, Co Chair, BPHC workforce Subcommittee	Best practice training research and programming	Support for training strategy for CC/HL

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.

Community health workers and other PPS care management staff will use a planned commercial care coordination management solution (CCMS) to support culturally competent outreach, education, care coordination referral, advocacy and other information provided to PPS patients. Based on protocols tailored to patient cultural cohorts, and on individual care plans where available, the CCMS will be used for such activities as:

• Running periodic reports to monitor cultural makeup and requirements of PPS patients, based on data collected in screenings, assessments, etc.

• Providing multilingual, multicultural care navigation and support

• Tracking and assisting patients with practice selection, active engagement in DSRIP programs, utilization tracking and pediatric-adult transitions

• Assisting patients with locating and accessing community resources, including for palliative care

• Supporting transitions and warm handoffs at discharge, with follow-up tracking

• Educating patients and families about wellness and care, and supporting patients in self-management and shared decision making related to their health needs

• Surveying patients and families regarding care experience.

Providers and staff in other workforce segments will be trained regarding specific population needs and effective patient engagement approaches.

IPQR Module 4.8 - Progress Reporting

Instructions :

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

BPHC will measure the success of our cultural competency/health literacy strategy through members' successful achievement of the Domain 1 CC/HL milestones as well as the milestones referenced above. BPHC will also measure progress through providers' participation in contracting agreements, which will incorporate the PPS's health literacy and cultural competency standards. The Senior Director for Quality Management and Analytics within the CSO will be responsible for conducting ongoing assessment of the PPS's cultural competency activities and related quality-improvement efforts.

Related to patient engagement and clinical improvement, BPHC's QCIS will be charged with overseeing implementation of clinical projects and holding providers and the PPS accountable for achieving targeted metrics and clinical outcomes. Further, because all BPHC projects were selected based on health disparities data within the CNA, achieving broader clinical targets will reflect favorably upon the PPS's success reducing health disparities and creating a culturally competent and linguistically appropriate system of care.

Additionally, BPHC will obtain feedback from providers on the effectiveness of cultural competency strategies and training programs. BPHC will also include cultural competency in BPHC patient satisfaction surveys in order to understand BPHC patient needs.

IPQR Module 4.9 - IA Monitoring

Instructions :

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Section 05 – IT Systems and Processes

IPQR Module 5.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	Completed	Detailed IT current state assessment. Relevant QEs (RHIOs/HIEs) should be involved in performing this assessment.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task Assess central PPS IT capabilities	Completed	Complete an assessment of IT capabilities for central PPS functions related to data collection requirements, performed by CSO in consultation with IT Sub-Committee.	04/01/2015	06/15/2015	04/01/2015	06/15/2015	06/30/2015	DY1 Q1	
Task Assess partner IT readiness	Completed	Organize, review and assess partner IT readiness assessment data collected to date re: EHR and other HIT platforms, RHIO/HIE adoption, interoperability/interfaces and data analytics/measurement/reporting capabilities.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Develop partner IT assessment database	Completed	Design, create and populate partner database to store partner IT assessment data.	04/01/2015	06/25/2015	04/01/2015	06/25/2015	06/30/2015	DY1 Q1	
Task Additional partner IT assessment	Completed	Conduct further data collection through partner surveys and interviews to fill gaps in partner data.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Assess current state of IT readiness	Completed	Review partner data to assess current state readiness re: EHRs, HIE, PCMH and other use of HIT.	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Share and validate findings	Completed	Communicate/validate findings and data-sharing requirement gaps with partners and Executive Committee.	12/15/2015	12/31/2015	12/15/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Document current state of IT readiness	Completed	Complete IT current state assessment supporting documentation for central PPS and partner IT.	10/15/2015	12/31/2015	10/15/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Develop an IT Change Management Strategy.	Completed	IT change management strategy, signed off by PPS Board. The strategy should include: -- Your approach to governance of the change process;	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
		-- A communication plan to manage communication and involvement of all stakeholders, including users; -- An education and training plan; -- An impact / risk assessment for the entire IT change process; and -- Defined workflows for authorizing and implementing IT changes							
Task Establish IT Sub-Committee	Completed	Establish IT Sub-Committee, reconstituted from IT & Analytics Planning Workgroup, incorporating new members according to governance nomination processes.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Document IT Sub-Committee Charter	Completed	Document IT Sub-Committee charter and processes including change management oversight.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Develop processes and protocols for partners	Completed	Create and update processes and protocols for adoption and use of IT that all partners must implement.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop communication and training for partners	Completed	Develop communication, education and training plans related to processes and protocols for adoption and use of IT.	08/30/2015	12/31/2015	08/30/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop impact and risk management strategy	Completed	Develop an impact and risk management strategy for IT change management.	11/02/2015	12/31/2015	11/02/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish workflows	Completed	Develop and document workflows for IT change management. Workflows may include (but are not limited to): Accepting change requests from partners and PPS leadership; Prioritizing and classifying changes; Coordinating assessment of change impact; Coordinating change approval; Planning/scheduling changes; Coordinating implementation of changes; Conducting testing and post-implementation reviews; and Providing management information about changes and change management performance.	12/07/2015	03/25/2016	12/07/2015	03/25/2016	03/31/2016	DY1 Q4	
Task Establish tracking and reporting structure	Completed	Develop approach for tracking and reporting on IT change management implementation.	01/11/2016	03/25/2016	01/11/2016	03/25/2016	03/31/2016	DY1 Q4	
Task Obtain EC approval of change management strategy	Completed	Obtain Executive Committee approval of IT governance and change management processes and policy.	02/01/2016	03/25/2016	02/01/2016	03/25/2016	03/31/2016	DY1 Q4	
Milestone #3 Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	Completed	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	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
		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).							
Task Survey current state of interoperability	Completed	Survey current clinical data-sharing and interoperability systems across PPS network to understand needs and requirements for specific hardware and software	04/01/2015	09/25/2015	04/01/2015	09/25/2015	09/30/2015	DY1 Q2	
Task Develop data exchange strategy	Completed	Establish priorities and develop plan for establishing data exchange capabilities and agreements with and among partners and vendors.	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Establish strategy for Care Coordination Management Solution implementation	Completed	Select and plan implementation and method of payment for of Care Coordination Management Solution across member organizations.	06/01/2015	09/15/2015	06/01/2015	09/15/2015	09/30/2015	DY1 Q2	
Task Integrate standards into partner contracts	Completed	Incorporate standards for clinical connectivity and funds flow into partner contracts.	09/15/2015	12/29/2015	09/15/2015	12/29/2015	12/31/2015	DY1 Q3	
Task Establish compliance strategy	Completed	Develop approach and establish governance for determining priorities and methods for promoting and ensuring partner compliance with connectivity standards and requirements.	10/19/2015	12/29/2015	10/19/2015	12/29/2015	12/31/2015	DY1 Q3	
Task Finalize clinical connectivity roadmap	Completed	Document clinical connectivity roadmap and obtain IT Sub-Committee approval.	11/02/2015	03/31/2016	11/02/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Share clinical connectivity plans with partners	Completed	Establish and communicate connectivity standards, priorities, compliance plan and partner support resources, including training plan and assistance program to partners.	12/07/2015	01/08/2016	12/07/2015	01/08/2016	03/31/2016	DY1 Q4	
Task Integrate standards into vendor contracts	Completed	Incorporate standards for clinical connectivity into vendor contracts and develop solutions where needed.	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Provide guidance on clinical data exchange	Completed	Document and provide partner guidance for exchanging clinical data set, including data sharing policies and procedures.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Conduct training on clinical data sharing and	Completed	Based on the systems implemented, in conjunction with workforce subcommittee, deploy training, i.e., on-site, in-	09/01/2015	03/31/2016	09/01/2015	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
interoperability		person and web-based learning management system.							
Task Ensure tracking of changes to data sharing agreements	Completed	Develop approach for tracking and reporting on changes to data sharing agreements.	01/11/2016	03/31/2016	01/11/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	Completed	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.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task Match attributed members	Completed	Validate/match attributed members against QE RHIO consents on file to inform engagement strategy/plan and develop a GAP analysis	08/03/2015	12/31/2015	08/03/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Review QE processes and challenges	Completed	Review current consent processes and lessons learned/challenges with QE consent.	09/01/2015	09/20/2015	09/01/2015	09/20/2015	09/30/2015	DY1 Q2	
Task Finalize strategy for obtaining consent	Completed	Develop recommendations for outreach and education of members for partners, clinical, MCO, or CBO, to follow; obtain IT Sub-Committee review and Executive Committee approval.	08/24/2015	12/31/2015	08/24/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop subscription alert strategy	Completed	Plan to implement subscription alerts or triggers through member touchpoints.	08/01/2015	09/30/2015	08/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Establish QE engagement reporting strategy	Completed	Develop approach for tracking and reporting partners' opprotunity to engage members in QE, possibly using patient health registries and communicate results to partners.	10/05/2015	11/28/2015	10/05/2015	11/28/2015	12/31/2015	DY1 Q3	
Milestone #5 Develop a data security and confidentiality plan.	Completed	Data security and confidentiality plan, signed off by PPS Board, including: -- Analysis of information security risks and design of controls to mitigate risks -- Plans for ongoing security testing and controls to be rolled out throughout network.	06/15/2015	03/31/2016	06/15/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Assess security risks and establish controls	Completed	Analyze information security risks, design controls and identify gaps that will include two factor authentication, data encryption requirements and data access.	06/15/2015	12/31/2015	06/15/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish CSO oversight for vendor security testing	Completed	Develop plan for ongoing CSO IT oversight - owned by Chief Security Information Officer - for vendor security testing, including multifactor authentication.	09/14/2015	10/30/2015	09/14/2015	10/30/2015	12/31/2015	DY1 Q3	
Task Finalize data security and confidentiality plan	Completed	Incorporate risk mitigation and security testing recommendations into data security and confidentiality plan and obtain IT Sub-Committee review and Executive Committee approval.	09/01/2015	11/01/2015	09/01/2015	11/01/2015	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 Establish implementation tracking system	Completed	Develop an IT approach for tracking and reporting on implementation of plan.	09/01/2015	11/01/2015	09/01/2015	11/01/2015	12/31/2015	DY1 Q3	
Task Communicate plan to partners and conduct trainings	Completed	Communicate data security and confidentiality plan to partners using email, webinars and training and education learning management system.	11/01/2015	12/31/2015	11/01/2015	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
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).	vchibiso	Meeting Materials	36_DY2Q1_IT_MDL51_PRES1_MM_1.0.2_Meeting_Schedule_IT_SubCom_3992.xlsx	IT subcommittee meeting schedule	07/22/2016 08:14 AM
	vchibiso	Report(s)	36_DY2Q1_IT_MDL51_PRES1_RPT_1.0.1_IT_Needs_Assessment_3991.docx	Updated Gap Assessment	07/22/2016 08:14 AM
Develop an IT Change Management Strategy.	vchibiso	Training Documentation	36_DY2Q1_IT_MDL51_PRES2_TRAIN_2.0.2_BPHC_IA_Training_Log-Schedule_master_3995.xlsx	BPHC training documents	07/22/2016 08:17 AM
	vchibiso	Meeting Materials	36_DY2Q1_IT_MDL51_PRES2_MM_2.0.3_Meeting_Schedule_IT_SubCom_3994.xlsx	IT subcommittee meeting schedule	07/22/2016 08:16 AM
	vchibiso	Policies/Procedures	36_DY2Q1_IT_MDL51_PRES2_P&P_2.0.1_Change_Control_Documentation_Ver_2_Jun_7_3993.docx	Change Control Document - updated	07/22/2016 08:16 AM
Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	zstopak	Other	36_DY2Q1_IT_MDL51_PRES3_OTH_M3_Board_Approval_Update_5171.docx	Roadmap - Board Approval Update	08/03/2016 05:12 PM
	vchibiso	Implementation Plan & Periodic Updates	36_DY2Q1_IT_MDL51_PRES3_IMP_3.0.1_Clinical_Connectivity_Roadmap_Milestone_Documentation_3998.docx	Clinical Connectivity Roadmap	07/22/2016 08:22 AM
	vchibiso	Meeting Materials	36_DY2Q1_IT_MDL51_PRES3_MM_3.0.3_Meeting_Schedule_IT_SubCom_3997.xlsx	IT subcommittee log	07/22/2016 08:21 AM
	vchibiso	Meeting Materials	36_DY2Q1_IT_MDL51_PRES3_MM_3.0.2_BPHC_IA_Training_Log-Schedule_master_-	BPHC training log	07/22/2016 08:18 AM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
			_Copy_3996.xlsx		
Develop a specific plan for engaging attributed members in Qualifying Entities	vchibiso	Policies/Procedures	36_DY2Q1_IT_MDL51_PRES4_P&P_4.0_QE_Consent_Engagement_Strategy_3990.docx	Updated QE Strategy	07/22/2016 08:13 AM
Develop a data security and confidentiality plan.	zstopak	Other	36_DY2Q1_IT_MDL51_PRES5_OTH_IT_M5_Remediation_Narrative_5951.docx	Remediation narrative.	09/19/2016 10:49 AM
	vchibiso	Policies/Procedures	36_DY2Q1_IT_MDL51_PRES5_P&P_Support_Documents_4974.docx	Supporting documentation to SSP workbooks.	08/03/2016 08:51 AM
	vchibiso	Policies/Procedures	36_DY2Q1_IT_MDL51_PRES5_P&P_SBH_DSRIP_WORKBOOKS_4973.DOCX	Full set of SSP workbooks (1-18)	08/03/2016 08:47 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	During the past quarter, a comprehensive analysis of the PPS's providers' Meaningful Use (MU) progress was conducted. Every MU eligibility and many process requirements were collected and documented from a number of sources. We now have a real understanding of the number of eligible providers, what stage of the process they are in, and where there are gaps in their MU attestation process. The PPS also continued with its PCMH program, collecting detailed analysis on independent providers. BPHC is continuing sourcing and storing IT infrastructure information in Salesforce, our CRM. Milestone is complete and will continue to be updated.
Develop an IT Change Management Strategy.	An update to the IT Change Management Policy and Procedures was put into place to elaborate upon and clarify the risk assessment workflow for IT system changes. The purpose of improving service reliability and how the process would be able to minimize risk was developed and elaborated upon. Clear determinants of the criteria for assessments identified are: 1) The number of users that may be impacted; 2) Financial impact; 3) Likelihood of a change, system or service failure could result in disclosure or misuse of PHI or malicious interruption of services; 4) Adverse safety, health, security, operational, environmental or mission implications; 5) Possible difficulty for user or support personnel to learn new or modified changes to the system; 6) Stability and supportability of the change; 7) Likelihood of failure of adverse events resulting from the change; 8) In the case of failure, what would be the impact of rolling back an implementation. We are continue to work to conclude contracting with care management vendors will look to begin implementation project plans that will follow change management policy with appropriate risk analysis followed by proper training of all involved. A workgroup is being formed out of the IT Subcommittee to oversee this process. This milestone is complete and will continue to be updated.
Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	During this quarter BPHC continued to refine its understanding of the current capabilities and needs for data exchange. Since finalizing our centralized CCMS system vendor selection has been taking longer than anticipated due to various factors, we have had some challenge finalizing our plan. Because of this, we did not get to put a final plan before IT Subcommittee or the Executive Committee, but instead continued to further investigate and re-define our current/target states. We also did not conduct formal trainings to teach about interoperability standards yet, as a result. To that end, BPHC pursued the following activities this quarter: 1) Documented additional workflows and data diagrams for each clinical project, to communicate proposed system vision, identify gaps in data flow, and further define build items for partner systems; 2) Created a one-page document of the data standards that our QE can currently receive and send data in (as a supplement to the QE's longer implementation guide); Reviewed existing partner practices and standards related to PHM and interoperability; Documented the proposed configuration of all known EMRs, CCMSs, QE, and other systems within the PPS so that the IT Subcommittee could review it for possible course corrections; Participated in GNYHA and downstate PPS collaboration to understand comprehensive care

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	management plan needs in terms of content, emerging C-CDA standard, and possible timelines. Our QE partner, the Bronx RHIO, obtained all remaining data use agreements (DUAs) from large partners who contribute data, which allow both patient and administrative data-sharing with BPHC, e.g., the consent rate at each organization, and ultimately the flow of data across the PPS. We expect to continue reviewing partner interoperability state and needs against the Bronx RHIO, pending CCMS software, developing care plan content and standards and be able to present a full meaningful plan to IT subcommittee by the end of DY2Q2.
Develop a specific plan for engaging attributed members in Qualifying Entities	A plan for engaging attributed members in the Bronx RHIO, our Qualifying Entity (QE) has been approved by the IT Subcommittee and is attached. The plan has continued to evolve as it is being implemented. We developed a strategy for individual patient consents to apply to the Central Services Organization which will allows us to effectively engage in population health and reporting. We are implementing best practices from our most successful members in a pilot program at one of our least successful FQHCs and Hospitals which have been further refined with the help of BxRHIO. Once the plan is demonstrated to be successful it will be implemented at a wider scale. The plan includes three elements. 1) Frontline staff training and workflows are being implemented to improve consent rates. 2) Reintroduction of the BxRHIO to providers to improve adoption. 3) Modifications to the EMR are being made to facilitate QE collection. We implemented controls and feedback mechanisms on our members' progress, which further inform the plan and provide feedback to team members. These measured have been and will be reported to the IT Subcommittee and Executive Committees. Milestone is complete and will continue to be updated.
Develop a data security and confidentiality plan.	We are submitting the fourth section of the SSP this quarter and are addressed the IA comments from the DY1Q4 submission. As our IT infrastructure expands we will adhere to all SSP rules and regulations. Milestone is completed.

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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.

Based on collaborative IT work to date, we are well prepared to continue to manage the challenges in evolving BPHC's current multi-stakeholder IT governance into an operational IT change management framework. While we anticipate reluctance on the part of some partners to agree to certain elements of network IT governance and requirements, we will educate partners on the need and justification for all requirements, processes and IT change management governance and have incorporated compliance provisions into Master DSRIP Service Agreements (MSAs) to eliminate ambiguity and make compliance contractually obligated.
Partners may be challenged to comply with data-sharing obligations, especially those that had not previously participated in data exchange or whose IT infrastructures may not meet certified EHR MU requirements. Again, we will educate all partners on the importance of data-sharing and compliance with data security and confidentiality policies and incorporate Business Associate Agreements into their MSAs.
We will work with the Bronx RHIO, our predominant QE and a close partner of SBH and Montefiore, among other BPHC participants, to understand gaps in patient engagement, as measured by consent, and to implement targeted strategies for obtaining consent from more attributed patients. Partners may be challenged, however, to participate in the Bronx RHIO, to interface their disparate IT systems for health information exchange or to acquire certified EHR solutions capable of interoperating. Failure to achieve connectivity and data sharing objectives will have particular impact on Project 2.a.i, since clinical interoperability is critical to development of an integrated delivery system. BPHC will establish programs to assist in these areas, including monitoring and direct assistance to partners in achieving these interoperability and data sharing objectives.
Multiple care coordination management systems (CCMS) are employed by health homes and patient -centered medical homes, and some partners lack systems with the necessary capabilities. Building a system with sufficient care management, referral management and system integration capacities in a timely manner poses a significant challenge. BPHC is working with a vendor to create a PPS-wide care management and referral management platform to enhance clinical integration and provider communications. The platform will serve as a unifying resource for partners with varying IT systems. Where partner organizations have existing tools, BPHC will supply data exchange and system interfaces to ensure a robust exchange of care management planning information.

IPQR Module 5.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

The IT workstream is dependent on strategies and requirements developed in the Performance Reporting, Clinical Integration and Population Health Management workstreams primarily, and to a lesser extent in all other organizational workstreams to the extent they identify IT expectations (e.g., for financial system enhancements in the Financial Sustainability workstream, or for workforce training and enablement using the planned care coordination management solution). In addition, the IT workstream will be highly interdependent with General Project

Implementation and in particular for Domain 2 & 3 project-specific strategies and their Domain 1 requirements. Elements of IT governance may be dependent on the Governance workstream since the IT Sub-Committee and other elements of IT governance will be integrated into overall BPHC governance. BPHC considers IT integral to all aspects of PPS performance.

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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
Chief Information Officer	Dr. Jitendra Barmecha, MD, MPH, FACP, Chief Information Officer, SVP—IT & Clinical Engineering, SBH	• BPHC IT strategy • Overall IT implementation • Data security and confidentiality planning and compliance • Partner and patient engagement technologies
Chief Information Security Officer	Sam Cooks - AVP-IT	• IT Infrastructure, • Data Security • Communication
IT Analyst for Information Security	Chris Delgado	Support the CSO on IT infrastructure/strategy, data security, communication
Senior Director, Quality Mgmt & Analytics, CSO	Janine Dimitrakakis	Overall delivery of QM and analytics reporting
Director of Partner Connectivity BxRHIO Partners	Greg Malloy, SBH IT Kathy Miller, Bronx RHIO Dr. Terri Elman, Bronx RHIO	• Partner connectivity strategy • Bronx RHIO and other QE relationships • Partner connectivity adoption, implementation and support
Director of Care Management Technologies	Zane Last, SBH IT	• Care management / population health management requirements definition • Care management / population health management IT implementation and support
Associate Director of HealthCare Data and Analytics	Jonathan Ong, SBH IT	IT infrastructure support and implementation
Montefiore Medical Center IT Liaison	Brian Hoch, MMC IT Chuck Anderson, MMC IT Jack Wolf, MMC IT	• Implementation, integration and support of critical IT systems and functions supporting BPHC
Key point person/project manager from provider organizations	Nicolette Guillou, Montefiore Akwasiba Rafaelin, Montefiore Twiggy Ramirez, Acacia Network Irene Borgen, SBH Health System Zena Nelson, Institute for Family Health (IFH) Fernando Alonso, Bronx United IPA Nieves Madrid, Morris Heights Dean Bertone, Union Community Health Center	• Connectivity adoption, implementation, integration and support at own organization (for participation in BPHC) • Data exchange support

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
IT Subcommittee	Nicole Atanasio, Lott, Inc. Jitendra Barmecha, SBH Health System Helen Dao, Union Community Health Center Brian Hoch, Montefiore Medical Center Jeeny Job, SBH Health System Tracie Jones, BronxWorks Vipul Khamar, Visiting Nurse Service of New York Elizabeth Lever, The Institute for Family Health Uday Madasu, Coordinated Behavioral Care IPA Mike Matteo, Centerlight Health System Kathy Miller, Bronx RHIO Edgardo Nieves, Morris Heights Health Center Anthony Ramirez, Acacia Network Sam Sarkissian, University Behavioral Associates Yvette Walker, AllMed Medical & Rehabilitation Centers Nicole Atanasio, Lott, Inc. Jitendra Barmecha, SBH Health System Helen Dao, Union Community Health Center Brian Hoch, Montefiore Medical Center Jeeny Job, SBH Health System	IT governance

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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		
Attributed Patients and Families/Caregivers	Recipient of care services delivered with support of effective IT	• Interaction sufficient to participate and take limited accountability for health and care-related activities
BPHC CSO Business Staff	Accountable for integration and effective use of IT in PPS services	• Oversight and integration of IT into BPHC operations
BPHC Governance Committee Members	Governance for effective integration and use of IT, centrally and across partners	• Oversight and integration of IT into BPHC operations
SBH Management/Leadership	Fiduciary oversight for effective integration and use of IT in BPHC operations	• Oversight and integration of IT into BPHC and SBH operations
SBH IT Leadership and Staff	Primary leadership, project management and support	• Coordinate, support and maintain coordinated BPHC (and SBH) IT solutions
Montefiore Management/Leadership	Accountable for integration of key Montefiore-supplied IT functionality for BPHC support	• Oversight and integration of Montefiore IT into BPHC operations
Montefiore CMO Staff	Effective use of BPHC IT to deliver care management services to patients	• Effective use of BPHC (and Montefiore) IT solutions
Montefiore Bronx Accountable Health Network Staff	Effective use of BPHC IT to deliver Health Home services to patients	• Effective use of BPHC (and Montefiore) IT solutions
Montefiore IT Leadership and Staff	Project management and support for integrated Montefiore IT	• Coordinate, support and maintain integrated Montefiore IT solutions
Partner Organization Providers and Staff	Integration, connectivity and effective use of BPHC IT solutions	• Adopt, implement use and support integrated BPHC IT solutions
External Stakeholders		
Bronx RHIO Management/Leadership and Staff	Accountable for integration of key Bronx RHIO-supplied IT functionality for BPHC support	• Oversight and integration of Bronx RHIO IT into BPHC operations
Bronx Community Advocates/Leaders/Elected Officials	Awareness of how IT is being used to effectively support BPHC and Bronx patients	• Consume stakeholder communication and participation in stakeholder events
Bronx Community Members/Public At-Large	Awareness of how IT is being used to effectively support BPHC and Bronx patients	• Consume stakeholder communication and participation in stakeholder events
Non-Partner Providers	Awareness of how IT is being used to effectively support Bronx patients and how they can participate in Bronx RHIO and other IT solutions related to BPHC	• Bronx RHIO or other QE participation as warranted to effectively treat patients
CBO partners with experience in MH/BH, I/DD and	Curriculum Development and/or training	Serve as subject matter experts to the vendor(s) or partner(s)

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
SAS (e.g., ACMH, Community Access, Communilife, Cardinal McCloskey Community Services, EAC, Inc., St. Ann's Corner of Harm Reduction)		involved in curriculum development and training.
Medicaid Managed Care Organizations (MCOs)	Awareness of how IT is/can be used to serve covered members	• Contribute data and participate in RHIO or other IT solutions as warranted to effectively serve members
NYCDOH	Awareness of how IT is being used by BPHC	• Offer solutions, participate in BPHC IT solutions in order to serve Bronx residents
NYSDOH	Provide guidance and tools, including MAPP/SIM, to support BPHC use of IT	• Guidance and tools to support BPHC IT use, including for efficient performance management and DOH reporting
Organized Labor	Awareness of how IT is being used by BPHC	• Member labor support for and training on BPHC IT solutions, as warranted
Other Bronx PPSs	Awareness of how IT is being used to effectively support Bronx patients and how multiple PPSs may be able to support each other's or share IT solutions	• Participation in joint IT planning and solution development as warranted

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IPQR Module 5.7 - Progress Reporting

Instructions :

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

IT workstream success will be measured according to the following:
• Governance – Multi-stakeholder representation and participation in IT Sub-Committee meetings, with timely decision-making for IT-related issues

• Strategy/Solution Development – Timely completion of current state assessment, IT connectivity roadmap, data sharing plan, etc.
• Strategy Monitoring – Progress against IT strategy objectives and milestones
• QE Adoption and Integration – Percentages of providers using Bronx RHIO and patients consenting to disclosure
• Partner IT Capabilities – Percentages of providers using certified EHR technology, Meaningful Use attestation, and PCMH 2014 recognition

• Patient Engagement – Progress against achieving patient engagement goals and documented use of IT in achieving goals

IPQR Module 5.8 - IA Monitoring

Instructions :

Section 06 – Performance Reporting

IPQR Module 6.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Establish reporting structure for PPS-wide performance reporting and communication.	Completed	Performance reporting and communications strategy, signed off by PPS Board. This should include: -- The identification of individuals responsible for clinical and financial outcomes of specific patient pathways; -- Your plans for the creation and use of clinical quality & performance dashboards -- Your approach to Rapid Cycle Evaluation	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Establish reporting oversight responsibilities	Completed	Designate reporting oversight responsibilities to Executive Committee, Quality and Care Innovation Sub-Committee and Finance and Sustainability Sub-Committee. BPHC Senior Director for Quality Management and Analytics will be responsible for working with the Quality and Care Innovation Sub-Committee on performance reporting activities.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Develop reporting and communication requirements	Completed	Complete analysis of state guidance to develop comprehensive requirements related to reporting and communication across all workstreams and projects.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Define performance reporting categories	Completed	Define categories of reporting (beyond those that are state-mandated) necessary for PPS performance management and operations, including Rapid Cycle Evaluation and monitoring of overall performance of BPHC and its network partners.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Analyze reporting capacities across PPS	Completed	Assess existing reporting capabilities of BPHC and its network partners to identify gaps between requirements and current capabilities.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Analyze MCO data exchange capacity	Completed	Assess MCO capabilities for data exchange relative to requirements for performance metric submission.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task	Completed	Identify CSO staff and network partner staff (i.e., end-users)	07/01/2015	09/30/2015	07/01/2015	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
Develop and test reporting mechanisms		who will participate in developing and beta-testing the functionality and technical specifications for reports.							
Task Hire performance reporting support staff	Completed	Identify/recruit qualified staff to support BPHC performance reporting according to the structure in the approved strategy.	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop performance reporting strategy	Completed	Develop a performance reporting strategy encompassing infrastructure, external and internal reporting (including CAHPS measures), quality and performance dashboard(s), approach to Rapid Cycle Evaluation and feedback, communication strategies, alignment with MCOs, and required staff capabilities and obtain Executive Committee approval.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #2 Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	Completed	Finalized performance reporting training program.	06/01/2015	06/30/2016	06/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Establish PPS reporting goals	Completed	Define clinical quality and performance reporting goals for the PPS.	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Define staff categories for training	Completed	Identify specific categories of end-users (e.g., CSO staff, partner leadership, care managers, etc.) who will be trained.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish reporting responsibilities	Completed	Determine site-specific reporting responsibilities by role.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish reporting goals by role	Completed	Define goals for reporting by role, helping staff understand targets and responsibilities toward meeting targets.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Provide technical assistance on interpreting data and reports for performance reporting	Completed	Assist staff by role how to use data and interpret reports (as appropriate for role)	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Contract with vendor to develop performance reporting training program	Completed	Identify a training vendor to work with BPHC to develop a performance reporting training program, including a schedule of training events for specific categories of end-users. Include training on Continuous Quality Improvement (CQI).	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Include roles, methods and tools specifications in training program	Completed	Ensure that training plan describes both reporting expectations by role and details methods and tools by which reports are generated.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Further define the role of workgroups as clinical quality councils	Completed	Establish role of workgroups as project-specific clinical quality councils that can provide feedback to site-specific reporters/implementation teams/DSRIP managers and clinical leadership.	09/01/2015	12/31/2015	09/01/2015	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 Obtain approval on training program	Completed	Vet and finalize the initial training program with the Executive Committee.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Create training materials	Completed	Develop draft training materials.	03/01/2016	06/30/2016	03/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Pilot the training materials	Completed	Conduct set of initial trainings.	05/01/2016	06/30/2016	05/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Develop orientation and training timeline	Completed	Develop new hire orientation program and annual training schedule.	03/01/2016	06/30/2016	03/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Establish feedback mechanism and conduct retraining as needed	Completed	Develop and implement a feedback mechanism for organizations and individuals that includes mechanisms for retraining if needed, when performance reporting falls short of needs.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Establish reporting structure for PPS-wide performance reporting and communication.	6338	Other	36_DY2Q1_PR_MDL61_PRES1_OTH_CCMP_BAA-2_Fully_Executed_3944.pdf	Community Care Management Partners (CCMP) Health Home BAA 2	07/20/2016 02:07 PM
	6338	Other	36_DY2Q1_PR_MDL61_PRES1_OTH_CCMP_BAA-1_Fully_Executed_3943.pdf	Community Care Management Partners (CCMP) Health Home BAA 1	07/20/2016 02:06 PM
	6338	Other	36_DY2Q1_PR_MDL61_PRES1_OTH_CBC_IPA_BAA-2_Fully_Executed_3942.pdf	Coordinated Behavioral Care (CBC) IPA BAA 2	07/20/2016 02:05 PM
	6338	Other	36_DY2Q1_PR_MDL61_PRES1_OTH_CBC_IPA_BAA-1_Fully_Executed_3941.pdf	Coordinated Behavioral Care (CBC) IPA BAA 1	07/20/2016 02:04 PM
	6338	Other	36_DY2Q1_PR_MDL61_PRES1_OTH_CBC_Health_Home_BAA-2_Fully_Executed_3940.pdf	Coordinated Behavioral Care (CBC) Health Home BAA 2	07/20/2016 02:03 PM
	6338	Other	36_DY2Q1_PR_MDL61_PRES1_OTH_CBC_Health_Home_BAA-1_Fully_Executed_3939.pdf	Coordinated Behavioral Care (CBC) Health Home BAA	07/20/2016 02:02 PM
Develop training program for organizations and individuals throughout the network, focused on	6338	Training Documentation	36_DY2Q1_PR_MDL61_PRES2_TRAIN_Performance_Reporting_and_CQI_Training_M2reporting_do	Clinical Quality and Performance Reporting Training Program	07/20/2016 02:10 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
clinical quality and performance reporting.			cument_final_3946.docx		
	6338	Templates	36_DY2Q1_PR_MDL61_PRES2_TEMPL_Performance_Reporting_Training_Schedule_Template_DY2Q1_M2_3945.xlsx	Updated Training Schedule Template	07/20/2016 02:09 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish reporting structure for PPS-wide performance reporting and communication.	BPHC has completed this milestone. Business Associate Agreements (BAAs) and Data Use Agreements have been put in place with all of our largest partners – between the partners and BPHC, as well as between the partners and Bronx RHIO. New data use agreements include: Community Care Management Partners (CCMP) Health Home, Coordinated Behavioral Care (CBC) Health Home and Coordinated Behavioral Care (CBC) IPA.
Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	BPHC has completed this milestone. BPHC identified and contracted with a vendor, Joselyn Levy & Associates. Together we developed a performance reporting and continuous quality improvement (CQI) training program for the CSO, our partner organizations and individuals within our PPS. BPHC has identified roles and available systems and data that may potentially be used for initial training sessions. Please see attached document which demonstrates that the plan includes detailed assessment of necessity of training, expected outcomes, and details according to the type of provider and PPS personnel. We outline our training tracking system, eeds© and include the schedule for training. The initial training curriculum will use examples from available systems (not all PPS planned reporting systems have been developed yet) and available data (PHI is still restricted in NY State systems). The task to "Obtain approval on training program, vet and finalize the initial training program with the Executive Committee" will not be performed. It was created prior to IA guidance regarding the milestone supporting documentation requirements, and the IA guidance does not specify that this training program should be presented to the Executive Committee. It was determined that Executive Committee approval is not relevant and appropriate for training of this nature, and thus Committee's approval would not be required.

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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.

1. Partners have varying levels of reporting capacity as well as interoperability, which makes it challenging to exchange standardized data and reports within our PPS. BPHC's comprehensive assessment of partners' reporting capabilities as well as activities in the IT Work Stream will identify gaps in capabilities and resources; BPHC will work closely with partners to close such gaps in time to meet DSRIP goals.

2. Partners have varying levels of analytical capabilities and will need training and support to understand how to interpret reports and use them to improve clinical and financial outcomes. We are currently designing BPHC's training program to educate key personnel within each network partner and ongoing trainings will be made available as new personnel join or as further support with respect to performance reporting is required. In addition, staff from the CSO will supplement formal trainings by providing "on the ground" support for data collection and quality control while partner staff ramp up their reporting staff and interpretation skills.

3. We continue to define and communicate the PPS's priorities and performance expectations within the CSO and between the CSO and network partners. Lack of understanding of the goals of BPHC and/or lack of understanding of how the day-to-day work of staff connects to those goals will lead to wasted and ineffective effort and will negatively affect the pace at which the goals of DSRIP are met. Because performance reporting and accountabilities are connected to every aspect of DSRIP implementation, there is a great need for an overarching vision for data analytics that serves the goals of the BPHC PPS. This vision has been drafted and includes clearly defined and articulated performance standards and expectations as well as a performance improvement strategy that articulates a feedback process between network partners and the CSO.

4. Because the PPSs is evolving and is a "learning entity," it is challenging for the CSO to maintain focus on those goals and to orient new staff to the culture shift. BPHC is in the process of developing a PPS-wide communication plan that addresses performance reporting expectations and processes. The communication plan is being continuously evaluated and updated to ensure BPHC is effectively reaching its partners through a range of methods (e.g., in-person meetings and webinars, newsletters and e-blasts, website updates, desk-side training and mentorship, etc.).

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.)

A clinical quality and performance reporting program will touch every aspect of the PPS. The PPS goals and performance standards, which influence the structure of reporting, have been developed through the committee structure implemented under the governance workstream. System improvements are planned, deployed and monitored through the IT workstream. To be effective, the clinical quality and performance reporting program must be developed in tandem with the clinicians' engagement strategy because the reporting tools developed must be

championed by clinicians in order for the culture of change to take root. BPHC's approach to care management and population health management inform the content of dashboards and reports and the capabilities of the IT infrastructure influence the types and timing of data available to be reported and analyzed. The program is also being developed with an eye towards the evolution of the PPS's workforce and serve the defined financial sustainability goals.

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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
Executive Director, CSO	Irene Kaufmann	BPHC overall performance management
Chief Financial Officer, CSO	Todd Gorlewski	Oversee financial metrics and outcome accountability
Senior Director, Quality Mgmt & Analytics, CSO	Janine Dimitrakakis	Overall delivery of QM and analytics reporting
Senior Director, Care Delivery & Practice Innovations, CSO	Dr. J. Robin Moon	Seamless connecting with and strategy for the QM and clinical projects
Associate Director, Information Services, SBH (IT)	Jonathan Ong	IT infrastructure support and implementation
Key point person/project manager from provider organizations	Nicolette Guillou, Montefiore (ambulatory) Akwasiba Rafaelin (ED and IP) Twiggy Rodriguez, Acacia Network Irene Borgen, SBH Health System Zena Nelson, Institute for Family Health (IFH) Fernando Alonso, Bronx United IPA Nieves Madrid, Morris Heights Health Center (MHHC) Dean Bertone, Union Community Health Center (UCHC)	Integration and support of the reporting functions, reporting requirement adoption, implementation and communication with BPHC
Chief Medical Officer, CSO	Dr. Amanda Ascher	Direct clinical CQI activities

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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		
Executive Committee: Eric Appelbaum, SBH; Maxine Golub, IFH; Marianne Kennedy, VNSNY; Pamela Mattel, Acacia; Fernando Oliver, Bronx United; Tosan Orwariye, MHHC; Amanda Parsons, MMC; Paul Rosenfield, Centerlight; Stephen Rosenthal MMC; Charles Scaglione, Bronx RHIO; Eileen Torres, BronxWorks; Len Walsch, SBH; Pat Wang, HealthFirst; Gladys Wrenwick, 1199; Douglas York, UCHC	Leadership on all performance reporting areas	Overall oversight of reporting process, including IT infrastructure, clinical quality metrics and financial issues
IT Sub-Committee members Nicole Atanasio, Lott Residence; Jitendra Barmecha, SBH; Helen Dao, UCHC; Brian Hoch, MMC; Jeeny Job, SBH; Tracie Jones, BronxWorks; Kate Nixon, VNSNY; Elizabeth Lever, IFH; Uday Madasu, Jewish Board; Michael Matteo, CenterLight; Kathy Miller, Bronx RHIO; Edgardo Nieves, MHHC; Anthony Ramirez, Acaia; Sam sarkissian, UBA	Leadership on tech decisions around the reporting process	Oversight and integration of the reporting infrastructure for BPHC PPS
Quality and Care Innovation Sub-Committee members Todd Ostrow, CenterLight; Kenneth Jones, MHHC; Dharti Vaghela, Essen; Frank Maseli, Bronx United; Chris Norwood, HealthPeople; Megan Fogarty, BronxWorks; Michele Quigley, United Cerebral Palsy Assoc; Debbie Pantin, VIP; Pablo Idez, IFH; Anne Meara, MMC; David Collymore, Acacia; Ed Telzak, DBH; Beverly Mosquera, Communilife; Rona Shapiro, 1199; Lizica Troneci, SBH	Leadership over the QA team at BPHC CSO	Oversight of defining quality report requirement and logistics

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Finance and Sustainability Sub-Committee members Carol Bouton, IFH; Carol Cassell, ArchCare; Tomas Del Rio, Acacia; Max Francios, Bronx United; Marcus Freeman, MHHC; Donna Friedman, RMHA; Todd Gorlewski, SBH; Mary Hartnett, UCHC; Josephine Incorvaia, CenterLight; David Koschitzki, MJHS; David Menashy, MMC; Kity Khudkar, Schevier Nursing; Denise Nunez, Divino Nino;l Ravi Ramaswamy, Families on the Move	Leadership on financial metrics	Oversight of financial reporting issues
Montefiore leadership Amanda Parsons, Stephen Rosenthal, John Williford	Accountable for integrating Montefiore quality measures with BPHC	Oversight and coordination of quality reporting to BPHC PPS
BPHC CSO clinical team staff Amanda Ascher, Janine Dimitrikakis, J Robin Moon	Accountable for timely communication and coordination with the QM team	Oversight and integration of the reporting into the QM
BPHC Executive Committee members Eric Appelbaum, SBH; Maxine Golub, IFH; Marianne Kennedy, VNSNY; Pamela Mattel, Acacia; Fernando Oliver, Bronx United; Tosan Orwariye, MHHC; Amanda Parsons, MMC; Paul Rosenfield, Centerlight; Stephen Rosenthal MMC; Charles Scaglione, Bronx RHIO; Eileen Torres, BronxWorks; Len Walsch, SBH; Pat Wang, HealthFirst; Gladys Wrenwick, 1199; Douglas York, UCHC	Leadership for and oversight of BPHC performance	Oversight of quality reporting into BPHC
Partner organization providers and staff, including DSRIP Program Managers/Directors	Accountable for meeting the PPS partnership requirement	Delivery of quality reporting requirements to BPHC
External Stakeholders		
Bronx RHIO Leadership and staff Charles Scaglione, Kathy Miller, Nance Shatkin, Keela Shatkin	Accountable for integration of key Bronx RHIO-supplied IT functionality for BPHC support	Oversight and integration of Bronx RHIO IT into BPHC operations
Other PPSs in NYC: Bronx Lebanon, OneCity, Staten Island, Advocate, Mount Sinai (initial idea exchange)	Exchange of ideas and plans utilized and potentially share solutions	Participation in joint planning, requirement development and mitigation strategies
1199SEIU TEF (Training vendor)	Accountable for training partners for reporting requirement and compliance	Fully developed training program. Train all partners.

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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.

BPHC intends to leverage shared data management and analytics infrastructure already present in the PPS, from Bronx RHIO. St. Barnabas Health System (SBH) has a close working and governance relationship with Bronx RHIO, as do Montefiore and Bronx Lebanon Hospital Center. Together, these organizations and others in the Bronx are already contributing data to Bronx RHIO, which manages the data for health information exchange and analytics, the latter under an ongoing Health Care Innovation Award from CMS. In either instance, the NYSDOH MAPP and Salient Interactive Miner (SIM) also contribute data utilized by BPHC's analytics team.

IPQR Module 6.8 - Progress Reporting

Instructions :

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

The success of this organizational workstream will be measured as follows:
Metric Submission – Successful and timely submission to DOH of performance measures and metrics that accurately reflect the progress of BPHC.
Rapid Cycle Evaluation – Effectiveness of clinical quality and performance dashboard tools in enabling BPHC to monitor progress and identify areas of strength and areas for improvement.
Analytics Staff Engagement and Communication – Training analytics staff to use the tools, to understand the goals of clinicians and leadership, and to communicate results to effectively translate metrics and measures into improved outcomes. This includes training on performance improvement and continuous quality improvement so that teams can take data that reflects poor or less-than-ideal performace and translate that into a PI project that will result in improved outcomes. As data reflects improved (or static) outcomes, continuous quality improvement strategies resule in further PI projects.
Staff and Leadership Engagement – Participation of clinicians and leadership in using clinical quality and performance measurement dashboards developed to improve care delivery and financial outcomes.
Informed Decision-Making – Integration of performance reporting into decision-making through the governance process to drive improvements, deploy resources, and assess progress against overall program goals.
Project level quality reporting--Successful and timely reporting to DOH of project level processes, outcomes, measures and metrics that accurately reflect the progress of each project.

IPQR Module 6.9 - IA Monitoring

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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.	Completed	Practitioner communication and engagement plan. This should include: -- Your plans for creating PPS-wide professional groups / communities and their role in the PPS structure -- The development of standard performance reports to professional groups --The identification of profession / peer-group representatives for relevant governing bodies, including (but not limited to) Clinical Quality Committee	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Select QCIS members	Completed	Work with key PPS organizations and community-based organizations to select thought leaders from among the major practitioner groups/CBOs (including primary care physicians, subspecialists, nurses, mental health professionals, social workers, and peers) who will participate in the Quality and Care Innovation Sub-Committee.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Create QCIS meeting schedule and agenda	Completed	Establish a regular meeting schedule for convening the Quality and Care Innovation Sub-Committee, which will include review of standard performance reports as a standing agenda item.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Select work group members	Completed	Work with key PPS organizations and CBOs to select thought leaders from among the major practitioner groups/CBOs (including primary care physicians, subspecialists, nurses, mental health professionals, social workers, and peers) who will form rapid deployment collaboratives that will develop engagement strategies specific to the PPS quality improvement agenda and DSRIP projects. These	07/01/2015	12/31/2015	07/01/2015	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
		collaboratives will also serve as project clinical quality councils.							
Task Produce a plan for practitioner communication and engagement	Completed	Document practitioner communication/engagement plan including composition and role of the RDCs, schedule for regular webinars, and an approach for in-person, peer-to-peer learning forums. Include methods to monitor provider engagement levels.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish web-based practitioner communication tool	Completed	Establish an online practitioner communication tool.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Finalize plan for practitioner communication and engagement	Completed	Submit practitioner communication and engagement plan to Quality & Care Innovation Sub-Committee for review and approval.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Create RDC meeting schedule	Completed	Establish regular meeting schedule for convening the rapid deployment collaboratives.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Produce standard reporting tools	Completed	Develop initial drafts of the content, format, frequency of standard performance reports (including rapid cycle evaluation and other reporting) addressing project-specific DSRIP metrics.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Create standard RDC meeting agenda	Completed	Establish standard agenda for the RDC meetings including (1) implementation strategies and tactics, and (2) review of the rapid cycle evaluation reports and other performance reports.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #2 Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	Completed	Practitioner training / education plan.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Categorize practitioners for training purposes	Completed	Review PPS practitioner listing and organize the list into provider specific types for DSRIP project training purposes.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop training curriculum	Completed	Contract with vendors and/or partners with curriculum development and/or training capabilities geared to DSRIP project and practitioner type. Include Subject Matter Experts from our PPS partners in MH/BH, I/DD, and SAS in the curriculum development process.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Obtain approval of curriculum	Completed	Quality and Care Innovation Sub-Committee reviews/approves curriculum.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Develop training timeline	Completed	Develop training schedule and logistics to maximize participation by practitioners and arrange CME credit (free to PPS members) if feasible.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop plan for continuous quality improvement mechanisms	Completed	Develop continuous quality improvement agenda and process and make recommendations to the Quality and Care Innovation Sub-Committee for approval.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Establish curriculum review process for quality improvement	Completed	Work with the Quality and Care Innovation Sub-Committee and the RDCs to establish a process for curriculum content reviews/updates for general and provider type-specific education programs to address issues of special relevance including culture change, BPHC's quality agenda and the impact of quality improvement on practitioner incentives.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Develop post-training tests	Completed	Develop CME-type post-training testing/evaluation for practitioners to measure success of training.	11/02/2015	12/31/2015	11/02/2015	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 Practitioners communication and engagement plan.	repstein	Meeting Materials	36_DY2Q1_PRCENG_MDL71_PRES1_MM_Practitioner_Engagement_Meeting_Schedule_DY2Q1_M1_3787.xlsx	Practitioner Engagement Meeting Schedule	07/18/2016 12:17 PM
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.	repstein	Training Documentation	36_DY2Q1_PRCENG_MDL71_PRES2_TRAIN_Practitioner_Engagement_Training_Schedule_DY2Q1_M2_3789.xlsx	Training schedule template	07/18/2016 12:20 PM
	repstein	Training Documentation	36_DY2Q1_PRCENG_MDL71_PRES2_TRAIN_Practitioner_Engagement_Education_and_Training_Plan_3788.xlsx	Training and education plan	07/18/2016 12:19 PM

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop Practitioners communication and engagement plan.	Update: BPHC has completed this milestone. There have been no changes to the Practitioner Communication and Engagement Plan.
Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	BPHC has completed this milestone. See attached Practitioner Training and Education Plan. Agreements have been developed with project-specific vendors who are also our partners (The Institute for Family Health, Montefiore's Care Management Organization [CMO], a.i.r. nyc, and Health People) to conduct trainings based on the Clinical Operations Plans (COPs) developed by the IWGs (described in Milestone 1 narrative). Project-specific trainings and trainings around cross-cutting issues (e.g., care coordination, cultural competency and health literacy, RHIO Encounter Notification System) continue to be developed and rolled out. BPHC's Chief Medical Officer achieved Continuing Medical Education credit in January 2016 for practitioner trainings. We created a Performance Reporting Training with Joslyn Levy & Associates that will also be provided to our practitioners.

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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.

1. To mitigate the risk of limited practitioner engagement in DSRIP, BPHC has included both primary care and subspecialist clinicians from key partners throughout the application planning process, through project planning and in implementation. Overall, the range of practitioner types represented includes physicians, nurse practitioners, nurses, social workers, health educators, mental health professionals, and substance abuse professionals. The PPS has held numerous "all member" webinars to educate practitioners about the transformative nature and resources that DSRIP will bring to the Bronx health care delivery system. We are expanding the number and types of practitioners included in the implementation process to include more physicians, nurses, social workers, care managers and behavioral health professionals. Our DSRIP launch and project launches included frontline clinicians and clinical leadership from across the PPS.

2. Practitioners may not be able to take the time from their practice to participate in the Quality and Care Innovation Subcommittee (QCIS), project-specific workgroups, and/or to attend the educational and training sessions provided for each of the projects in which they have committed to participate. This is especially a risk for primary care practitioners (PCP) and their care team members to whom much of the training will be directed; virtually all of the DSRIP projects BPHC has selected impact PCPs in some way. BPHC will mitigate this risk by offering trainings at various times and through various formats (such as, in-person, webinar, self-directed.)

3. Provider turnover during the DSRIP period could also pose a risk to achieving DSRIP performance goals. We will implement a practitioner tracking system and provide regularly repeated orientations and briefings on the complexities of project implementation, which will be accompanied by our Clinical Operations Plan and evidence-based guidelines for new practitioners to use as a guide.

4. Some BPHC practitioners are participating in multiple clinical projects within our PPS and are also participating in projects run by other PPSs. The sheer number of new projects to implement may be overwhelming for practitioners. To mitigate this risk, BPHC has conducted joint clinical planning efforts with other Bronx PPSs to align projects and project interventions. We plan to continue joint planning discussions over the course of DSRIP.

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.)

It is difficult to point to a DSRIP workstream for which practitioner engagement is not interdependent. For example, IT use is fundamental to: practitioners adopting population health management, the CSO tracking quality metrics, practitioners monitoring patient activity between visits, and practitioners receiving alerts that enable quick follow up and communication when patients are in the hospital or emergency department. All of

these capabilities advance BPHC's abilities to improve quality of care and patient outcomes that ultimately lead to cost reductions and financial sustainability. The long term success of clinical improvement projects in Domain 3 depends on practitioner willingness across the PPS network to adopt standardized clinical guidelines, processes and protocols proven to result in lower costs and better outcomes. Funds flow also is crucial for all practitioners' implementation of clinical projects, both for project operationalization and as a mechanism to reward practitioners for their commitment to the DSRIP projects. Finally, practitioners are a fundamental portion of the DSRIP workforce, and practitioner engagement is crucial to practitioner recruitment and retention efforts.

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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
BPHC CMO	Dr. Amanda Ascher	Provide oversight in the areas of the provider engagement and clinical/delivery strategy
Senior Director, Care Delivery and Practice Innovations	Dr. J. Robin Moon	Develop communication and support plans that are project-specific
BPHC Workforce Sub-Committee Co-Chairs	Mary Morris, Co-Chair, SBH Health System Rosa Mejias, Co-Chair, 1199 TEF	• Develop curriculum to support the quality agenda • Develop training materials that are project specific
Implementation Workgroups	Chairs of the IWGs	Solicit feedback from provider community on curriculum and quality agenda
Montefiore provider engagement liaison	Laura DeMaria	Assist in development and implementation of the communication and engagement plan
Bronx United IPA	Frank Maselli	Assist in development and implementation of the communication and engagement plan
NYSNA	Lourdes Blanco	Assist in development and implementation of the communication and engagement plan

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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		
Provider partners	Recipients of training and education in BPHC's quality goals	Participate in the training sessions and demonstrate practice change in support of BPHC's quality agenda
CBO partners with experience in MH/BH, I/DD and SAS (e.g., ACMH, Community Access, Communilife, Cardinal McCloskey Community Services, EAC, Inc., St. Ann's Corner of Harm Reduction)	Curriculum Development and/or training	Serve as subject matter experts to the vendor(s) or partner(s) involved in curriculum development and training.
BPHC training vendors (including 1199 TEF), Montefiore CMO, Institute for Family Health, a.i.r. NYC	Training and retraining of the work force	• Develop curriculum to support the quality agenda • Develop training materials that are project specific
Provider partners: Amanda Parsons, Montefiore Medical Group; Frank Maselli, Bronx United IPA; David Collymore, Acacia; Erica Gayle, IFH; Nelson Eng, UCHC; Dr. Tosan Oruwariye, MHHC	Management staff of these key providers will lead organization efforts to engage practitioners in critical trainings	Practitioners participate in the training sessions and demonstrate practice change in support of BPHC's quality agenda
Quality and Care Innovation Sub-Committee members Chairs: Dr. David Collymore, Acacia; Debbie Pantin, VIP Community Services	Provide quality standards and strategy	Approve the strategy and content for communication and engagement plan
External Stakeholders		
Other PPSs Damara Gutnick, MHV PPS; Kallanna Manjunath, Albany PPS; Anna Flatteau, OneCity Health	Sharing best practices	Regular communication stream
GNYHA--Mary-Ann Etiebet	Convener of all PPS CMO/Medical Directors' meetings	Regular communication stream
Bronx Medical Society	Provide discussion and feedback on clinical changes.	Help to engage provider partners in transformation (PCMH)

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IPQR Module 7.7 - IT Expectations

Instructions :

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

BPHC has implemented a commercial customer relationship management (CRM) platform based in Salesforce to manage our physician network, including support for physician communication and engagement.
BPHC has demo-ed and will continue to build awareness among physicians of the capabilities of the BPHC care coordination management solution (CCMS) currently under development, focusing on how the infrastructure will be used to provide better service and outcomes to their patients and make their practices more efficient, allowing them to deliver higher quality patient care, along with:
• Providing multi-lingual, multi-cultural care navigation and support
• Tracking and assisting patients with practice selection, active engagement in DSRIP programs, utilization tracking and pediatric-adult transitions

• Assisting patients with locating and accessing community resources
• Support transitions and warm handoffs at discharge, with follow-up tracking
• Educating patients and families about wellness and care, and supporting patients in self-management and shared decision making related to their health needs
• Surveying patients and families regarding care experience
In addition, physician training in evidence-based medicine, care coordination, population health management and other topics pertinent to BPHC and DSRIP will be scheduled, delivered and tracked using a learning management system (LMS) administered by the BPHC CSO.

IPQR Module 7.8 - Progress Reporting

Instructions :

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

The PPS measures the success of this workstream in four ways. First, at the most basic level, we monitor attendance at education and training sessions, all-member webinars, and other learning forums provided by the CSO. We track attendance at clinical governance meetings, including our implementation and quality workgroups. Second, we have developed CME-type post-training testing for practitioners to measure the success and effects of the training. Third, to track long-term success of the practitioner engagement trainings, the CSO tracks practitioner performance on each project through rapid cycle evaluation (RCE) and auditing adherence to evidence-based guidelines and processes and protocols on a periodic basis. (e.g. Behavioral Health Integration into Primary Care, Care Management referrals, Diabetic Outcomes, etc.) Fourth, we periodically bring RCE results to the Rapid Deployment Collaboratives (Implementation Work Groups acting as clinical quality councils and reporting to the Quality and Care Innovations Subcommittee) to gain knowledge about provider experiences and concerns regarding DSRIP project implementation and impact on them and their patients.

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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.	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4	NO
Task Envision PHM for PPS future state	Completed	Develop a population health management (PHM) vision	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Conduct gap analysis	Completed	Conduct gap analysis between current state and future vision, including assessing the gaps and barriers to achieving the PHM vision	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop Site-Specific Implementation Teams	Completed	Identify clinical champions and operational leaders in each primary care provider organization to develop and lead each of their providers/sites along the path to PCMH recognition. These facility-based champions/leaders form the Site-Specific Implementation Teams.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop technical assistance mechanisms for PCMH recognition	Completed	Develop centralized technical assistance programs to assist primary care practices in achieving NCQA Level 3 PCMH recognition	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Develop PHM roadmap	Completed	Draft PHM roadmap informed by gap analysis and assessment of PHM capabilities throughout the PPS	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Analyze current PHM capacity	Completed	Assess current PHM capabilities throughout the PPS with a special focus on primary care and behavioral health practice organizations; assessment will include their readiness for	12/01/2015	03/31/2016	12/01/2015	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
		embedding PHM practices and workflows that support PCMH Level 3 and their staffing infrastructure to support PHM							
Task Partner with Bronx RHIO	Completed	Establish partnership with RHIO that covers all PPS partners that need to receive and/or contribute patient data	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Obtain member buy-in for PHM roadmap	In Progress	Review PHM roadmap with IT Sub-Committee and Executive Committee	04/01/2016	06/30/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Develop PHM registries	In Progress	Develop, with RHIO, PPS-wide PHM registries, for both PPS wide metrics as well as facility-level PHM capabilities.	07/01/2015	06/30/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Develop training methodology for registry and care plan systems	In Progress	Develop methodology for training on registry use and Care Plans Systems use as well as accountability for PHM outcomes, and evaluation, feedback and Continuous Quality Improvement for Site-Specific Implementation Teams.	04/01/2016	06/30/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Achieve PPS-wide PCMH recognition	In Progress	Move all primary care practices to NCQA Level 3 2014 PCMH recognition by end of DY3	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4	
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.	08/01/2015	12/31/2018	08/01/2015	12/31/2018	12/31/2018	DY4 Q3	NO
Task Engage members in bed reduction strategy	Completed	Convene Executive Committee to discuss bed reduction plan	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Analyze hospital utilization patterns	Completed	Assess current inpatient hospital utilization rate trends in the Bronx	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Analyze hospital physical plants	In Progress	Assess long term viability, deferred maintenance, and efficiency of hospital physical plants	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Create bed-need projection strategy	In Progress	Develop methodology to project future bed need based on analysis of secular trends and impact of DSRIP interventions on inpatient utilization by hospital	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Refine bed-need projection strategy	Not Started	Test methodology to project future bed need, refine as needed and apply to PPS hospital providers to estimate bed reductions	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Engage SDOH in bed reduction strategy	Not Started	Work with SDOH to develop options to accomplish bed reductions and sustain and build capacity to provide a wide range of ambulatory services	01/01/2017	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1	
Task Project financial implications of bed reduction strategy	Not Started	Incorporate options under consideration into financial sustainability plan	07/01/2017	09/30/2017	07/01/2017	09/30/2017	09/30/2017	DY3 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Obtain approval for bed reduction strategy	Not Started	Present bed reduction plan to Executive Committee for review and approval	01/01/2018	03/31/2018	01/01/2018	03/31/2018	03/31/2018	DY3 Q4	
Task Monitor utilization and quality trends	Not Started	Track changes in occupancy, utilization rates overall, and discharges for PPRs, PQIs, and PDIs	04/01/2018	12/31/2018	04/01/2018	12/31/2018	12/31/2018	DY4 Q3	
Task Refine bed reduction projections and plans	Not Started	Reforecast bed reduction projections annually and update bed reduction plan accordingly	04/01/2018	12/31/2018	04/01/2018	12/31/2018	12/31/2018	DY4 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
Develop population health management roadmap.	During DY2Q1, BPHC Central Services Organization (CSO) distributed DSRIP startup funds for population health management (PHM) capabilities, IT infrastructure and staffing (clinical and non-clinical) among the largest 7 primary care organization partners. The PCMH consultants' activities to support practice redesign to achieve the PCMH 2014 level 3 have been underway for some time. The consultants are coaching the primary care practices in the workflow changes necessary to achieve the transformation. 21 practices (269 practitioners) have already achieved PCMH Level 3 2014 recognition. BPHC continues to expand our work with the Bronx RHIO. In addition to working with them on increasing connectivity, we are developing the Spectrum analytic product, one of the uses of which will be PHM. Registry development continues; however, we cannot train partners on registry use and care plan systems that are not yet fully deployed. To mitigate this delay, we have developed a performance reporting training which addresses PHM training, using proxy registries. We await finalization of CCMS contracting and registry builds before we will review our PHM Roadmap with the IT and Executive Committees. Milestone on track for completion by DY3Q4.
Finalize PPS-wide bed reduction plan.	Update: BPHC remains in the planning phase for PPS-wide bed reduction. The bed reduction plan was discussed with the Executive Committee. Analysis of hospital utilization patterns was started in Salient/SIM and will be continued throughout DY2 for presentation to several groups within the PPS. Milestone on track for completion by DY4Q3.

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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. Many primary care providers (PCPs) and community-based organizations lack an understanding of how to achieve population health management (PHM). While achieving NCQA PCMH 2014 Level 3 recognition significantly moves practices towards full population health management, it does not completely achieve this goal. This lack of understanding among providers may impede provider acceptance of the need to adopt new technologies and workflows to support PHM. To mitigate this risk, the CSO has implemented a practitioner communications and education strategy to enhance providers' understanding and acceptance of PHM. The CSO will also develop and centralize resources and technologies to support providers' transition to PHM.

2. Implementation of and providers' adoption of new technologies will be slow and will require significant resources devoted to training and oversight to ensure optimization. Leadership buy-in from our network partners will be key. Many have PHM experience with HEDIS measures for Quality Assurance Reporting Requirements with their MCO contracts. This will help mitigate the risk but the scale of PHM needed for success in DSRIP is much greater. Additional staff may be required to meet the needs of running PHM reports (see Performance Reporting work stream) and doing the outreach to bring patients in for missing services. BPHC continues to assess the capabilities of our network, including providers and community-based organizations, to determine what resources will be needed for PHM across the PPS.

3. Slow implementation of technologic solutions has resulted in delays in meeting DSRIP speed and scale targets for patient engagement and achievement of Domain 1 project requirements. To mitigate these risks, BPHC continues to work with our technology vendors to speed solution implementation. We will also use a variety of training methods to reach providers, including in-person, web-based, and call-in technical support, to provide training and technical assistance during off-hours to meet provider needs. Challenges with RHIO and patient engagement are further outlined in our IT work stream and overcoming the barriers outlined there will be key to success of our PHM registries.

4. There is a risk that not all primary care provider sites will achieve NCQA PCMH 2014 Level 3 recognition by the end of DY3. The process for achieving 2014 NCQA PCMH Level 3 recognition is time consuming and requires strong support from leadership. Many primary care practice organizations have small numbers of personnel in leadership and administrative positions, creating a risk that they will not be able to devote sufficient attention to the process for attaining PCMH recognition. Some of the smaller practices may not have adequate staffing to meet all of the NCQA Level 3 2014 requirements nor enough Medicaid patients to guarantee a return on investment. To mitigate these risks, BPHC is providing technical assistance to and investing resources in practices to ensure that there is sufficient internal and external leadership support and basic staff resources to meet the NCQA 2014 PCMH goal within the DSRIP-required time period. We are also actively exploring APC models for the smaller practices.

IPQR Module 8.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

Population health management has the following major interdependencies with other workstreams.
Dependency #1: While IT systems alone will not yield a highly functioning population health management-based primary care practice, they are a necessary component of the change that will need to occur if population health management is to be successfully embedded into the daily workflows of a primary care practice. Close alignment of IT architecture and its components with population health management goals must be central to planning. The selection of IT applications and phasing in of new technologies, along with training capabilities, are key to success in population health management.
Dependency #2: Clinical integration and the PCMH roadmap intersect with the population health management roadmap in multiple areas, specifically regarding conducting readiness assessments and the identification of data needs. For example, these workstreams require BPHC to integrate data from social service organizations, supportive housing providers and other community-based organizations into care planning and registry tools.
Dependency #3: BPHC's ability to achieve its vision of population health management will depend on its success at engaging and educating practitioners on how to use data effectively in improving outcomes and in implementing common protocols and processes to achieve DSRIP goals. In addition, BPHC must be successful in its performance reporting efforts.
Dependency #4: Timely implementation of our population health management roadmap is heavily dependent on our workforce strategy. For example, moving all primary care practices to NCQA Level 3 PCMH recognition by the end of DY3 will require adequate healthcare worker capacity in primary care sites and training to ensure that staff are functioning as a care team as envisioned by NCQA. In addition, the BPHC workforce will be heavily involved in planning efforts regarding PPS bed reduction. Finally, successful implementation of cultural competency and health literacy training and recruitment of culturally competent staff will be critical to patient engagement.
Dependency #5: The development of care coordination and care management programs as part of our clinical project implementation will be critical to the success of our primary care providers attaining Level 3 PCMH recognition and our PPS's success in moving to an integrated delivery system.

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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
Quality and Care Innovation Sub-Committee	Sub-Committee members	Develop strategy for deploying effective population health for BPHC attributed patients and the communities it serves
Central Services Organization (CSO)	All CSO staff	Conduct assessment and gap analysis of BPHC provider capabilities in implementing population health strategies
CIO, BPHC	Dr. Jitendra Barmecha, CIO, SBH	Develop architecture of IT applications that can automate PHM functions, and integrate care management software with provider IT technologies
Senior Director, Quality Management and Analytics	Dr. Amanda Ascher, CMO BPHC	Produce patient cohorts that will be targeted for population health interventions including tactics surrounding predictive modeling and risk stratification
Senior Director, Care Delivery & Practice Innovations	Dr. J. Robin Moon	Deploy evidence-based tools and care management functions that support patient engagement and activation
IT Sub-Committee	Dr. Jitendra Barmecha, Chair, SBH Health System	Assist in selecting PHM related applications, developing phase in implementation schedule
Executive Committee	Len Walsh, Chair	Develop a bed reduction plan for BPHC member hospitals
Partner IT Liaisons	Nicole Atansasio, Lott, Inc; Helen Dao, Union; Brian Hoch, Montefiore; Jeeny Job, SBH; Tracie Jones, BronxWorks; Vipul Khamar, VNSNY; Elizabeth Lever, The Institute for Family Health; Uday Madasu, CBC IPA; Mike Matteo, Centerlight; Kathy Miller, Bronx RHIO; Edgardo Nieves, Morris Heights; Anthony Ramirez, Acacia; Sam Sarkissian, UBA; Uvette Walker, Allmed	Implement, adopt and integrate with BPHC population health tools

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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		
Attributed patients	Recipients of services	Participate in care management
Providers in BPHC	Identify patients for care management	Participate in training on clinical and billing documentation to enable appropriate population identification and selection for PHM. Participate in technical assistance and project management for PCMH NCQA certification.
Care managers at partner organizations, including BAHN, CCMP and CBC	Manage risk reduction in identified populations	Create care plans and manage populations to reduce adverse outcomes including reductions in disease burden
CBOs	Promote health by actively engaging patient on social determinants	Intervene on patients identified with social determinants
External Stakeholders		
NYCDOHMH	Coordinating Domain 4 goal achievement	Coordinates and collaborates with NYC PPSs in developing strategies to improve MHSA infrastructure and retention in HIV care
State DOH	Oversees state DSRIP implementation and effectiveness	Creates timelines and deliverables for DSRIP program
Other PPSs participating in the same Domain 4 projects: OneCity, Community Care Brooklyn, Bronx Health Access, Mount Sinai, Brooklyn Bridges, NewYork Hospital Queens	Collaboration, information exchange, shared workforce development	Key deliverables/resps: Collaborate on shared projects and organizational initiatives, strategize on information exchange, and collaborate on shared workforce development

IPQR Module 8.7 - IT Expectations

Instructions :

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

Current population health management IT capabilities in place in BPHC include Montefiore CMO's comprehensive care management system which is being used by 400 care management employees to coordinate care for more than 300,000 individuals across employer-sponsored coverage and Medicare and Medicaid managed care. In addition, care management agencies supporting our partner Health Home populations are using smaller scale care management solutions, while other partners are using homegrown analytics to track patients across settings and within condition cohorts. Finally, the Bronx RHIO has developed the Bronx Regional Analytics Database (BRAD) under a multi-year grant from the CMS Center for Medicare and Medicaid Innovation.

A primary BPHC objective is to develop a standardized approach to population health management on behalf of our attributed population across all PPS participants based on a new IT infrastructure – portions of which are being selected in collaboration with Montefiore CMO and Montefiore's Hudson Valley PPS and portions of which build on existing capabilities. Our plans for leveraging and developing a new and integrated IT infrastructure for population health management are based on the following:

• Central data management and analytics through the Bronx RHIO.
• Patient and provider matching and master data management through Bronx RHIO to provide a single integrated view of each patient and a unified, standard and navigable view of participating partners to each other.
• A common commercial care coordination management solution (CCMS) selected from among three finalist vendors being assessed by a cross-functional team of Montefiore and BPHC clinical, operational and technology subject matter experts.
• Health information exchange through Bronx RHIO to achieve required data sharing between electronic medical records and the CCMS, across BPHC and potentially with other PPSs.
• Performance management and metrics (analytics) for internal analysis and reporting and NYSDOH reporting, based on Bronx RHIO and Montefiore Enterprise Data Warehouse capabilities.
• Assessment, monitoring and support programs and resources to help partners implement certified EHRs, adopt and integrate with RHIO services and, if eligible, use the combined IT infrastructure to achieve PCMH 2014 recognition.
• A digital health strategy for patient engagement, including telehealth, remote monitoring, a patient portal and personal health record sharing and digital health apps that are culturally competent.

IPQR Module 8.8 - Progress Reporting

Instructions :

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

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BPHC will measure the success of the population health management workstream using the following metrics:
• The number of primary care practice team members who have begun training on population health management applications
• The number of primary care practice team members who have completed training on population health management applications
• The number of providers (primary care team, behavioral health teams and others) that actively use electronic medical records, care planning tools, and patient registries
• The number of primary care practices that have submitted to the CSO work plans and timelines for attaining NCQA 2014 PCMH recognition

• The number of primary care practices that have begun the process per their work plan for achieving NCQA Level 1, 2 or 3 PCMH recognition

• The number of primary practices that achieved NCQA Level 1, 2 or 3 PCMH recognition
• The approval of a bed reduction plan by the Executive Committee
• DSRIP project-specific metrics such as PQIs, PDIs, PPRs, PPVs, and HEDIS metrics such as hemoglobin A1c, LDL, flu shots, and others

IPQR Module 8.9 - IA Monitoring

Instructions :

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Section 09 – Clinical Integration

IPQR Module 9.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform a clinical integration 'needs assessment'.	Completed	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 Envision clinical integration end-state	Completed	Define end-state clinical integration model, aligned with requirements for Project 2.a.i and IT Systems & Processes.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Identify care protocols for clinical integration	Completed	Determine which project-specific care protocols require clinical integration. Protocols will be determined as outlined in second milestone "Developing a Clinical Integration Strategy."	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Investigate gaps and needs across PPS related to clinical integration	Completed	Conduct data collection with partners to complete assessment of key DSRIP project requirements, clinical service gaps, workforce and process gaps, data sharing and interface needs, etc.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish definition of clinical integration for partners	Completed	Define clinical integration for our Provider Partners as the need for PPS-wide standardization and alignment with high-value treatment protocols that various provider partners can implement in their practices; this includes, but is not limited to, promoting effective care transitions.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Analyze data on gaps and needs across PPS	Completed	Complete analysis of data collected to identify clinical integration needs, potential strategies/programs and priorities,	06/01/2015	12/31/2015	06/01/2015	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
related to clinical integration		based on project, partner and PPS management goals.							
Task Report findings on gaps and needs across PPS related to clinical integration	Completed	Document assessment findings and recommendations, with prioritized clinical integration activities.	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Develop a Clinical Integration strategy.	Completed	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 Create project-based work groups to develop clinical guidelines	Completed	Form project-based workgroups to recommend, for clinical use across the PPS, high value treatment protocols and evidence based guidelines and clinical recommendations.	06/15/2015	09/30/2015	06/15/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Identify overlaps between project and PCMH requirements	Completed	Develop cross-walks for the project specific metrics with PCMH 2014 level 3 requirements.	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Identify overlaps between clinical project requirements	Completed	Develop crosswalks across all selected projects to assure clinical integration across projects and to avoid siloed implementation and integration plans.	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Create mechanism for approval of workgroup recommendations by QCIS	Completed	Establish methodology for workgroup recommendations to be vetted and approved by QCIS	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop PPS clinical integration strategy	Completed	Develop strategy for clinical integration, based on needs assessment findings and recommendations, in consultation with the Quality and Care Innovation Sub-Committee and the Executive Committee.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop data sharing and clinical interoperability implementation plan	Completed	Identify and document data sharing and clinical interoperability implementation plan, including standardized workflow and protocols, staff and partner role definitions, and strategies such as event notification, clinical messaging and	08/01/2015	03/31/2016	08/01/2015	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
		other protocols specific to supporting care transitions across settings.							
Task Foster two-way communications for transfer of clinical information	Completed	Establish expectations for two-way communication with multidisciplinary care teams that interact with and treat patients, ensuring seamless clinical information transfer.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish site-specific implementation teams	Completed	Identify Provider-based Implementation Teams	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop dissemination strategy for implementation tools and procedures	Completed	Develop strategy for dissemination of recommendations, training on guidelines/protocols/implementation strategies	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Further define the role of workgroups as clinical quality councils	Completed	Develop methodologies for project-based workgroups to serve as project quality councils.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish feedback mechanisms	Completed	Develop feedback mechanisms for accountability and Continuous Quality Improvement	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Implement communications strategy to engage partners in clinical interoperability planning	Completed	Communicate clinical interoperability implementation plan to partners using email, webinars and formal training and education designed to engage providers/partners in clinical integration efforts.	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Create care transitions strategy	Completed	Work with vendor to develop care transitions strategy across patient and provider types, including impementation plan. Care transition planning steps will include but not be limited to: Stakeholder Identification, finalizing workplan, curriculum development, staffing plan development, workflow for PCP appointment scheduling, evaluate IT needs including ENS, staff recruitment and training, site-specific support during and post-implementation.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop care coordination training strategy	Completed	Identify and decide on options for staff training on care coordination skills, patient centered communication skills and the use of care coordination tools.	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Identify training curricula	Completed	Identify training curricula for providers on behavioral health assessments to identify unmet needs of patients.	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Establish regular review of and updates to evidence based guidelines	Completed	Develop mechanisms for regular review of project-selected Evidence Based Guidelines (by project quality councils) to assure our PPS is utilizing the most up-to-date tools and that those upadated guidelines/protocols continue to be clinically integrated across the PPS.	12/01/2015	03/31/2016	12/01/2015	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
Perform a clinical integration 'needs assessment'.	6338	Other	36_DY2Q1_CI_MDL91_PRES1_OTH_M1_BPHC_Updated_Provider_List_for_Clinical_Integration_via_PCMH_Engagement_3754.xlsx	M1_BPHC Updated Provider List for Clinical Integration via PCMH Engagement	07/15/2016 01:31 PM
	6338	Templates	36_DY2Q1_CI_MDL91_PRES1_TEMPL_Clinical_Integration_Meeting_Schedule_DY2Q1_M1_3753.xlsx	Clinical Integration Meeting Schedule	07/15/2016 01:30 PM
Develop a Clinical Integration strategy.	6338	Other	36_DY2Q1_CI_MDL91_PRES2_OTH_Clinical_Integration_Provider_Training_Schedule_DY2Q1_M2_3756.xlsx	Clinical Integration Training Schedule for Providers	07/15/2016 01:36 PM
	6338	Other	36_DY2Q1_CI_MDL91_PRES2_OTH_Clinical_Integration_Operations_Training_Schedule_DY2Q1_M2_3755.xlsx	Clinical Integration Training Schedule for Operations Staff	07/15/2016 01:35 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform a clinical integration 'needs assessment'.	BPHC has completed this milestone. There have been no changes to the Clinical Integration Needs Assessment, and the list of providers who have been integrated has been updated. Meeting schedule template attached.
Develop a Clinical Integration strategy.	BPHC has completed this milestone. There have been no updates to the Clinical Integration Strategy. Training templates attached.

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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. We have found that our network participants have embraced collaborative clinical integration assessment and strategy activities, and that they are eager to engage in greater clinical integration. We recognize, however, that our partners often already feel stretched thin by the operating requirements of their existing organizations and that creating and managing an effective integrated workflow across a high number of partners may present a challenge. We have based metrics and integration goals on specific project and organizational requirements identified in other work streams, and on measures and rapid cycle evaluation (RCE) metrics that can provide quantitative evidence of integration improving patient outcomes. With our partners we have defined common and standardized workflows and protocols for clinical integration that can be implemented without a substantial additional burden.

2. Our partners have many disparate technologies and data sets produced by them, posing additional changes to the PPS-wide clinical integration and interoperability. We continue to mitigate these risks by thoroughly assessing and analyzing partner interoperability and staff capabilities and readiness, as described in the IT Systems & Processes work stream, and providing formal PPS program support for achieving EHR implementation and integration, QE participation and PCMH recognition.

IPQR Module 9.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

The strategies developed in the Clinical Integration workstream are closely related to requirements and strategies in the Workforce Strategy, IT Systems and Processes, Performance Reporting, Physician Engagement and Population Health Management workstreams. In addition, the Clinical Integration workstream is highly interdependent with General Project Implementation and in particular for Domain 2 & 3 project-specific strategies and their Domain 1 requirements, including primary care providers attaining 2014 Level 3 PCMH recognition. Many of the goals and requirements of project 2.a.i are closely related to clinical integration. Finally, physician engagement is a core component and prerequisite for establishing a clinically integrated network.

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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
Senior Director, Care Delivery & Practice Innovations	Dr. J. Robin Moon	• Oversight of project management and clinical integration • Clinical integration strategy
Clinical Project Directors, CSO	Vitaly Chibisov, Benny Turner, Caitlin Verrilli, Monica Chierici, Zoe Stopak-Behr	• Completed and analyzed provider and CBO surveys • Clinical Integration strategy
Executive Committee, BPHC	Len Walsh, Chair	• Oversight of clinical integration
QCI Subcommittee	Co-chairs: Dr. David Collymore, Acacia Debbie Pantin, VIP Community Services	• Oversight of performance reporting structure and plan
Workforce Subcommittee	Mary Morris, Co-Chair, SBH Health System Rosa Mejias, Co-Chair, 1199 TEF	• Provider training plan and tools
Key Point Person/DSRIP Project Managers	Nicolette Guillou, Montefiore (ambulatory) Akwasiba Rafaelin (ED and in patient) Twiggy Rodriguez, Acacia Network Irene Borgen, SBH Health System Zena Nelson, Institute for Family Health (IFH) Fernando Alonso, Bronx United IPA Nieves Madrid, Morris Heights Health Center (MHHC) Dean Bertone, Union Community Health Center (UCHC)	• Regular communication • Timely reporting on pertinent data • Feedback on the integration process
Clinical Liaisons	Site-Specific Medical Directors/Designees	• Regular communication • Timely reporting on pertinent data • Feedback on the integration process
Montefiore CMO Liaisons	Anne Meara, Associate Vice President, Network Care Management, Montefiore Care Management Organization Alex Alvarez, Director, Care Management Resource Unit	• Regular communication • Timely reporting on pertinent data • Feedback on the integration process
IT team, CSO	SBH IT Team led by Dr. Jitendra Barmecha, CIO	• IT infrastructure to support the data integration
Mental Health Liasions	Virna Little, IFH Dr. Lizica Troneci, Chair Psychiatry, SBH	BH clinical integration
Substance Use Liaisons	Debbie Pantin, SAED, VIP Pam Mattel, CEO, Acacia,	Substance Use clinical integration

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
BPHC Chief Medical Officer	Dr. Amanda Ascher,	• Oversight of clinical integration implementation • Clinical integration strategy

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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		
Bronx RHIO leadership: Kathryn Miller, Charles Scaglione	Health information exchange provider	Support in analyzing current state of IT interoperability and developing strategies to support, broaden and enhance future clinical integration with data exchange
IT team, SBH: Dr. Jitendra Barmecho, CIO, Jonathan Ong, Zane Last, Gregg Malloy	Provide data exchange, IT interoperability and systems integration strategy and support	Alignment with IT systems and processes related to clinical integration; input into data sharing and interoperability strategies, including IT interfaces and messaging to support clinical integration
Montefiore CMO: Peggy Czinger, John Williford	Provide clinical integration experience and expertise from ongoing care	Lessons learned from and input into future team-based care management, care coordination and organizational supports (e.g., staffing, IT, contact center, etc.)
External Stakeholders		
NYC DOHMH	Support for the Domain 3 project's planning and execution	Domain 3 projects planning process
Other Bronx PPSs: Advocate PPS OneCity Health PPS Bronx Lebanon PPS	Accountability and sharing of best practices	Regular communication stream
OASAS	Support for PC/BH Integration and MHSA	Support with review of clinical guidelines to align with best practices.

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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.

Nearly all components of BPHC's shared IT infrastructure will support and are critical to clinical integration:
• Central data management and analytics through the Bronx RHIO will provide common data and outcomes measurement to bind together partners and help them track common integration results in a standardized way.
• Patient and provider matching and master data management through Bronx RHIO will provide a single integrated view of each patient and a unified, standard and navigable view of participating partners to each other.
• A common care coordination management solution (CCMS) will further present an integrated view of the patient and provide a common tool for interacting with patients and with other partners
• Data sharing and interoperability standards and protocols embedded in partner contracts will support transitions and care management and promote an integrated and longitudinal view of the patient through secure messaging, event notification and potential aggregated portal data sets and other patient- and provider-facing applications.

IPQR Module 9.8 - Progress Reporting

Instructions :

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

Clinical integration will be measured by: evidence of high value treatment protocols implemented by providers across the PPS; improvements in clinical outcomes (e.g., improved rates of LDL and HTN control in CVD patients, improved A1C rates in Diabetics, improved depression screening and improving PHQ9 scores in patients receiving care in a BH integrated model.) Clinical integration success will also be measured by the level of Provider based engagement in Continuous Quality improvement, as measured by our workgroups which serve as project-specific quality councils.

IPQR Module 9.9 - IA Monitoring:

Instructions :

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Section 10 – General Project Reporting

IPQR Module 10.1 - Overall approach to implementation

Instructions :

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

BPHC is committed to establishing a care delivery model with mutually reinforcing resources and capabilities across the PPS. These aim to measurably improve patient satisfaction, improve outcomes, lower costs and enable the transition from volume to value-based care. To this end: 1) BPHC is establishing a population health management-driven HIT architecture to allow electronic data sharing across providers and access to patient-level information. This will facilitate rapid treatment and care management decisions among collaborating providers and beneficiaries about physical, behavioral, and social problems that impact beneficiaries' lives and support attainment of PCMH Level 3 2014 standards. 2) BPHC is creating an analytics capability for access to timely performance reports, to help accountable parties measure and track the impact of their actions on both a patient and population level and identify areas for improvement. The analytics team monitors the PPS and partners' progress towards meeting project targets. 3) BPHC is developing a workforce recruitment and retention strategy including career paths, higher education incentives, and excellent training and competitive salaries for a culturally and linguistically competent care management staff to engage, educate, and support individuals in need of assistance in managing both medical and social chronic conditions. 4) BPHC is leveraging the clinical and administrative leadership within each PPS partner and will ensure they have adequate dedicated time to drive overall DSRIP implementation. Partners' clinical and administrative leadership will: educate and motivate staff to embrace evidence-based practices; use technology to help improve patient outcomes; ensure that staff engage in DSRIP project-related training; provide quality oversight; and oversee the achievement of PCMH NCQA Level 3 2014 recognition. 5) BPHC has established a Quality and Care Innovation Sub-Committee (QCIS) to act as BPHC's clinical governance body. The QCIS draws from key partners and include diverse, well-informed, activist practitioner thought leaders, ranging from PCPs, subspecialists, nurses, mental health professionals, and social workers. The QCIS analytics support team will acquire and present data to rapidly and decisively direct attention to high performers for best practices and to low performers for remediation. The clinical governance body will: provide clear direction and a strong voice in defining and implementing change at the provider level to create a culture of quality and accountability; advocate for clinical integration to improve care; and seize opportunities to collaborate with other PPSs. 6) BPHC is developing a financial sustainability plan that begins with a transparent and coordinated inter-project budgeting system that: supports DSRIP central services; accurately reflects needed investments in PPS provider staffing and IT infrastructure; accounts for overlapping project personnel and training curricula; and moves in phases to a total cost of care model that expands upon the risk-based model now in place for some PPS providers via Healthfirst and other MCO contracts. 7) BPHC is actively collaborating with other Bronx PPSs, including the HHC and Bronx-Lebanon-led PPSs and the Advocate Community Providers PPS, on multiple areas including clinical planning, workforce development, community engagement, and information sharing. 8) BPHC has established a Central Services Organization (CSO) to provide a range of services to PPS partners, including clinical supervision, information technology, financial, training, analytics, administrative, and care management/care coordination infrastructure services. The CSO will also ensure partners' compliance with project requirements and track the project implementation and patient engagement speed commitments across all projects.

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

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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.

BPHC sees its DSRIP projects as a suite of programs that enable one another and magnify the impact of individual projects and workstreams. Some of the major dependencies include the following: Population health management and IT systems & processes: Attaining PCMH Level 3 recognition is widely viewed among clinicians who have been involved in DSRIP planning as the "master DSRIP project milestone" off of which virtually all other DSRIP projects and elements are built, including patient engagement and follow up. The BPHC HIT architecture is geared to providing IT capabilities that support work flows and protocols used by high-functioning Level 3 PCMHs to transition to population health management, such as electronic medical records, best practice alerts, care planning systems, patient registries, and tracking and stratification tools. Underlying these capabilities are a central data storage and management plan, robust data governance, and RHIO connectivity. Project implementation, IT systems & processes, and financial sustainability: Clinical improvement projects focused on cardiovascular disease, diabetes, asthma, and behavioral health will be built upon the chronic care management foundation provided by a high functioning Level 3 PCMH. Key PCMH features that promote effective chronic care management include use of evidence-based guidelines selected by consensus of the clinical governance body and data sharing that enables practitioners and embedded care managers to assess and develop effective care plans for the target populations. Ultimately, the establishment of Level 3 PCMHs across the PPS will be the impetus for moving to value-based payments that build a sustainable delivery system. Implementation of clinical improvement projects will be designed to build upon IT, workflows and clinical training used in the NCQA PCMH recognition process. Performance reporting, clinical integration and practitioner engagement: Practitioner accountability will be built on performance reporting that provides provider-specific and comparative performance data on the patient, practice and population level. Performance reporting is a key provider engagement tactic. Workforce strategy: A robust and well-trained workforce, rooted in the diverse communities of the Bronx, and engaged in the transformative change required under DSRIP will be central to the success of DSRIP project implementation. BPHC has identified a four-part workforce strategy that will be fleshed out based on the needs of our clinical projects. Our strategy includes: (1) redeployment of workers to respond to shifting staffing needs and ensure any displaced workers are connected to new employment; (2) training and education to address the needs for both retraining of existing staff and onboarding those newly hired under DSRIP; (3) robust recruitment to attract new workers; and (4) active engagement of labor and frontline staff.

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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
Executive Director, CSO	Irene Kaufmann	• Oversee all of the PPS work and CSO activities to accomplish all of the projects' implementation. • Communicate with the Executive Committee, and represent the CSO to all of the Sub-Committees. • Project monitoring and performance reporting. • Support and report to BPHC governance. • Act as liaison to NYSDOH and other PPSs.
Chief Medical Officer, CSO	Dr. Amanda Ascher	• Oversee project-specific provider engagement and clinical/delivery strategies and monitoring of performance/ outcomes. • Collaborate with BPHC members' CMOs. • Liaison with other PPSs on evidence-based practice implementation.
Senior Director, Care Delivery & Practice Innovations, CSO	Dr. J. Robin Moon	• Oversee all of the clinical projects implementation (Domains 1-4), including monitoring and reporting. • Work closely with the Quality Management team. • Monitor speed and scale • Identify and promote care delivery and practice innovations.
Senior Director, Quality Management & Informatics, CSO	Janine Dimitrakakis	• Oversee the development of quality metrics, and monitoring and reporting of them. • Work closely with the clinical projects team and the SBH IT team.
BPHC Workforce Liaison	Mary Morris	• Work with project participants to implement workforce implementation plans to meet participants' recruitment, training and worker retention needs. • Collect and analyze workforce data and report on training effectiveness.
BPHC Director of Financial Planning	Ronald Sextus	• Conduct financial evaluation of each project. • Develop, implement and manage funds distribution methodologies.

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		• Develop value-based payment models. • Produce quarterly reports for Executive Director and governance.
BPHC Chief Technology Officer	Jitandra Barmecha	• Work with project participants to develop and implement IT components of project plans. • Advise governance, Executive Director and Director of Finance of resource gaps that may impede IT implementation. • Liaison with Bronx RHIO and other PPSs.
BPHC Compliance Officer	Suzette Gordon	• Monitor and develop corrective action plans as needed to ensure member compliance with rules and regulations of regulatory agencies and with BPHC's by-laws and policies & procedures. • Disseminate current, revised and new policies and procedures.
BPHC Director of Collaboration	Albert Alvarez	• Manage BPHC member engagement and outreach to CBOs and community stakeholders. • Manage website, social media and communications for and within BPHC.
BPHC Executive Committee Chair	Leonard Walsh	• Governance: Oversight of and support for all aspects of deployment of DSRIP projects.
BPHC Partners' Project Liaisons	Akwasiba Rafaelin, Montefiore (ED and IP) Nicolette Guillou, Montefiore (ambulatory) Irene Borgen, SBH Health System Twiggy Rodriguez, Acacia Network Nieves Madrid, Morris Heights Health Center (MHHC) Dean Bertone, Union Community Health Center (UCHC) Zena Nelson, Institute for Family Health (IFH) Fernando Alonso, Bronx United IPA	• Coordinate with project transitional work groups and CSO project directors to oversee implementation activities at participating sites.

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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		
SBH Health System Leonard Walsh Eric Appelbaum	Lead Applicant	Fiduciary for DSRIP; Chair of Executive Committee for BPHC
Montefiore Medical Center Steven Rosenthal Amanda Parsons	Largest provider in BPHC	Member of Executive Committee of BPHC; contractor to provide key technical assistance on projects 2.b.iii and 2.b.iv; committed provider in all DSRIP projects
Institute for Family Health Maxine Golub	FQHC providing primary care services in several high-need areas of the Bronx	Member of Executive Committee of BPHC; contractor to provide technical assistance on project 3.a.i; committed provider in DSRIP projects 2.a.i, 2.a.iii, 3.a.i, 3.b.i, 3.c.i, 3.d.ii
Acacia Network Pam Mattel	FQHC providing primary care services in several high-need areas of the Bronx; behavioral health provider, SNF and respite housing provider	Member of Executive Committee of BPHC; contractor to provide technical assistance on project 3.a.i; committed provider in DSRIP projects 2.a.i, 2.a.iii, 3.b.i, 3.c.i, 3.d.ii
Union Community Health Center Doug York	FQHC providing primary care services in several high-need areas of the Bronx	Member of Executive Committee of BPHC; contractor to provide technical assistance on project 3.a.i; committed provider in DSRIP projects 2.a.i, 2.a.iii, 3.b.i, 3.c.i, 3.d.ii
Bronx United IPA Fernando Oliver	IPA group providing primary care services in several high-need areas of the Bronx	Member of Executive Committee of BPHC; contractor to provide technical assistance on project 3.a.i; committed provider in DSRIP projects 2.a.i, 2.a.iii, 2.b.iv, 3.b.i, 3.c.i, 3.d.ii
Morris Heights Health Center Tosan Oruwariye	FQHC providing primary care services in several high-need areas of the Bronx	Member of Executive Committee of BPHC; contractor to provide technical assistance on project 3.a.i; committed provider in DSRIP projects 2.a.i, 2.a.iii, 2.b.iii, 3.b.i, 3.c.i, 3.d.ii
Health People Chris Norwood	CBO providing evidence-based education to patients in the Bronx with chronic illnesses	Member of DSRIP Quality and Care Innovation Sub-Committee and clinical work group; contractor for delivering Stanford Model program to target groups for projects 3.b.i and 3.c.i
VNSNY Marianne Kennedy	Home care provider and MLTC provider	Member of the BPHC Executive Committee; committed partner in project 2.b.iv
Bronx Works Eileen Torres	CBO that provides numerous support and social services	Member of the BPHC Executive Committee
Bronx RHIO Charles Scaglione	Non-profit organization that provides health information exchange, shared data management and supporting data analytics, and	Member of the BPHC Executive Committee

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
	performance monitoring	
CenterLight Paul Rosenfeld	Home care and MLTC provider	Member of the BPHC Executive Committee; committed partner in projects 2.a.iii and 2.b.iv
1199 TEF	Workforce vendor that will support execution of workforce planning and training related activities including participation on the Sub-Committee, best practices, information from other PPSs, helping to screen candidates for new hires, assessment, remediation and culture change, preparation of reports to the State and dispute resolution.	Member of BPHC Executive Committee; committed to being primary vendor for implementing BPHC workforce strategy including training, re-training, education programs and re-deployment support
Healthfirst Pat Wang	Managed care organization providing coverage to a majority of patients attributed to BPHC	Member of Executive Committee of BPHC; will work with PPS on movement to full risk-based contracting
External Stakeholders		
1199 TEF	Workforce vendor that will support execution of workforce planning and training related activities including participation on the Sub-Committee, best practices, information from other PPSs, helping to screen candidates for new hires, assessment, remediation and culture change, preparation of reports to the State and dispute resolution.	Committed to being primary vendor for implementing BPHC workforce strategy including training, re-training, education programs and re-deployment support

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.

In order to support its projects and to act as an effective integrated performing provider system, BPHC will require and implement the following IT infrastructure: Care coordination & management: Collaboratively with the Montefiore CMO and the Montefiore-sponsored Hudson Valley PPS, BPHC is in the process of evaluating and procuring a care coordination management solution (CCMS) for population stratification, patient engagement, patient assessment, care planning, clinical and social service navigation, care transition management, patient registries and care management workflow, capacity and task management. Health information exchange (HIE): BPHC will build on the close governance and working relationship that SBH and key PPS partners have with Bronx RHIO to achieve project milestones related to health information exchange and data sharing. Bronx RHIO enjoys significant penetration with Bronx providers, including BPHC members. BPHC is working with Bronx RHIO to perform due diligence on its HIE capacity and capabilities and has undertaken further assessment of PPS partners' current level of integration with the RHIO and their readiness to achieve the level of integration required by BPHC projects. In addition, BPHC and Bronx RHIO are working on arrangements for cross-PPS/QE collaboration and will co-develop interfaces to the CCMS. Connections to the SHIN-NY are also being explored. Central data management: The Bronx RHIO will provide data governance, data specification and acquisition capabilities, data normalization/quality, patient and provider matching, master data management (MDM), central data storage and authorized access in an operational data store, and bi-directional data sharing with BPHC partners. Performance management and metrics (analytics): While much NYSDOH DSRIP metric reporting will be claims-based, and will be performed by the DOH in the Salient MAPP system, BPHC will need to identify its own required level of detail for performance monitoring. Assessment, monitoring and support programs and resources: Based on a current state assessment of PPS partner capabilities against BPHC and DOH requirements, the BPHC CSO will establish program management services for monitoring or assisting PPS partners as required with acquiring EHRs certified for Meaningful Use attestation, achieving PCMH 2014 recognition and participating and integrating with the Bronx RHIO for health information exchange. Digital health strategy for patient engagement: Beyond the IT discussed above, BPHC is developing strategies for implementing patient engagement and activation mechanisms to promote patient self-management in PPS/IDS programs. This may in the future include developing a comprehensive strategy for telehealth, remote monitoring and patient engagement through digital health apps that are culturally competent and sensitive to patient circumstances and needs. In addition, BPHC is exploring opportunities for connecting community-based organizations to the PPS's IT infrastructure to facilitate patient engagement, provider communication, and closed loop referral tracking.

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's CSO analytics and IT staff, BPHC Chief Medical Officer, the CSO's Senior Director of Quality Management & Informatics, and the Quality & Care Innovation Sub-Committee (QCI) will work together closely to design reporting formats for three audiences—providers, CSO clinical

project team members and QCI Sub-Committee members—that integrate Domain 1 process metrics, Domain 2 and 3 quality and outcome metrics, and other internal PPS reporting metrics selected by the QCI into its performance reporting dashboard and resulting performance reports to be shared with PPS members. The rapid cycle evaluation process will be the basic method used to monitor progress and identify providers that appear to be at risk of missing performance targets. We will also work with our partners at the provider level to ensure that they have a continuous quality improvement process in place to detect and address operational problems in each of the projects they participate in on an ongoing basis. Under the leadership of the BPHC CMO and Senior Director of Quality Management & Informatics, the CSO will organize and support a continuous quality improvement process to be carried out both centrally and internally by participants. The continuous quality improvement process will include identifying areas for both partner-specific and cross-partner improvement strategies and tactics, monitoring progress against improvement targets, assisting with root cause analysis, and convening cross-PPS work groups on special topics that emerge from reporting via the analytics team.

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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.

Throughout implementation, BPHC will continue to encourage and insist upon extensive community involvement, which includes representation from a diverse group of Bronx provider & community-based organizations (CBOs) in its project advisory committee. BPHC has hired a multilingual Director of Collaboration with deep roots in the community, responsible for managing outreach to community stakeholders & CBOs. Our community engagement efforts provide bidirectional dialogue to ensure project implementation is achieving results & allow for course correction & innovation. These efforts aim to develop capacity within the community to ensure sustainability. We are creating new connections & resources through sharing of information, skills & tools, & collaboration with other Bronx PPSs. In addition, we are creating job opportunities & career pathways for community members. BPHC is undertaking the following steps to ensure that the Bronx community continues to be deeply involved: PPS has conducted a survey to enhance our knowledge of the services offered by & capacity of CBOs in our PPS, which will provide the basis for a web-based CBO service directory to facilitate direct referrals to support services. BPHC met regularly with CBOs to gain input & build a community engagement strategy. Through Community-based Discussion Sessions, members of the organizations defined aim-focused, common issues among licensed & grant-funded CBOs & organizations providing community-based services & to express participation needs & questions. Targeted participants included CBOs providing senior care, food pantries, social services, home health, legal, farmers markets, housing, education, behavioral health, developmental disabilities, & family & children services. Minutes & common themes from the sessions were distributed to participants, followed by an invitation to join the Community Engagement Plan Workgroup. The Workgroup identified the need for 3 additional groups: Communications Strategies (to create efficient & effective methods of communication from CBO to CBO & from CBO to PPS constituent, with additional focus on consumer involvement & patient engagement); Outreach & Engagement (conduct networking events, define level of CBO participation, & build proactive relationships on behalf of the PPS with new & existing CBOs); & Interconnectivity (continue to work on connecting CBO resources via available technology). All CBOs are invited to join the community engagement process. To engage the community stakeholders further, BPHC will encourage & solicit feedback through its website, presentations, publications, social media platforms, & public fora. BPHC produces & publishes a biweekly bulletin & a quarterly newsletter & will continue to host all-Member webinars. BPHC has begun contracting with CBOs that will be major contributors to the success of our DSRIP projects. BPHC is contracting with Health People: Community Preventive Health Institute (CBO specializing in evidence-based patient education for chronic disease management) & a.i.r. nyc (a CBO providing home-based services to families with asthma). In the Bronx, the biggest risk associated with community engagement is that the level of need for community resources, such as behavioral health & social support services, exceeds the resources available. Other risks may include insufficient infrastructure to manage the number of CBOs & people engaged, address the complexity associated with serving a diverse population in culturally meaningful ways, ensure rapid response to community need & suggestions, & support communication at the community level via information technology. However, DSRIP provides a unique opportunity to increase the reach & impact of existing resources & improve & build new infrastructure to engage our community in efforts to improve health in the Bronx.

IPQR Module 10.8 - IA Monitoring

Instructions :

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Section 11 – Workforce

IPQR Module 11.1 - Workforce Strategy Spending (Baseline)

Instructions :

Please include details on expected workforce spending on a semi-annual basis. Funds may be shifted from one funding type category to another within the workforce strategy spending table, as long as the PPS adheres to their overall spend commitments. However, the PPS may apply a 25% discount factor to the DY1 Workforce Strategy Spend target. If the PPS applies this discount in DY1, the PPS will be expected to reallocate those funds appropriately in DY2-4 to fully meet their DY1-4 total commitment.

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	750,000.00	750,000.00	1,002,326.00	1,002,326.00	518,573.00	518,573.00	401,854.00	401,854.00	192,099.00	192,099.00	5,729,704.00
Redeployment	37,500.00	37,500.00	50,116.00	50,116.00	37,041.00	37,041.00	28,704.00	28,704.00	12,807.00	12,807.00	332,336.00
New Hires	93,750.00	93,750.00	100,233.00	100,233.00	74,082.00	74,082.00	14,352.00	14,352.00	16,008.00	16,008.00	596,850.00
Other	750,000.00	750,000.00	1,002,326.00	1,002,326.00	444,491.00	444,491.00	344,446.00	344,446.00	179,292.00	179,292.00	5,441,110.00
Total Expenditures	**1,631,250.00**	**1,631,250.00**	**2,155,001.00**	**2,155,001.00**	**1,074,187.00**	**1,074,187.00**	**789,356.00**	**789,356.00**	**400,206.00**	**400,206.00**	**12,100,000.00**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

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IPQR Module 11.2 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Define target workforce state (in line with DSRIP program's goals).	In Progress	Finalized PPS target workforce state, signed off by PPS workforce governance body.	07/01/2015	06/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Establish and convene Workforce Project Team	Completed	Establish and convene Workforce Project Team (including Workforce Sub-Committee, Workforce Workgroups, workforce liaison and other supportive staff from the CSO, 1199 SEIU Training and Employment Funds (TEF), subject matter experts and stakeholders) responsible for implementing, executing and overseeing workforce activities.	07/01/2015	07/01/2015	07/01/2015	07/01/2015	09/30/2015	DY1 Q2	
Task Identify the requirements for each DSRIP project	Completed	Identify the requirements for each DSRIP project and the new services that will be delivered, in conjunction with the Quality and Care Innovation Sub-Committee.	07/17/2015	06/30/2016	07/17/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Identify types and numbers of workers needed for each DSRIP project	Completed	Identify the types and numbers of workers needed for each DSRIP project.	07/17/2015	06/30/2016	07/17/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Identify competencies, skills, training and roles required for each DSRIP project	Completed	Identify the competencies, skills, training and roles required for each DSRIP project, with particular attention to developing common standards and definitions for care management roles.	07/31/2015	06/30/2016	07/31/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Consolidate project-by-project analysis	Completed	Consolidate project-by-project analysis to develop a comprehensive view of the workforce needs to support all DSRIP projects.	04/30/2016	06/30/2016	04/30/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Finalize target workforce state	Completed	Finalize target workforce state and receive signoff from Workforce Sub-Committee and Executive Committee.	04/30/2016	06/30/2016	04/30/2016	06/30/2016	06/30/2016	DY2 Q1	
Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	In Progress	Completed workforce transition roadmap, signed off by PPS workforce governance body.	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Convene Workforce Sub-Committee	Completed	Convene Workforce Sub-Committee to provide input on the approach for developing the workforce transition roadmap.	07/01/2015	09/09/2015	07/01/2015	09/09/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Provide PPS member organizations with individualized survey data to determine their current workforce state	In Progress	Working with the Center for Health Workforce Studies (CHWS), provide PPS member organizations with individualized survey data to determine their current workforce state.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Draft a workforce transition roadmap template	In Progress	Based on current workforce state and future targeted workforce state (as defined in the milestone above and below), work with TEF to draft a workforce transition plan template that addresses workforce volume including hiring, training, deploying staff as well as the timeline for the changes and the related dependencies to assist PPS member organizations in developing individualized workforce transition roadmaps.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Obtain approval of transition plan template	Not Started	Obtain approval of transition plan template by Workforce Sub-Committee and Executive Committee to assist PPS member organizations in achieving future target workforce state.	08/01/2016	09/30/2016	08/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	In Progress	Current state assessment report & gap analysis, signed off by PPS workforce governance body.	11/01/2015	09/30/2016	11/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Gather baseline information on current workforce state	Completed	Work with CHWS to gather baseline information on current workforce state through member surveys and available workforce data. Baseline information will include an assessment of staff volume, staff titles/types, competencies and credentials related to implementing each DSRIP project	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Identify overall change in numbers, FTEs, salary, and benefits, by organization and in the aggregate as well as identify causes of potential workforce changes	In Progress	Work with CHWS and TEF to identify overall change in numbers, FTEs, salary, and benefits, by organization and in the aggregate as well as identify if the potential workforce changes are a result of: retraining, redeployment, new hires, or attrition.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Apply training costs and training strategies to the retraining of health workforce staff and identify any other training costs	In Progress	Work with TEF to apply training costs and training strategies to the retraining of health workforce staff and identify any other training costs (i.e. CBOS w/o new staff, but may need training to understand DSRIP and the process).	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Link training strategies and training costs to PPS DSRIP projects	In Progress	Work with TEF to link training strategies and training costs to PPS DSRIP projects.	11/01/2015	09/30/2016	11/01/2015	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
Task Identify staff who could be redeployed into future state roles to implement DSRIP projects	In Progress	Work with PPS partners, including unions, to identify staff who could be redeployed into future state roles to implement DSRIP projects. Workforce Advisory Work Group will be available to facilitate.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Conduct a job analysis of at-risk positions and a skill transferability analysis to create job transition maps and career ladders within the PPS	In Progress	Work with TEF and other members of the Workforce Sub-Committee to conduct a job analysis of at-risk positions and a skill transferability analysis to create job transition maps and career ladders within the PPS.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Identify new hire needs to implement DSRIP projects	In Progress	Identify new hire needs to implement DSRIP projects	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Perform workforce budget analysis for each DSRIP project over the duration of the projects	In Progress	Perform workforce budget analysis for each DSRIP project over the duration of the projects, taking into consideration overlap of training needs in projects.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Obtain sign-off on current state assessment report and gap analysis	In Progress	Obtain sign-off on current state assessment report and gap analysis from Workforce Sub-Committee and Executive Committee.	05/15/2016	09/30/2016	05/15/2016	09/30/2016	09/30/2016	DY2 Q2	
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.	Completed	Compensation and benefit analysis report, signed off by PPS workforce governance body.	11/01/2015	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	YES
Task Identify compensation and benefits ranges for current staff critical to implementation of DSRIP projects	Completed	As part of gathering baseline information from CHWS in the milestone above through member surveys and available workforce data, work with partners and stakeholders (including unions) to identify compensation and benefits ranges for current staff critical to implementation of DSRIP projects, including care managers.	11/01/2015	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Develop impact analysis on staff needing to be retrained and redeployed across PPS member organization	Completed	Working with TEF, build on analysis of at risk positions to develop impact analysis on staff needing to be retrained and redeployed across PPS member organizations.	11/01/2015	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Develop compensation and benefit range targets for staff positions, including new hires, critical to DSRIP implementation	Completed	Work with PPS members and targeted stakeholders to develop compensation and benefit range targets for staff positions, including new hires, critical to DSRIP implementation to inform PPS budgeting and workforce	11/01/2015	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		impact analysis.							
Task Calculate the number of partially and fully placed staff and develop a tracking system	Completed	Work with TEF to calculate the number of partially and fully placed staff and develop a tracking system	11/01/2015	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Determine impacts to partial placement staff and potential contingencies and develop and incorporate policies for staff who face partial placement and for staff who refuse retraining or redeployment	Completed	Convene the Workforce Advisory Work Group to determine impacts to partial placement staff and potential contingencies and develop and incorporate policies for staff who face partial placement and for staff who refuse retraining or redeployment, taking into consideration Collective Bargaining Agreements and HR policies at Partner organizations.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Draft comprehensive compensation and benefit analysis report	Completed	Draft comprehensive compensation and benefit analysis report.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Review and approval of compensation and benefit analysis report	Completed	Review and approval of compensation and benefit analysis report by Workforce Sub-Committee and Executive Committee.	05/01/2016	06/30/2016	05/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Milestone #5 Develop training strategy.	In Progress	Finalized training strategy, signed off by PPS workforce governance body.	11/01/2015	09/30/2016	11/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Provide training, as well as case management, counseling, job search assistance, employment workshops and tracking systems for impacted workers	In Progress	Contract with 1199 Training and Employment Fund to provide training, as well as case management, counseling, job search assistance, employment workshops and tracking systems for impacted workers.	11/01/2015	09/30/2016	11/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Provide specialized training for specific DSRIP projects	In Progress	Contract with other organizations (CBOs) to provide specialized training for specific DSRIP projects, including training on cultural competency and health literacy strategies, as needed.	11/01/2015	09/30/2016	11/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Create an inventory of needed training to implement each DSRIP project	In Progress	In concert with the Workforce Sub-Committee, Quality and Care Innovation Sub-Committee and workforce vendors and through member surveys and stakeholder input, create an inventory of needed training to implement each DSRIP project, including specific skills, certifications and competencies.	11/01/2015	09/30/2016	11/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Identify existing staff and new hires that will need to be retrained, and the competencies and skills they will need in the future to implement DSRIP projects	In Progress	As part of the inventory effort and the above milestones, work with TEF to identify existing staff and new hires that will need to be retrained, and the competencies and skills they will need in the future to implement DSRIP projects.	11/01/2015	09/30/2016	11/01/2015	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
Task Develop vision, goals and objectives for training strategy and draft detailed training strategy	In Progress	Work with TEF to develop vision, goals and objectives for training strategy and draft detailed training strategy, including plans and process to develop training curricula in concert with training vendors and the associated timeline.	01/29/2016	09/30/2016	01/29/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Develop mechanism to measure effectiveness of training in relation to training goals to implement DSRIP projects	In Progress	Work with partner organization HR leads to develop a mechanism to measure effectiveness of training in relation to training goals to implement DSRIP projects	01/29/2016	09/30/2016	01/29/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Finalize, review and approve training strategy	Not Started	Finalize, review and approve training strategy by Workforce Sub-Committee and Executive Committee.	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	

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
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.	zstopak	Other	36_DY2Q1_WF_MDL112_PRES4_OTH_Remediation_Workforce_M4_Narrative_Explanation_5864.docx	Narrative explanation	09/15/2016 05:09 PM
	zstopak	Meeting Materials	36_DY2Q1_WF_MDL112_PRES4_MM_Remediation_Workforce_M4_Approval_-_Workforce_Subcomittee_Meeting_Minutes_7.14.16_5863.docx	Board Approval	09/15/2016 05:08 PM
	repstein	Documentation/Certification	36_DY2Q1_WF_MDL112_PRES4_DOC_BPHC_Workforce_Compensation_and_Benefits_Report_Draft_7.5.16_3964.docx	BPHC Compensation and Benefit Analysis	07/21/2016 11:35 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Define target workforce state (in line with DSRIP program's goals).	BPHC led a workforce collaboration with four other PPSs (HHC OneCity Health PPS, NYU Lutheran PPS, and Maimonides Community Care of Brooklyn PPS) in Workforce Consortium and selected BDO as our joint vendor to help us define the target workforce state for each of the five PPSs, in an effort to not only save

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	cost but also to standardize the methodology and process of the deliverable. BPHC agreed to a subcontracting agreement between BDO and its subcontractor IHS Global, using simulation technology to work jointly on this deliverable in conjunction with BPHC. The BPHC Target Workforce State has identified BPHC's projected workforce needs by the end of DY5 (2020) by use of microsimulation modeling as predictive analytic tool, using the national data and other relevant evidence and aggregate measures. In addition to the impact of the DSRIP implementation, the modeling also considers the combined impacts of a growing and aging population in the Bronx, as well as expanded medical insurance coverage under the Affordable Care Act. The Target Workforce Analysis will be used in conjunction with the current state workforce survey results and the PPS workforce gap analysis to formulate the workforce transition roadmap, to be delivered in DY2Q2. The BPHC Target Workforce State has been completed; documentation will be submitted DY2Q2 per the State's push back of the deadline.
Create a workforce transition roadmap for achieving defined target workforce state.	BPHC Workforce Subcommittee has continued to identify steps that will be taken to transform its workforce in order to meet the DSRIP needs and prepare for subsequent healthcare transformation. Some key considerations in DY2Q1 have included the Identification of short- and long-term strategies to address workforce gaps between the current staff and the projected needs of the future workforce. This includes determination of 1) which workforce gaps can be addressed through short-term strategies of re-training and re-deployment of existing staff, 2) which gaps may be addressed through long-term strategies in partnerships with academic institutions, and 3) which strategies will require talent pools to support hiring new staff. In addition, we have completed work on Identifying risks to building workforce capabilities and mitigation strategies, including enhanced new media strategies for workforce communication and engagement. This milestone is on track for completion in DY2Q2.
Perform detailed gap analysis between current state assessment of workforce and projected future state.	BPHC, leveraging its current and target workforce state assessments, is in the process of identifying comprehensive workforce gaps. These gaps will be identified across people, processes, and technology, following these steps: 1) collect and aggregate data from the current state survey and target state assessment; 2) Identify key findings, patterns and themes; 3) perform a gap analysis to compare and contrast the current workforce state to the future workforce state; 4) analyze capacity to utilize current resources to reach future state and supplement current resources, as required; 5) identify areas where BPHC will have challenges in meeting future state due to existing workforce shortages, barriers to hire etc.; and 6) document findings in the Gap Analysis Report. At this time, we are on step 4, analyzing the current capacity within the PPS and determining what additional resources will be needed. This milestone is on track for completion in DY2Q2.
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.	BPHC led a workforce collaboration with four other PPSs (HHC OneCity Health PPS, NYU Lutheran PPS, and Maimonides Community Care of Brooklyn PPS) in Workforce Consortium and selected BDO as our joint vendor to survey the PPS member organizations and provide a Compensation and Benefit Analysis, among other deliverables. BPHC also worked to promote a subcontracting agreement between BDO and the Center for Health Workforce Studies at State University of New York in Albany, to complete the survey design, implementation and analysis. In collaboration with BPHC's Workforce Subcommittee and Workforce Consortium members, the survey was designed and distributed to BPHC's network ("Participants") to collect current state workforce data as well as compensation and benefits data by job title including average hourly wages, fringe benefits (%), and collective bargaining agreements in place at the respondents' organizations. The Participants surveyed were asked by BDO to provide compensation and benefit data as of December 31, 2015, to satisfy anti-trust provisions. The BPHC PPS identified the following job titles as new positions resulting from the DSRIP: Care Coordinator, DSRIP Program Manager/Director, Nurse Care Management Supervisor, Outreach Workers, Care Coordinator Assistant, Community Health Worker, Administrative Referral Coordinator, Receptionist, Depression Care Manager and Patient/Care Navigator. All of such new positions were identified as being full re-deployments (i.e., no partial) or new full hires. The BPHC Compensation and Benefit Analysis has been completed as part of the DY2Q1 submission. The BPHC Workforce Subcommittee voted to approve the analysis on July 14, 2016.
Develop training strategy.	BPHC and its Workforce Subcommittee, along with our workforce vendor, 1199 Training and Education Fund (TEF), have continued to develop the BPHC

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	Training Strategy. The training plan and timeline will be supported by the BPHC approach to the assessment of training needs, assessment results, the BPHC strategy for workforce changes, mechanisms for measuring training effectiveness and the association to the workforce communication and engagement plan. BPHC has also determined that there will be integration of the training strategy with the cultural competency training strategy and the training strategy for community-based organizations. This milestone is on track for completion in DY2Q2.

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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.

BPHC has intense retraining and training needs. We anticipate 5,000-10,000 existing staff will need retraining to implement the PPS's clinical projects and additional work streams. BPHC also anticipates up to 750 new jobs created within the PPS, all of which will require training.

To mitigate this risk, BPHC has engaged the services of the 1199 Training and Employment Funds to assist in the planning, implementation and administration of all of BPHC's training initiatives. The Director of Workforce Innovation from the BPHC CSO is working closely with the Workforce Subcommittee on the Workforce Plan, which is characterized by career ladders, continuous quality improvement and the use of evidence based teaching methods (including e-learning and basic skills support, as needed).

BPHC has a large and diverse workforce. We originally estimated our workforce to be 35,000. After completing our current state survey analysis, BPHC determined that the number of staff is twice that size, or approximately 70,000 total staff in 230 organizations. Communicating and engaging a staff of that size, including home care, which is the largest group represented at 27,198 (many in part time roles) is challenging.

To mitigate this risk, the Workforce Communication and Engagement Work Group representing multiple organizations in the PPS, has reconvened to determine what additional steps can be taken to expand the outreach to staff. The current focus is on using new media in addition to the elements already contained in the workforce communication and engagement plan. In addition, BPHC has identified the key workforce contact in each organization to help facilitate communication and information exchange. Focus groups have been planned for the fall, to gather additional ideas and input from staff across the PPS and gage the progress of current efforts toward staff engagement.

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.)

BPHC's workforce strategy has interdependencies with many workstreams, including clinical project implementation, cultural competency, IT systems and processes, and finance and budgeting.

• Project Implementation Interdependencies: The number and types of staff that must be retrained or redeployed and the number and type of staff that needs to be newly hired depend on the needs and services of the clinical projects. As the implementation of the clinical projects evolves, it will be important to closely monitor any changes that could impact workforce needs.

• Cultural Competency Workstream Interdependencies: The success of the PPS' recruitment and training strategy will impact the provision of culturally competent care. The PPS will work with 1199 TEF, CUNY, and contracted CBOs to develop training curricula that meet cultural competency and health literacy standards and incorporate these trainings into all new hire orientations, refresher courses, and provider

agreements.

• IT Systems & Processes: To support a robust IT infrastructure, BPHC is planning to implement an electronic care planning tool across the PPS. The success of this tool is heavily dependent on the ability of the healthcare workforce to use this platform to track and manage care. BPHC's CSO will institute extensive training for the care management workforce on the use of the care planning tool.

• Finance and Budgeting: BPHC anticipates that partners will require funding to hire and deploy additional staff and potentially to adjust compensation for existing staff critical to successful implementation of the DSRIP projects.

• Governance: Establishment of the Workforce Sub-committee will be critical to engaging workers and thus ensuring the success of each DSRIP project.

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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
Director of Workforce Innovation, BPHC	Mary Morris	Responsible for the development and implementation of all workforce implementation plans including providing leadership and advisement to the Workforce Sub-Committee, reporting to the Executive Committee.
Director of Collaboration, BPHC	Albert Alvarez	Responsible for obtaining input from the community on workforce needs.
Workforce Sub-Committee	The WSC has 12-15 voting members including representation from unions, HR, workforce experts, frontline staff (for all names, please see Membership Template in Governance workstream).	Responsible for implementing the workforce strategy, including Workforce Communication and Workforce Advisory facilitated by the 1199 Labor Management staff to ensure workforce input and identify concerns and structural barriers for collaborative decision making.
Workforce Training Vendor	1199 Training and Employment Funds (Rosa Mejias)	TEF will support execution of workforce training related activities including participation on the Sub-Committee, providing research on training vendors, best practices, information from other PPSs, helping to screen candidates for new hires, assessment, remediation and case management for candidates, culture change, preparation of reports to the State and dispute resolution.
Labor Representatives	Representatives from 1199 SEIU, NYSNA and CIR (Tom Cloutier, Teresa Pica, Gladys Wrenick, Rosa Mejias, and others)	Provide expertise on CBAs, and insight in retraining, redeployment and hiring needs.

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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		
Linda Reid, Annie Wiseman, Susan Roti	Training Leads in Partner Organizations	Provide best practice training approaches and guidance in program implementation
Erlinda Girado, Victoria Izaylevsky, Katrina Jones, Marc Wolf, Gloria Kenny	HR Leads in Partner Organizations	Support data collection for staff FTEs, comp and benefits, CBO information, hiring needs
Patricia Belair	SVP, Ambulatory Services and Strategy, SBH Health System	Advisor on ambulatory care competencies/jobs
External Stakeholders		
1199 SEIU, NYSNA, CIR	Labor Union Representatives	Facilitate worker engagement
Curtis Dann-Messier	CUNY liaison	Coordinate curriculum development, supply talent
Marilyn Aquirre-Molina, Executive Director, CUNY Institute for Health Equity	Connection to Bronx Borough President Ruben Diaz's Not 62 Campaign	Input for curriculum development. Provide action-research on the social determinants of health that contribute to the high rates of morbidity and mortality in the Bronx, and technical support for training curriculum to enable us to better address health equity.
Swawna Trager, Executive Director of the NY Alliance for Health Careers	Provide talent pool of new staff for CHWs and other "peer" roles.	Potential training funding source-city and federal funding including stipends for training, tuition reimbursement, wrap arounds and paid internships, Curriculum development consultation.
Jessica Hill, Director Bronx-Westchester AHEC	Provides Bronx resident talent pipelines for various PPS staff positions.	Creates community-based health professional training opportunities and public health programs. Strengthens community networks to increase minority representation in all healthcare professions.
GNYHA	Provide training on key areas of care coordination teams and cultural competency.	Provide research findings on NYC health issues.

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 development of shared IT infrastructure across the PPS will be important in storing information, tracking progress on workforce transitions, and delivering and tracking training to ensure success of the DSRIP clinical projects. Shared IT infrastructure will be especially important given the high volume of training, redeployment and new hires that needs to take place in order to implement the DSRIP projects.
1) Storing Information. BPHC will need to document information from all of the PPS Partners regarding their current workforce state, including volume, competencies and skills. It will be important to have an IT platform that will store this large volume of information in an organized way.
2) Tracking. BPHC anticipates that there will be extensive movement and changes in the workforce that will need to be tracked over time in order to ensure that BPHC reaches the future targeted workforce state. It will be crucial to track these changes across the PPS. The IT infrastructure will be key in reporting workforce process measures in the quarterly reports.
3) Training. Providers and staff will be trained regarding specific population needs and effective patient engagement approaches. Training will be scheduled, delivered and tracked using a learning management system (LMS) administered by the BPHC CSO.
4) Job Listings. BPHC will also use the IT infrastructure to post job openings on the "job board" across the PPS in order to recruit and hire qualified staff.

IPQR Module 11.9 - Progress Reporting

Instructions :

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

BPHC will measure the success of its workforce strategy through the milestones listed above. BPHC will focus on monitoring key workforce measures, such as the number and type of staff who are retrained or redeployed as well as new hires. The Workforce Sub-Committee will be charged with monitoring the comprehensive workforce strategy to ensure that BPHC retains, trains, and hires the staff necessary to support successful implementation of DSRIP projects. The Workforce Sub-Committee will be supported by two workgroups: 1) Workforce Communications Workgroup and 2) Workforce Advisory Workgroup that will support workforce efforts.

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IPQR Module 11.10 - Staff Impact

Instructions :

Please upload the Workforce Staffing Impact (Baseline) table provided for quarterly reporting.

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
zstopak	Other	36_DY2Q1_WF_MDL1110_OTH_11.10_Supporting_doc_4682.docx	Support	08/01/2016 04:34 PM

Narrative Text :

Impact analysis to be submitted for the first time in DY2 Q2, per SDOH guidance stating: "PPS are not required to submit Workforce Impact Analysis projections as part of their DY2, Q1 Quarterly Report submission."

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IPQR Module 11.11 - Workforce Strategy Spending (Quarterly):

Instructions :

Please include details on workforce spending for DY2. The workforce spending actuals should reflect only what was spent during the relevant quarters and is not cumulative across semi-annual periods. The PPS can shift funding across categories; e.g., from Retraining to New Hires. Please note that the "Cumulative Percent of Commitments Expended through Current DSRIP Year (DY2)" section is calculated based on the total yearly commitments.

Benchmarks	
Year	**Amount($)**
Total Cumulative Spending Commitment through Current DSRIP Year(DY2)	7,572,502.00

Funding Type	Workforce Spending Actuals		Cumulative Spending to Date (DY1-DY5)($)	Cumulative Percent of Commitments Expended through Current DSRIP Year (DY2)
	DY1(Q1/Q2)($)	DY1(Q3/Q4)($)		
Retraining	0.00	0.00	1,796,512.00	51.26%
Redeployment	0.00	0.00	0.00	0.00%
New Hires	0.00	0.00	406,696.00	104.83%
Other	0.00	0.00	558,693.00	15.94%
Total Expenditures	**0.00**	**0.00**	**2,761,901.00**	**36.47%**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

Cumulative DY2 Q1 and Q2 to be submitted in DY2 Q2, per SDOH instructions.

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IPQR Module 11.12 - 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.

IDS Risk and Mitigation
1) If providers and BPHC cannot agree on contract terms BPHC may fail to fully achieve its provider participation goals. BPHC is therefore working to understand provider capabilities, provide support, set clear performance expectations and evolve a DSRIP payment distribution based , at least in part, on performance until a fully VBP contract is achieved that is satisfactory to providers and BPHC.

2) CBOs participating in BPHC may not have the capacity to meet the PPS's interconnectivity/interoperability requirements. Through its Community Needs Assessment and various organizational and service surveys, BPHC has profiled its CBO member organizations and developed comprehensive profiles compiled into a database which will be used to facilitate referrals. A Community Engagement Work Group made up of BPHC CBOs, works to involve BPHC CBOs in meaningful participation that will ensure BPHC meets CBO needs and PPS DSRIP goals.

3) Lack of integration and continuity between CCMS systems of HHs within BPHC may lead to information silos and poor PHM results. BPHC is signing MSAs with all HHs in the PPS which detail policies, procedures and agreement to adopt standards. BPHC is advocating use of a single CCMS, , for all members, but will work to integrate other CCMS solutions chosen by other member organizations..

4) If providers do not fully embrace Care Management (CM) or PHM, PCPs will continue to provide uncoordinated care. BPHC educates providers how the change in SDOH incentives reward CM/PHM. BPHC provides CM/PHM CMEs, TA and tools in different PCPs settings.

5) If BPHC does not reach its incremental performance goals and DSRIP funding is affected, there will be risks to future transformation. BPHC is installing critical control measures to monitor program implementation, progress towards PHM and outcomes measures. CQI and change management trainings are being designed for our network partners so that these processes become part of regular operations. Frequent budgeting and contracting cycles are used to ensure continuous sustainable operations.

6) If providers do not implement EHR systems that meet MU and PCMH 2014 Level 3 standards by DY3Q4, their ability to fully participate in coordinated interventions, CM, PHM across the IDS will be affected and negatively impact patient outcomes. BPHC comprehensive PCMH/MU plan deploys external consulting resources, and provides customized technical assistance, coaching, and care team training modules so that practices achieve DSRIP goals.

7) If the Bronx RHIO fails to satisfy partner demand for secure messaging, alerts and patient record lookup, or providers do not integrate and use functions by DY3Q4, then planned clinical interventions, CM and PHM will be at risk across the IDS. BPHC will develop a timeline to prioritize practices for phased connectivity, and mechanisms to monitor the expansion of HIE / IDS. BPHC is exploring the expansion of local HIE DIRECT messaging outside of the RHIO, and the abilities of CCMS systems to message and alert. These would allow partners more options, leverage existing partner infrastructure where it exists, and provide a level of redundancy in case the RHIO cannot keep pace with partner demand.

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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)	Prescribed Due Date	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.	DY4 Q4	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Define pro forma role of all PPS providers in BPHC's network model of care (prioritized programs/projects, target patient populations, interventions, accountabilities, use of care plans, funds flow, etc.) to establish BPHC-wide expectations, building on clinical planning to date and planned population health management, clinical integration and IT assessment and planning detailed in those work streams		Project		Completed	08/01/2015	06/15/2016	08/01/2015	06/15/2016	06/30/2016	DY2 Q1
Task Draft Master Services Agreement (MSA) and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure		Project		Completed	04/01/2015	05/21/2015	04/01/2015	05/21/2015	06/30/2015	DY1 Q1
Task Solicit comments on MSA from partners through distribution to members, opportunity to submit written comments, and review in Committee and Sub-Committee meetings.		Project		Completed	05/21/2015	06/08/2015	05/21/2015	06/08/2015	06/30/2015	DY1 Q1
Task Finalize MSA agreement		Project		Completed	07/01/2015	07/23/2015	07/01/2015	07/23/2015	09/30/2015	DY1 Q2
Task Develop and finalize project schedules in concert with Clinical Operations Plans (COPs)		Project		Completed	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Review and negotiate project schedules with partner		Project		Completed	08/15/2015	12/31/2015	08/15/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
organizations. The order in which project schedules will be negotiated will be based on prioritization of partner organizations developed by SBH										
Task Complete first round of contracting with all PPS partners		Project		Completed	08/15/2015	03/20/2016	08/15/2015	03/20/2016	03/31/2016	DY1 Q4
Task Identify payers and social service organizations required to support IDS strategy that are not already identified as PPS member partners; schedule, conduct and document regular meetings to discuss formal mechanisms for them to participate in BPHC		Project		Completed	03/20/2016	06/30/2016	03/20/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	DY2 Q4	Project	N/A	Completed	08/30/2015	03/31/2016	08/30/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS produces a list of participating HHs and ACOs.		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.		Project		Completed	08/30/2015	03/31/2016	08/30/2015	03/31/2016	03/31/2016	DY1 Q4
Task Define contracting, coordination and assessment strategy for Montefiore BAHN ACO, and care model expectations, coordination and contracting strategies related to BAHN, CBC and CCMP partner Health Homes, based on requirement frameworks developed to date and those that will result from planned assessment and planning activities in other work streams		Project		Completed	09/10/2015	03/31/2016	09/10/2015	03/31/2016	03/31/2016	DY1 Q4
Task Assess HH and ACO population health management capabilities to determine if the skills and experience of the ACO and other organizations can be leveraged by BPHC, based on strategies and expectations; incorporate into BPHC operational strategy/plan		Project		Completed	08/30/2015	03/31/2016	08/30/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop and implement effective referral strategy to the HH/ACO, including referral tracking		Project		Completed	10/30/2015	02/25/2016	10/30/2015	02/25/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Integrate HHs and ACOs into the IT infrastructure		Project		Completed	09/30/2015	03/31/2016	09/30/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	DY2 Q4	Project	N/A	In Progress	08/15/2015	03/31/2017	08/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.		Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.		Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.		Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task PPS trains staff on IDS protocols and processes.		Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Identify and document required clinical and care management protocols for priority programs, projects and interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data		Project		Completed	08/15/2015	12/31/2015	08/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations for how interventions will be logged, tracked and reported.		Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Deploy systems to improve and promote effective care transitions, include protocols for tracking and follow-up		Project		Completed	01/15/2016	02/28/2016	01/15/2016	02/28/2016	03/31/2016	DY1 Q4
Task Operationalize partner and workforce roles by providing gap analysis and appropriate training to clinicians and care management staff (including licensed care managers, care coordinators, patient navigators/community health workers, medical assistants and front-office staff).		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Establish data collection, survey and reporting mechanisms to		Project		Completed	02/01/2016	06/15/2016	02/01/2016	06/15/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
enable BPHC monitoring to ensure that patients are receiving appropriate health care and community support in priority projects, based on needs identified in prior planning activities										
Task Review process for rapid cycle evaluation and continuous improvement of data collection, survey and reporting methods based on priority project experience and modify process as needed to ensure patients receive appropriate health care and community support		Project		Not Started	08/01/2016	09/01/2016	08/01/2016	09/01/2016	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.	DY3 Q4	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	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	07/01/2015	03/31/2018	07/01/2015	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	07/01/2015	03/31/2018	07/01/2015	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	07/01/2015	03/31/2018	07/01/2015	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	07/01/2015	03/31/2018	07/01/2015	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	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Identify safety net provider data sharing requirements and assess partner and QE data sharing capabilities and current HIE participation		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Coordinate with Bronx RHIO to develop comprehensive HIE adoption program to encourage and support partner participation and integration		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Begin coordinated interface and service development with Bronx RHIO										
Task Establish BPHC program to manage support for safety net providers to ensure that all are actively sharing health information, coordinating with Bronx RHIO to encourage, track and support partner participation and integration/data sharing		Project		Completed	03/01/2016	04/25/2016	03/01/2016	04/25/2016	06/30/2016	DY2 Q1
Task Track status and manage support to ensure that all PPS safety net providers are actively sharing health information through Bronx RHIO or alternative health information exchange		Project		In Progress	03/01/2016	03/31/2018	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	DY3 Q4	Project	N/A	In Progress	06/30/2015	03/31/2018	06/30/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).		Project		Not Started	03/31/2018	03/31/2018	03/31/2018	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	Not Started	03/31/2018	03/31/2018	03/31/2018	03/31/2018	03/31/2018	DY3 Q4
Task Assess eligible participating partner EHR use relative to Meaningful Use and PCMH 2014 Level 3 standards		Project		Completed	06/30/2015	12/31/2015	06/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish BPHC program to educate, encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, including potential use of incentive-based payments for implementation		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Recruit or contract for EHR implementation resources as needed		Project		Completed	11/01/2015	06/30/2016	11/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner EHR implementation and progress towards Meaningful Use and PCMH standards		Project		Not Started	08/01/2016	12/31/2016	08/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Track status and manage support to ensure all eligible safety net providers are using certified EHR systems that meet Meaningful Use and PCMH 2014 Level 3 standards		Project		In Progress	10/15/2015	03/15/2018	10/15/2015	03/15/2018	03/31/2018	DY3 Q4
Milestone #6	DY4 Q4	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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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	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform gap analysis and identify priories to achieving integration of patient record.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.		Project		Completed	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget to build registry and acquire necessary resources		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers,		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1

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emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care										
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.		Project		In Progress	04/01/2016	09/27/2016	04/01/2016	09/27/2016	09/30/2016	DY2 Q2
Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	DY3 Q4	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		Not Started	01/01/2018	03/31/2018	01/01/2018	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		Not Started	01/01/2018	03/31/2018	01/01/2018	03/31/2018	03/31/2018	DY3 Q4
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recruit or contract for PCMH practice certification resources as needed		Project		Completed	05/01/2015	12/31/2015	05/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task		Project		Completed	01/01/2016	04/15/2016	01/01/2016	04/15/2016	06/30/2016	DY2 Q1

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Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition										
Task Perform gap analysis by practice and identify key priorities.		Project		Completed	01/01/2016	04/15/2016	01/01/2016	04/15/2016	06/30/2016	DY2 Q1
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.		Project		Completed	01/01/2016	04/15/2016	01/01/2016	04/15/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition		Project		In Progress	01/01/2016	11/30/2016	01/01/2016	11/30/2016	12/31/2016	DY2 Q3
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed.		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	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.	DY4 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Medicaid Managed Care contract(s) are in place that include value-based payments.		Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Review final State value-based payment roadmap and PPS value-based payment plan		Project		Completed	07/01/2015	08/04/2015	07/01/2015	08/04/2015	09/30/2015	DY1 Q2
Task Identify Medicaid MCOs engaged with our attributed patients and actively engage them in developing new and strengthening existing value-based payment arrangements through a structured stakeholder engagement process.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Establish partner value-based payment reporting requirements and procedures to enable ongoing monitoring of PPS value-based payment revenue in accordance with State roadmap goals		Project		In Progress	03/01/2016	05/31/2016	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2

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Develop detailed analysis of PPS partners' existing value-based payment arrangements with Medicaid MCOs and other payers by reviewing claims-level data										
Task Engage MCOs in defining PPS MCO contracting strategy and organizational requirements necessary to support the development of contracts with Medicaid MCOs		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Engage PPS partners to assist in defining PPS MCO contracting strategy and organizational requirements necessary to support the development of contracts with Medicaid MCOs		Project		In Progress	11/15/2015	09/30/2016	11/15/2015	09/30/2016	09/30/2016	DY2 Q2
Task Develop or contract with an organizational structure (e.g. IPA, ACO, etc.) or multiple organizational structures to support contracting with Medicaid MCOs and other payers as an integrated system		Project		In Progress	11/15/2015	09/30/2016	11/15/2015	09/30/2016	09/30/2016	DY2 Q2
Task Develop value-based payment arrangements for presentation to Medicaid MCOs and other payers		Project		In Progress	02/15/2016	09/30/2016	02/15/2016	09/30/2016	09/30/2016	DY2 Q2
Task Develop PPS plan, overseen by Finance and Sustainability Sub-committee, to achieve 90% value based payments by DY5 and present to the Executive Committee for review and signoff		Project		In Progress	07/15/2015	12/31/2016	07/15/2015	12/31/2016	12/31/2016	DY2 Q3
Task Produce quarterly report to Executive Committee on transition to value-based payment, based on plan developed and approved in earlier steps		Project		Not Started	11/01/2016	11/30/2016	11/01/2016	11/30/2016	12/31/2016	DY2 Q3
Task Complete annual process to initiate new and assess and refine existing PPS value-based payment arrangements, based on reporting and ongoing monitoring procedures, options analysis and plans/strategies established in earlier steps		Project		Not Started	02/01/2017	03/31/2017	02/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Recruit senior Medicaid MCO leadership to serve on Executive Committee. Identify and appoint HMO industry expert to F&S Sub-Committee.		Project		Completed	04/01/2015	05/21/2015	04/01/2015	05/21/2015	06/30/2015	DY1 Q1
Task Develop provider education and engagement strategy through a structured stakeholder engagement process, which will facilitate participant understanding of and input to value-based payments and potential contracting arrangements.		Project		In Progress	12/07/2015	09/30/2016	12/07/2015	09/30/2016	09/30/2016	DY2 Q2

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Task Assess PPS progress in meeting State roadmap value-based payment goals for DY 3 and DY 4		Project		Not Started	02/01/2017	03/31/2017	02/01/2017	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.	DY2 Q4	Project	N/A	In Progress	07/01/2015	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Review final State value-based payment roadmap and PPS value-based payment plan		Project		Completed	07/01/2015	08/04/2015	07/01/2015	08/04/2015	09/30/2015	DY1 Q2
Task Identify Medicaid MCOs and other payers that serve PPS service area and obtain key DSRIP contact at each Medicaid MCO for participation in PPS activities		Project		In Progress	10/01/2015	04/15/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Establish reporting mechanisms to collect and analyze Medicaid MCO and PPS partner data relative to utilization, performance, and payment reform		Project		In Progress	10/01/2015	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Convene first monthly meeting of Medicaid MCO workgroup; membership will be a subset of the Finance and Sustainability Sub-committee with the potential to add members from PPS providers and MCO representatives		Project		In Progress	01/01/2016	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Collect and analyze PPS data and prepare framework for reports to Medicaid MCOs		Project		In Progress	01/15/2016	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	DY4 Q4	Project	N/A	In Progress	08/15/2015	03/31/2017	08/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation		Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.		Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Establish reporting mechanisms and framework for collecting and analyzing data on patient outcomes by PPS partners and		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4

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providers										
Task Develop provider education and engagement strategy through a structured stakeholder engagement process, which will facilitate participant understanding of and input to value-based payments and potential contracting arrangements.		Project		In Progress	08/15/2015	09/30/2016	08/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task Collect and analyze data on patient outcomes by PPS partners and providers		Project		In Progress	01/15/2016	09/30/2016	01/15/2016	09/30/2016	09/30/2016	DY2 Q2
Task Develop recommendation for allocation of internal PPS provider bonus payments to reflect PPS partner and provider performance relative to patient outcomes		Project		In Progress	04/01/2016	05/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Present recommendation for allocation of internal PPS provider bonus payments to Executive Committee		Project		In Progress	05/30/2016	06/30/2016	05/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Engage MCO workgroup and participating MCO organizations to reconcile and align PPS and MCO activities related to provider compensation associated with patient outcome		Project		In Progress	05/30/2016	06/30/2016	05/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Issue first internal PPS provider bonus payments for high-performing partners exceeding outcome and quality thresholds		Project		Not Started	08/01/2016	09/30/2016	08/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Complete first quarterly report to Executive Committee on progress toward aligning provider compensation with patient outcomes.		Project		Not Started	08/01/2016	09/30/2016	08/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Develop provider value-based compensation framework through the Finance and Sustainability Sub-Committee, Medicaid MCO workgroup and the Executive Committee.		Project		Not Started	09/01/2016	12/31/2016	09/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Complete first annual evaluation of PPS value-based payment plan and recommend changes, if needed		Project		In Progress	11/01/2015	09/30/2016	11/01/2015	09/30/2016	09/30/2016	DY2 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.	DY4 Q4	Project	N/A	In Progress	04/01/2015	11/30/2016	04/01/2015	11/30/2016	12/31/2016	DY2 Q3
Task Community health workers and community-based organizations		Project		Not Started	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2

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utilized in IDS for outreach and navigation activities.										
Task Identify community based services relevant to the community, and identify organizations that provide them, to gain an understanding of their willingness in and capability to expand their services and to contractually engage with BPHC to engage patients in their care through outreach activities, peforming patient screening and assessment, helping patients navigate service providers (including engagement and activation with primary care) and providing patient education and self-management assistance		Project		Completed	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify CBOs to contract with in DY1, via: 1) project-specific work groups identifying CBOs to target and engage based on the services they provide and how those services address the predominant social determinants of health in the Bronx by primary condition (diabetes, CVD, asthma, etc), based on the initial Bronx CNA (November 2014); 2) CSO implement a survey of current CBO members of our PPS to profile their services and their interest and capacity to participate as partner organizations in our DSRIP projects; 3) hosting weekly forums with groups of CBOs designed to inform them about the CBO role as member organizations and to facilitate their participation in our DSRIP projects.		Project		Completed	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Draft Master Services Agreement (MSA) and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure.		Project		Completed	04/01/2015	05/21/2015	04/01/2015	05/21/2015	06/30/2015	DY1 Q1
Task Solicit comments on MSA from PPS members through distribution to members, opportunity for submission of written comments, and review in Committee and Sub-Committee meetings.		Project		Completed	05/21/2015	06/08/2015	05/21/2015	06/08/2015	06/30/2015	DY1 Q1
Task Finalize MSA.		Project		Completed	07/01/2015	07/23/2015	07/01/2015	07/23/2015	09/30/2015	DY1 Q2
Task Develop and finalize CBO project schedules in concert with Clinical Operational Plans.		Project		Completed	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Review and negotiate project schedules with CBOs.		Project		Completed	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task		Project		Completed	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Execute agreements and project schedules for CBOs.										
Task Develop patient engagement and activation protocols for priority projects, target subpopulations or interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	11/30/2016	12/31/2016	DY2 Q3
Task Begin patient outreach, engagement, screening/assessment, navigation activation and education for high priority projects and population		Project		Not Started	10/15/2016	11/30/2016	10/15/2016	11/30/2016	12/31/2016	DY2 Q3
Task Define patient engagement and patient engagement metrics. Define mechanisms for evaluation, feedback and continuous quality improvement.		Project		Completed	07/22/2015	06/30/2016	07/22/2015	06/30/2016	06/30/2016	DY2 Q1

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
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.	zstopak	Other	36_DY2Q1_PROJ2ai_MDL2ai2_PRES1_OTH_Remediation_IDS_M1_Narrative_Explanation_5962.docx	remediation narrative	09/19/2016 11:19 AM
	vchibiso	Contracts and Agreements	36_DY2Q1_PROJ2ai_MDL2ai2_PRES1_CONTR_1.0_BPHC_Contracts_3999.pptx	List of contracts/agreements	07/22/2016 08:45 AM
Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	vchibiso	Report(s)	36_DY2Q1_PROJ2ai_MDL2ai2_PRES2_RPT_M2_HH_Engagement_-_Progress_Report_DY2_Q1_4004.docx	Progress Report	07/22/2016 09:24 AM
	vchibiso	Meeting Materials	36_DY2Q1_PROJ2ai_MDL2ai2_PRES2_MM_M2_HH_Engagement_-_Meeting_Schedule_Template_-_DY2_Q1_4003.xlsx	Meeting Schedule	07/22/2016 09:23 AM

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	Remediation: BPHC has moved out the deadline for this milestone. The additional time will be used to review the value of contracting with the remaining providers listed in the PIT, given the capability and capacity of each, and ensure that all eligible providers are included formally in the IDS through contractual arrangements. Original: BPHC continues to gather documents and build relationships with members which provide diverse services to BPHC attributed patients. BPHC also continues to

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
organizations, as necessary to support its strategy.	develop standard processes, policies and procedures via collaboration between members, with the help of leadership groups representing these members. The PPS finalized the Master Services Agreement (MSA) structure, implemented processes for collecting them, and collected MSAs covering approximately 75% primary care providers (PCPs) and 79 non-PCPs (who account for 97% of PCP services to BPHC attributed members). CSO solicited the partners' startup funding needs through a Request for Information (RFI) process to partners who have a signed MSA with the CSO. Responses were reviewed and analyzed by CSO leadership to determine support to be provided for staffing, IT, population health management, and other needs. For all but 4% of these providers who are part of a complicated independent physician association, a budget was negotiated based on the RFI and subsequently turned into a Schedule A (contracts). A similar process was used to develop Schedule A with all hospital systems in the PPS to implement specifically the ED Care Triage and Care Transitions projects. This past quarter another community-based organization (CBO), Health People, entered the contract with BPHC for Diabetes Self-Management peer education program services, in addition to other CBOs who've already signed contracts with BPHC (a.i.r. nyc and Institute for Family Health). The Community Engagement Work Group (CEWG) met to discuss how to provide training opportunities for CBO's. The CEWG provided advice and consent on what should be included as topics in community health literacy trainings. This resulted in a survey being distributed for comment to the Project Managers of the Central Services Organization, Implementation Work Groups, Site Specific Implementation Teams, DSRIP Project Directors and the Cultural Responsiveness Work Group. From the CEWG created another subgroup, the Community Health Literacy Work Group (CHLWG), which discussed topics that should be offered for training, while reviewing the results of the surveys and further defined what to include in a subsequent Request for Letter of Intent (LOI) from the membership. BPHC along with the CHLWG and the CEWG will continue to develop an RFP to address the training needs of the CBOs and the community. Through the community health literacy LOI/RFP process, a member can change status to become a partner if the agreement to receive funding becomes an MSA. A PCMH program has been under way to bring in technical assistants (TAs) for practice transformation for eligible groups of PCPs and BPHC member organizations. After a vetting, matching, and interview process of the TAs and member organizations, comprehensive gap assessments were conducted of over 80 FQHC, voluntary and independent practices. These resulted in 59 work plans upon which contracts between BPHC and TAs were formed and signed. Eight TA groups received funding through this effort which thus far yielded 21 practices with PCMH 2014 Level 3 achievement which accounts for 269 primary care physicians. Agreements have also been signed with two of the three health homes – Community Care Management Partners (CCMP) and Coordinated Behavioral Care (CBC) – and we will sign one with Bronx Accountable Healthcare Network (BAHN) next quarter. The BPHC pharmacy workgroup was convened to discuss the challenges pharmacies face in helping our patients and identify
Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	This milestone was completed in DY1Q4. BPHC continues to work closely with its accountable care organization (ACO) partners and engage Health Homes in the Integrated Delivery System, utilizing existing capabilities to deepen PPS-wide clinical integration. BPHC has convened a cross-Health Home group for collaboration around provider and community education, bottom-up referral processes, minimum standards for PCP-Health Home communications, Health Home At-Risk service provision, and other topics. The first meeting of the group was held in June 2016 with participation from the three organizations serving the vast majority of BPHC attributed Health Home enrolled patients: Bronx Accountable Healthcare Network (BAHN), Community Care Management Partners (CCMP), and Coordinated Behavioral Care (CBC). During the meeting the Health Home representatives agreed that focus groups should be conducted with Primary Care Providers and Health Home Care Managers to capture each group's requests regarding the content, frequency and format of communications between parties. The eventual output would be basic processes and basic templates for communications and data exchange. It was also determined that the BPHC Central Services Organization (CSO) and the Health Homes will undergo a process to match small/solo practices with designated Care Management Agencies (CMAs) to build relationships and ensure consistency of care coordination service provision. Health Homes will also consider whether they would like their CMAs to identify Care Managers for participation in BPHC-organized care coordination trainings. Finally, Health Home representatives will report back to the CSO regarding what sort of data they would find useful in guiding their work and the CSO will determine BPHC's ability to access and compile the requested data into meaningful reports for the Health Homes. BPHC-affiliated Health Home representatives will continue to meet regularly and collaborate in this fashion going forward. Additionally, BPHC has begun engagement with the Community Healthcare Network (CHN) Health Home, upon determining that the Health Home provides services to a significant number of patients attributed to the PPS. The CSO also developed a request for proposals that will be released in early DY2 Q2, for Health Homes interested in providing Critical Time Intervention (CTI) services to seriously mentally ill (SMI) and homeless/precariously housed patients referred from the BPHC Care Transitions program.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	We are building an integrated delivery system (IDS) that has the capacity and diversity to ensure patients receive appropriate health care and community support. We developed the Clinical Operation Plan (COP) for all projects as well as for overarching, cross-cutting clinical/care delivery elements, and distributed them to our member organizations and PCMH consultants. The COP defines sets of narratives, policies and procedures of how members will provide various services to patients in a standardized, most effective way within the most efficient structure. We have signed a contract with the Bronx RHIO and will leverage their technology as an encounter notification system (ENS). Some of our members are already piloting the system. The BPHC Workforce Training Strategy has been further developed during DY2Q1and includes three initial sets of curricula. The first is a set of four courses designed to train staff hired with DSRIP funds to support the BPHC Care Management Model. The four courses included in this series are a nine day course for Care Coordinators (launching on July 13); a ten day course for Nurse Supervisors of Care Coordinators which will be the Care Coordination course plus a one day supervisory program; a Medical Office Assistant Program resulting in National Certification (the second cohort of 20 participants began their 9 day program on June 21); and a two day program for all other titles, the Essentials of Care Coordination due to launch in September. The second set of coursework constitutes our training strategy for cultural competency and includes seven different programs for various staff including providers, three of which are being developed by Community Based Organizations. The last set of programs is for CBOs and has been developed based on a focused needs assessment of BPHC CBOs. The first is an introduction to DSRIP, the second is a course on cultural competency in the Bronx, and the third is a day long program in Motivational Interviewing. In addition, the Workforce Sub Committee has approved projected numbers for five milestones, both the Impact and New Hire Analysis, the Compensation and Benefit Analysis and the Target Workforce State, as well as the Cultural Competency Training Strategy. This work was accomplished through multiple work groups and inputs from throughout the PPS. A Pharmacy Work Group has been put in place to identify the role pharmacies can play in ensuring patients receive appropriate care. Rapid Cycle Evaluation (RCE) program has been developed which is powered by Salesforce to easily collect, survey and report data to enable BPHC monitoring to ensure that patients are receiving appropriate health care and community support in priority projects. The milestone is on track for completion.
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.	We are executing a comprehensive plan to support our safety net providers in Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) which includes EHR support and connectivity of data captured therein. Our agreement with Bronx RHIO will continue to serve as the foundation to achieve next quarter's tasks and those of the future to support this Milestone. Our MU plan will be part of a package of IT interventions for those providers which have yet to achieve connectivity. With the help of NYC DOHMH's Primary Care Information Project (PCIP) we performed a gap assessment of all BPHC providers and using an existing network map we attributed them to organizations. The gap assessment looked at eligibility of physicians, and if eligible, where they are in the MU process. Based on this process a work plan is being developed for each individual organization, prioritizing those physicians which have yet to start the program. As part of the work plan, we are including other IT infrastructure improvements, such as EHR implementation and RHIO connectivity and encounter notification systems deployment. We estimate a maximum MU opportunity of ~$60 million which will help fund this work. Part of this plan will also be RHIO incentive funding and other revenue streams. The milestone is on track for completion.
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.	We are executing a comprehensive plan to support our safety net providers in Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) which includes EHR support and connectivity of data captured therein. A process has been started already to ensure all applicable providers meet PCMH recognition and MU accreditation and that we meet our obligation to the previously agreed tasks. We have hired and deployed expert PCMH consultants to perform detailed gap analyses with about 111 practices, with 80 locations already evaluated thus far. Of the provider locations in the PPS, 95% are compliant with this milestone. Funding has been earmarked for IT expansion and process for this funding's distribution have been developed and communicated to the member organizations. Schedule As (i.e., contracts) have been developed to distribute some of this funding as a result of the process. Our MU plan will be part of a package of IT interventions for those providers which have yet to achieve connectivity. With the help of Primary Care Information Project (PCIP) we performed a gap assessment of all BPHC providers and using an existing network map we attributed them to organizations. The gap assessment looked at eligibility of physicians, and if eligible, where they are in the MU process. Based on this process a work plan is being developed for each individual organization, prioritizing those physicians which have yet to start the program. As part of the work plan, we are including other IT infrastructure improvements, such as EHR implementation and RHIO connectivity and encounter notification systems deployment. In conjunction with PCIP, the PPS is tracking providers' IT infrastructure, developing training materials, and other types of support for EHR use and deployment. The milestone is on track for completion.
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	We are executing a comprehensive plan to support our safety net providers in obtaining Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) certification, which includes the use of targeted patient registries in conjunctions with our clinical projects. We have a strategy in place for care management which includes the uses of registries, EHRs, Care Coordination Management Systems, and referral tracking systems. Our major partners which account for 87% of BPHC PCPs and 81% of non-PCPs, are already sharing clinical data to varying degrees with the Bronx RHIO and anticipate the quality and quantity of this data to increase. We reviewed DSRIP

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Milestone Name	Narrative Text
	performance measures and Quality and Care Innovations Subcommittee recommended registry fields, and have been working with BxRHIO to further define which are most feasible to build out and release to our largest partners in DY2. Bronx RHIO has conducted a gap analysis on data currently in the RHIO and identified missing and other data quality issues relevant to those initial proxy measures and registries. Bronx RHIO had already begun development of Spectrum, its population health management (PHM) and analytics tool, which the PPS will utilize as part of our PHM solution. Though still in development this quarter, we obtained accounts and initial training on Spectrum for key staff in the CSO to begin understanding it. We are also simultaneously exploring potentials to utilize the MAPP/Salient resources to use as additional PHM source to understand the population we serve and their utilization patterns. Furthermore, we are actively pursuing to improve consent rates for Bronx RHIO and initiated a data use agreement (DUA) where each partner allows the Bronx RHIO to share their data with BPHC to create an environment where PHM will be more comprehensively implemented. We are confident that we are also close to securing a Care Coordination and Management System (CCMS) for the PPS. BPHC also deployed a rapid cycle evaluation (RCE) process and selected initial set of key process measures to support our implementation progress. The milestone is on track for completion. Some tasks under this milestone have been pushed out because: We did fully execute a contract in DY1Q4 with the Bronx RHIO to support registry development and PHM. However, we continue to negotiate with our leading CCMS vendor, Acupera. Delays on their part have contributed to our inability to fully execute a contract to acquire their CCMS. We will likely sign a contract for a CCMS by September 30, 2016 (end of DY2Q2) and are therefore changing the PPS task completion date until then for this task. As registries and CCMS platforms are deployed, we will execute our registry testing plan and training programs for providers and care managers. Given that we have yet to contract for/acquire a CCMS platform, and our registries are still in build for Spectrum, the Bronx RHIO's data analytics tool, we cannot yet execute our training plan for providers and care managers. We expect that training on registry use for PHM will begin by September 30, 2016, but that training on our CCMS platform won't begin until January 2017. We are changing the completion date for this PPS task to March 31, 2017 (end of DY2Q4.) As registries and CCMS platforms are deployed, we will issue CCMS user credentials and train partner providers and care managers in the use of the integrated solution. Given that we have yet to contract for/acquire a CCMS platform, we cannot yet issue user credentials nor disseminate standardized IT protocols and data security requirements across the system. We expect that training on our CCMS platform won't begin until January 2017, at which point we will issue user credentials, IT protocols and data security requirements. We are changing the completion date for this PPS task to March 31, 2017 (end of DY2Q4.)
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.	We are executing a comprehensive plan to support our safety net providers in Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) which includes EHR support and connectivity of data captured therein. A process has been started to ensure all applicable providers meet PCMH recognition and MU accreditation where possible and that we meet our obligation to the previously agreed tasks. Consultants have been deployed to perform detailed gap analyses with about 115 practices, with 80 locations already evaluated thus far. Of those, 21 practices have already submitted their PCMH 2014 attestations, with all achieving level 3, which accounts for 30% of the PCPs identified by SDOH in the PPS. Of note is SDOH's latest guidelines which will decrease the number of physicians identified as PCMH eligible and thus drastically increase the share of eligible physicians which have already completed this process. Contracting is complete with six consulting groups for the work on the remaining practices. We are starting to also discuss Advance Primary Care and Transforming Clinical Practice Initiative with SDOH-certified consultants and are identifying locations which would be good candidates for the programs. These six consulting groups are part of a Community of Practice ("CoP") we are organizing to build/establish best practices, share and collaborate with experts on PCMH transformation, and possibly transfer the experience and knowledge to other population health initiatives. PCMH progress is tracked and reported on at every Executive Committee meeting. The milestone is on track for completion.
Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	As noted in the prior quarter and in the milestone subtasks, contracting with Medicaid Managed Care Organizations, as an integrated delivery system, is contingent upon developing a larger VBP plan and determining the most appropriate governance structure given existing and / or emerging arrangements. Many of the subtasks within this milestone section are being deferred until after the baseline assessment is completed and after the VBP plan towards achieving 90% value-based payments across the PPS network by year 5 which is due DY2 Q4 (3/31/17). As outlined in the Finance section under Milestone 4, BPHC engaged Manatt to assist with VBP planning efforts.

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	The engagement's objective is to assist BPHC with VBP modeling and understanding the various contractual arrangements that may be used. The engagement also focuses on the current structures and capabilities of the Montefiore ACO and analyzing the features of the VBP Innovator Pilot program with which Montefiore and St. Barnabas Hospital are pursuing together. This will serve as the foundation of a potential IDS and VBP plan which can then be leveraged to this milestone that addresses contracting. Although no contracts are achievable under an IDS without first achieving an IDS structure, there has been open communication with BPHC and the MCOs through the Equity Infrastructure Program ("EIP") and Equity Performance Program ("EPP") reporting requirements. In addition, through relationships between MCO and PPS providers, the dialogue has shifted from individual arrangements to a prospective focus on a larger arrangement through an ACO or IPA. The issue, however, continues to remain the ability and infrastructure of the MCOs to administer VBP arrangements and accommodate the data needs of an IDS given their existing business model of fee-for-service schedules, denials and other back-office hurdles to process a claim payment.
Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	Consistent with the notations above, Milestone 9 is predicated on first establishing an IDS and governance structure and then having the ability to contract from this new formation. Many of the subtasks within this milestone cannot be started or have been deferred as part of the developing the VBP plan towards achieving 90% value-based payments across the PPS network by year 5 which is due DY2 Q4 (3/31/17). BPHC continues to press the issues in obtaining claims data that it can push to its PPS members in a timely manner. BPHC recognizes this milestone as a key component in obtaining actionable data that can be shared and analyzed through a central back-office function within an ACO such as Montefiore Care Management Organization or extension thereof through BPHC.
Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	As noted in the Finance sections that refer to Value Based Payment efforts, BPHC remains committed to enforcing a culture of VBP and aligning payment reform with the appropriate cost of care. Many of the subtasks within this milestone cannot be started or have been deferred as part of the developing the VBP plan towards achieving 90% value-based payments across the PPS network by year 5 which is due DY2 Q4 (3/31/17). The lion's share of the subtasks in milestone 10 will be deferred as significant hurdles need to be first addressed including ACO governance structure, leveraging and improving existing back-office functions and understanding the VBP impact across non-Hospital providers such as FQHCs, Behavior Health (Article 31 and 32) and Community Based Organizations. In every discussion with PPS members, BPHC will continue to foster and promote a culture of aligning patient care outcomes and efficiencies to reimbursement.
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.	BPHC continues to progress in this milestone. The Community Engagement Work Group (CEWG) met to discuss how to provide training opportunities for CBO's. The CEWG provided advice and consent on what should be included as topics in community health literacy trainings. This resulted in a survey being distributed for comment to the Project Managers of the Central Services Organization, Implementation Work Groups, Site Specific Implementation Teams, DSRIP Project Directors and the Cultural Responsiveness Work Group. From the CEWG created another subgroup, the Community Health Literacy Work Group (CHLWG), which discussed topics that should be offered for training, while reviewing the results of the surveys and further defined what to include in a subsequent Request for Letter of Intent (LOI) from the membership. BPHC along with the CHLWG and the CEWG will continue to develop an RFP to address the training needs of the CBOs and the community. Through the community health literacy LOI/RFP process, a member can change status to become a partner if the agreement to receive funding becomes an MSA. The CEWG held a focus group to discuss website redevelopment and what should be included in a resource directory, which would be an essential development in creating a referral management system. The initial stage of the resource directory is being hosted on a website, pulling the data from our central repository system, Salesforce. In the future stages the data in Salesforce will drive the interactive web portal. Letters of Intent (LOIs) have been solicited to be turned into RFPs with CBOs for two community engagement projects which were recommended by the CEWG. BPHC contracted with a.i.r. nyc, Institute for Family Health, and Health People; the two community-based organizations (CBOs) to lead in the implementation of specific projects and one to support a specific project. Similarly, Montefiore's Care Management Organization (CMO) is contracted to work on ED and Care Transition projects. Finally, the PPS has entered in a contract with Bronx RHIO for services. The milestone is on track for completion pending the resolution of PHI issue. One task under this milestone has been pushed out because BPHC has not accepted PHI information concerning its attributed population due to concerns over meeting regulatory requirements set forth by the SDOH. It is still not understood how BPHC can use this information effectively with its downstream partners without violating SSPs and HIPAA. Additionally, while Bronx Partners has reviewed MAPP data in aggregate on the dashboard, until the security process is complete we are not permitted to view

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	patient identifiers.

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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
Milestone Mid-Point Assessment	Completed	Mid-Point Assessment			06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Mid-Point Assessment	zstopak	Templates	36_DY2Q1_PROJ2ai_MDL2ai3_PPS1537_TEMPL_2a_Mid-Point_Assessment_Project_Narrative_2ai_FINAL_4764.docx	Mid-Point Assessment project narrative (2.a.i - IDS)	08/02/2016 11:57 AM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment	

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

Instructions :

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

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

Instructions :

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

(1) A major risk to successful implementation of 2.a.iii relates to provider access to an electronic care management (CM) and referral management tool that can be shared across BPHC providers. Multiple IT systems are employed by Health Homes (HH) and PCMHs, and some partners lack systems with the necessary capabilities. Building a system with sufficient CM, referral management and system integration capacities in a timely manner poses a significant challenge. BPHC is working with a vendor to create a PPS-wide CM and referral management platform to enhance clinical integration and provider communications. The platform will unify partners' varied IT systems. BPHC will supply data exchange and system interfaces to ensure robust exchange of care management planning information.
(2) Patient access to and willingness to engage in CM services also pose a risk. BPHC is working with CBO partners to provide education to patients on accessing and navigating the healthcare system, as well as providing CBOs the tools to make direct referrals for patients in need of CM services. To enhance patient activation in care coordination, BPHC will train care coordinators on motivational interviewing.
(3) A risk exists if PCPs do not see the added value of CM. In such cases PCPs would not refer patients into HH or HH At-Risk services, and thus anticipated improved patient outcomes would not be realized. BPHC is working with its HH partners and primary care organizations to improve provider education on the benefits of CM and to establish expectations and minimum standards for communication and information exchange between Care Managers and PCPs.
(4) Recruiting and training sufficient CM staff to serve the needs of the Bronx is a challenge, particularly bilingual staff. BPHC's workforce strategy looks to mitigate this risk, by working with community colleges and coordinating with the 1199 Training and Education Fund (TEF), Montefiore CMO, and NYSNA to identify capable workers and provide training in Spanish when needed. BPHC also is coordinating with other Bronx PPSs on workforce strategy to align priorities and reduce competition.
(5) Maintaining a short-term care management intervention for HH At-Risk patients is necessary to preserve optimal caseloads for Care Coordinators (CCs) and to extend services to as many patients as required under BPHC's speed and scale commitments. However, partners' experience with CM suggests it can be difficult to "graduate" patients out of CM once they have been engaged. BPHC seeks to mitigate this risk by providing training to CCs to set realistic, time-limited goals to allow patients to achieve their objectives and disenroll from care management within the allotted 3- to 9-month intervention period. The PPS is also exploring "step-down" models to ease the transition, such as enrollment in a group of peers after "graduation" from HH At-Risk CM.
(7) A number of factors—including those listed above—contribute to BPHC's risk of missing patient engagement targets for project 2.a.iii. Another related risk involves the availability of data on patients with CM plans. Issues around access to patient names and CIN numbers have arisen with partners conducting CM on behalf of MCOs. This represents a significant portion of the Comprehensive CM Plans currently being developed within BPHC's provider network. BPHC is pursuing data sharing agreements with these third parties to overcome data access challenges.

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY3,Q4	40,320

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	5,040	10,080	15,120	20,160
	Quarterly Update	905	0	0	0
	Percent(%) of Commitment	17.96%	0.00%	0.00%	0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment	0.00%	0.00%	0.00%	0.00%

Warning: PPS Reported - Please note that your patients engaged to date (905) does not meet your committed amount (5,040) for 'DY2,Q1'

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
zstopak	Report(s)	36_DY2Q1_PROJ2aiii_MDL2aiii2_PES_RPT_BPHC-PATIENTLIST-2aiii-DY2Q1_905pts_FINAL_4766.xlsx	Patient engagement list - 2.a.iii (Health Home At-Risk) - DY2 Q1	08/02/2016 12:15 PM

Narrative Text :

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

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task A clear strategic plan is in place which includes, at a minimum: - Definition of the Health Home At-Risk Intervention Program - Development of comprehensive care management plan, with definition of roles of PCMH/APC PCPs and HHs		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Develop a workplan and timeline to develop the clinical operations plan (COPs) and implement a strategy for the HH at-risk population that aligns with the patient engagement speed and scale application submission		Project		Completed	04/01/2015	05/15/2015	04/01/2015	05/15/2015	06/30/2015	DY1 Q1
Task Convene representative group of PPS members including Health Homes (HH), PCMHs, SUD providers and SMEs, and others to participate in developing project plan for HH at-risk project (2.a.iii)		Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Define the population to be targeted by the HH at-risk intervention, such as individuals with diabetes, substance use disorders, mild to moderate depression or other single uncontrolled chronic conditions (see requirement #5)		Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Define a care management (CM) staffing model, in conjunction with Workforce Subcommittee, to address the needs of the target population including staff qualifications, care team roles (including PCP and care manager), functions, and panel size of team members		Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Develop financial model to cost out CM team		Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Develop and document the COP to define the elements of the program including the roles of PCPs and Health Homes, health		Project		Completed	05/01/2015	10/31/2015	05/01/2015	10/31/2015	12/31/2015	DY1 Q3

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information exchange and technology requirements, and evidence-based guidelines										
Task Develop project implementation budget		Project		Completed	05/01/2015	10/31/2015	05/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Working with Workforce Subcommittee, design training and recruitment strategy for care managers and care teams		Project		Completed	06/30/2015	10/31/2015	06/30/2015	10/31/2015	12/31/2015	DY1 Q3
Task Submit COP and budget to Quality and Care Innovation Sub-Committee for approval		Project		Completed	08/01/2015	10/31/2015	08/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Prepare/disseminate gap analysis tool based on COP to participating providers to determine CM resource needs against project plan and care management team staffing model		Project		Completed	08/15/2015	10/31/2015	08/15/2015	10/31/2015	12/31/2015	DY1 Q3
Task Identify site-specific implementation teams.		Project		Completed	08/15/2015	10/31/2015	08/15/2015	10/31/2015	12/31/2015	DY1 Q3
Task Launch recruitment and training programs with participating providers		Project		Completed	10/01/2015	10/31/2015	10/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Complete assessment of CM staffing needs of each participating site		Project		Completed	08/01/2015	11/30/2015	08/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Define metrics for rapid cycle evaluation		Project		Completed	09/01/2015	01/31/2016	09/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task Use rapid cycle evaluation to track implementation successes and shortcomings and develop corrective actions		Project		In Progress	02/01/2016	03/31/2017	02/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and 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 Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task		Project		Completed	05/01/2015	12/31/2015	05/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Recruit or contract for PCMH practice certification resources as needed										
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition		Project		Completed	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Perform gap analysis by practice and identify key priorities.		Project		Completed	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.		Project		Completed	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition		Project		In Progress	01/01/2016	11/30/2016	01/01/2016	11/30/2016	12/31/2016	DY2 Q3
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed.		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #3 Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.	DY3 Q4	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	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	07/01/2015	03/31/2018	07/01/2015	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	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Case Management / Health Home	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4

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Task Identify safety net provider data sharing requirements and assess partner and QE data sharing capabilities and current HIE participation		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Coordinate with Bronx RHIO to develop comprehensive HIE adoption program to encourage and support partner participation and integration		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Begin coordinated interface and service development with Bronx RHIO		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish BPHC program to manage support for safety net providers, including, but not limited to primary care providers, mental health and substance use providers, hospitals, and others, to ensure that all are actively sharing health information, coordinating with Bronx RHIO to encourage, track and support partner participation and integration/data sharing		Project		Completed	03/01/2016	04/25/2016	03/01/2016	04/25/2016	06/30/2016	DY2 Q1
Task Track status and manage support to ensure that all PPS safety net providers are actively sharing health information through Bronx RHIO or alternative health information exchange		Project		In Progress	03/01/2016	03/31/2018	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Assess eligible participating partner EHR use relative to Meaningful Use and PCMH 2014 Level 3 standards		Project		Completed	06/30/2015	08/30/2015	06/30/2015	08/30/2015	09/30/2015	DY1 Q2
Task Establish BPHC program to educate, encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, including potential use of incentive-based payments for implementation		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Task Recruit or contract for EHR implementation resources as needed		Project		Completed	11/01/2015	06/30/2016	11/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner EHR implementation and progress towards Meaningful Use and PCMH standards		Project		Not Started	08/01/2016	12/31/2016	08/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Track status and manage support to ensure all eligible safety net providers are using certified EHR systems that meet Meaningful Use and PCMH 2014 Level 3 standards		Project		In Progress	10/15/2015	03/15/2018	10/15/2015	03/15/2018	03/31/2018	DY3 Q4
Milestone #5 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	DY3 Q4	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform gap analysis and identify priories to achieving integration of patient record.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.		Project		Completed	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget to build registry and acquire necessary resources		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1

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Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Milestone #6 Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Procedures to engage at-risk patients with care management plan instituted.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Develop clinical requirements/use cases and technical requirements for web-based comprehensive care management plan		Project		Completed	05/01/2015	06/30/2015	05/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Identify qualified coordinated care management (CCMS)		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2

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vendors										
Task Design/document outreach, intake, assessment, and patient engagement process for HH at-risk population that includes development of written comprehensive care management plan and referrals to Health Homes, substance use providers, community-based organizations, and other providers		Project		Completed	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Convene representative group from PPS providers to participate in care management plan development process		Project		Completed	05/01/2015	10/31/2015	05/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Select/contract with CCMS system(s) that meet requirements		Project		In Progress	10/01/2015	04/01/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Develop, in conjunction with Workforce Subcommittee, training curriculum for PPS provider staff		Project		Completed	10/01/2015	04/01/2016	10/01/2015	04/01/2016	06/30/2016	DY2 Q1
Task Select metrics and use CCMS system to track if care management plan is successful in "reducing patient risk factors"		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Implement comprehensive care management plan system in all participating sites		Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provide ongoing technical assistance support to participating sites		Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Use rapid cycle evaluation to track implementation successes and shortcomings with regard to the reduction of patient risk factors and develop corrective actions		Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.	DY2 Q4	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Each identified PCP establish partnerships with the local Health Home for care management services.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Each identified PCP establish partnerships with the local Health Home for care management services.		Provider	Case Management / Health Home	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify participating primary care practices		Project		Completed	07/01/2015	10/31/2015	07/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task		Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Assess participating practices' care management staffing needs to meet care management service needs of HH at-risk population, with particular attention to the complex needs of patients with co-occurring disorders, homelessness and SUD.										
Task Begin developing partnership agreements with HHs, their downstream Care Management Agencies (CMAs) and primary care practices		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Complete partnership agreements with HHs, their downstream Care Management Agencies (CMAs) and primary care practices that include standards for care management services for HH at-risk patients, data collection and reporting, referral processes, care plan content, communication and other policies and procedures		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).	DY2 Q4	Project	N/A	In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS has established partnerships to medical, behavioral health, and social services.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS has established partnerships to medical, behavioral health, and social services.		Provider	Case Management / Health Home	In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Identify CBO partners that can provide needed social support services to the HH at-risk population		Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop policies and procedures for CBO-PCP-HH patient referral to mental health, substance abuse, and other services, patient follow up, use of Care Coordination Management Systems (CCMS) tool for care planning & tracking, participation in case conferences, and other policies and procedures, as needed		Project		Completed	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task		Project		Completed	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Develop contractual agreements with CBOs and HHs to provide social support services to patients assessed as eligible for HH at-risk CM services										
Task Implement CBO-PCP-HH patient referral, patient follow up, care planning & tracking, participation in case conferences, and other protocols for facilitating and documenting service coordination in the CCMS, integrated with EHRs via HIE		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Ensure that select CBOs have access to relevant portions of the electronic care management plan/CCMS and are able to document relevant client information in the care management plan		Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Execute contractual agreements with CBOs and HHs to provide social support services to patients assessed as eligible for HH at-risk CM services		Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone #9 Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.	DY2 Q4	Project	N/A	In Progress	05/01/2015	03/31/2017	05/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate evidence-based practice guidelines developed and process implemented.		Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.		Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task PPS has included social services agencies in development of risk reduction and care practice guidelines.		Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Convene work groups composed of PCPs and subject matter experts, (SMEs) including MH/SUD and social service agencies, to define target population, select evidence- based guidelines (EBGs) for target population and make recommendations to		Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2

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Quality & Care Innovation Sub-Committee (QCI) on EBGs for chronic conditions and collaborative care.										
Task Working with select CBOs, primary care practices and SMEs, including MH/SUD and social service agencies, develop educational materials, suitable to the needs, culture, literacy, and language of the target populations		Project		Completed	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task QCI reviews educational materials and revises as needed; QCI approves educational materials		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task QCI agendas begin to include evaluation of evidence-based guidelines as a topic for discussion at least annually		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task CSO implements EBG and educational material dissemination plan across the PPS		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop mechanisms for regular review of project-selected evidence-based guidelines (EBGs) by implementation work group to assure our PPS is utilizing the most up-to-date tools and that those upadated guidelines/protocols continue to be clinically integrated across the PPS		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Develop feedback mechansims for accountability and continuous quality improvement		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2

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 a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.	Bronx Partners for Healthy Communities (BPHC) worked this quarter to complete the roll-out of its Health Home At-Risk Intervention Program by fostering the conditions necessary to fully implement the care management models developed by PPS members and outlined in the Clinical Operations Plan (COP). The Central Services Organization (CSO) deployed funds to its large primary care organization partners to recruit, hire and/or redeploy personnel to serve in the care coordination team roles of Care Coordinator, Nurse Care Management Supervisor, Care Coordination Assistant, and Population Health Manager. As these staffing efforts got underway, the CSO met with each of the funded organizations to emphasize key implementation priorities and to identify any anticipated challenges to full development of the primary care-

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	embedded care coordination and chronic disease management models. In order to provide Health Home At-Risk care management services to patients of practices that do not have a panel large enough to warrant embedded care coordination teams, BPHC worked closely with its Health Home partners to further define a process to match these practices with designated Care Management Agencies (CMAs). It was deemed a priority to ensure a single CMA would be associated with each practice, to encourage relationship building between partners and ensure consistency in care coordination service provision. During this quarter an initial set of rapid cycle evaluation (RCE) metrics was introduced to the partner organizations in order to track their monthly progress on priority interventions. These RCEs currently track hiring progress, development of comprehensive care management plans, and bottom-up referrals to Health Homes. During the May meeting of the Health Home At-Risk Intervention Program Implementation Work Group (IWG), members had the opportunity to review early data from the RCEs, vote on evidence-based guidelines, and share ideas around implementation challenges affecting patient engagement numbers for this project. This milestone remains on track for completion.
Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.	We are executing a comprehensive plan to support our safety net providers in Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) which includes EHR support and connectivity of data captured therein. A process has been started to ensure all applicable providers meet PCMH recognition and MU accreditation where possible and that we meet our obligation to the previously agreed tasks. Consultants have been deployed to perform detailed gap analyses with about 115 practices, with 80 locations already evaluated thus far. Of those, 21 practices have already submitted their PCMH 2014 attestations, with all achieving level 3, which accounts for 30% of the PCPs identified by SDOH in the PPS. Of note is SDOH's latest guidelines which will decrease the number of physicians identified as PCMH eligible and thus drastically increase the share of eligible physicians which have already completed this process. Contracting is complete with six consulting groups for the work on the remaining practices. We are starting to also discuss Advance Primary Care and Transforming Clinical Practice Initiative with SDOH-certified consultants and are identifying locations which would be good candidates for the programs. These six consulting groups are part of a Community of Practice ("CoP") we are organizing to build/establish best practices, share and collaborate with experts on PCMH transformation, and possibly transfer the experience and knowledge to other population health initiatives. PCMH progress is tracked and reported on at every Executive Committee meeting. The milestone is on track for completion.
Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.	We are executing a comprehensive plan to support our safety net providers in Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) which includes EHR support and connectivity of data captured therein. Our agreement with Bronx RHIO will continue to serve as the foundation to achieve next quarter's tasks and those of the future to support this Milestone. Our MU plan will be part of a package of IT interventions for those providers which have yet to achieve connectivity. With the help of NYC DOHMH's Primary Care Information Project (PCIP) we performed a gap assessment of all BPHC providers and using an existing network map we attributed them to organizations. The gap assessment looked at eligibility of physicians, and if eligible, where they are in the MU process. Based on this process a work plan is being developed for each individual organization, prioritizing those physicians which have yet to start the program. As part of the work plan, we are including other IT infrastructure improvements, such as EHR implementation and RHIO connectivity and encounter notification systems deployment. We estimate a maximum MU opportunity of ~$60 million which will help fund this work. Part of this plan will also be RHIO incentive funding and other revenue streams. The milestone is on track for completion.
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.	We are executing a comprehensive plan to support our safety net providers in Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) which includes EHR support and connectivity of data captured therein. A process has been started already to ensure all applicable providers meet PCMH recognition and MU accreditation and that we meet our obligation to the previously agreed tasks. We have hired and deployed expert PCMH consultants to perform detailed gap analyses with about 111 practices, with 80 locations already evaluated thus far. Of the provider locations in the PPS, 95% are compliant with this milestone. Funding has been earmarked for IT expansion and process for this funding's distribution have been developed and communicated to the member organizations. Schedule As (i.e., contracts) have been developed to distribute some of this funding as a result of the process. Our MU plan will be part of a package of IT interventions for those providers which have yet to achieve connectivity. With the help of Primary Care Information Project (PCIP) we performed a gap assessment of all BPHC providers and using an existing network map we attributed them to organizations. The gap assessment looked at eligibility of physicians, and if eligible, where they are in the MU process. Based on this process a work plan is being developed for each individual organization, prioritizing those physicians which have yet to start the program. As part of the work plan, we are including other IT infrastructure improvements, such as EHR implementation and RHIO connectivity and encounter notification systems deployment. In conjunction with PCIP, the PPS is tracking providers' IT infrastructure, developing training materials, and other types of support for EHR use and deployment. The milestone is on track for completion.
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	We are executing a comprehensive plan to support our safety net providers in obtaining Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) certification, which includes the use of targeted patient registries in conjunctions with our clinical projects. We have a strategy in place for care management which includes the uses of registries, EHRs, Care Coordination Management Systems, and referral tracking systems.. Our major partners which account for 87% of BPHC PCPs and 81% of non-

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	PCPs, are already sharing clinical data to varying degrees with the Bronx RHIO and anticipate the quality and quantity of this data to increase. We reviewed DSRIP performance measures and Quality and Care Innovations Subcommittee recommended registry fields, and have been working with BxRHIO to further define which are most feasible to build out and release to our largest partners in DY2. Bronx RHIO has conducted a gap analysis on data currently in the RHIO and identified missing and other data quality issues relevant to those initial proxy measures and registries. Bronx RHIO had already begun development of Spectrum, its population health management (PHM) and analytics tool, which the PPS will utilize as part of our PHM solution. Though still in development this quarter, we obtained accounts and initial training on Spectrum for key staff in the CSO to begin understanding it. We are also simultaneously exploring potentials to utilize the MAPP/Salient resources to use as additional PHM source to understand the population we serve and their utilization patterns. Furthermore, we are actively pursuing to improve consent rates for Bronx RHIO and initiated a data use agreement (DUA) where each partner allows the Bronx RHIO to share their data with BPHC to create an environment where PHM will be more comprehensively implemented. We are confident that we are also close to securing a Care Coordination and Management System (CCMS) for the PPS. BPHC also deployed a rapid cycle evaluation (RCE) process and selected initial set of key process measures to support our implementation progress. . Completion dates for the milestone and three tasks have been altered to align with the milestone deadlines in project 2.a.i (IDS) and reflect BPHC's current implementation timeline: We have fully executed a contract in DY1Q4 with the Bronx RHIO to support registry development and PHM. However, we continue to negotiate with our leading CCMS vendor, Acupera. Delays on their part have contributed to our inability to fully execute a contract to acquire their CCMS. We will likely sign a contract for a CCMS by September 30, 2016 (end of DY2Q2). As registries and CCMS platforms are deployed, we will execute our registry testing plan and training programs for providers and care managers. Given that we have yet to contract for/acquire a CCMS platform, and our registries are still in build for Spectrum, the Bronx RHIO's data analytics tool, we cannot yet execute our training plan for providers and care managers. We expect that training on registry use for PHM will begin by September 30, 2016, but that training on our CCMS platform won't begin until January 2017. As registries and CCMS platforms are deployed, we will issue CCMS user credentials and train partner providers and care managers in the use of the integrated solution. Given that we have yet to contract for/acquire a CCMS platform, we cannot yet issue user credentials nor disseminate standardized IT protocols and data security requirements across the system. We expect that training on our CCMS platform won't begin until January 2017, at which point we will issue user credentials, IT protocols and data security requirements.
Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.	The BPHC Clinical Operations Plan for Health Home At-Risk describes the roles, responsibilities, and procedures for primary care practices to refer patients to care management services, assess patient needs, set goals with patients, and identify appropriate interventions. These elements make up the comprehensive care management plan for at-risk patients. During this quarter, BPHC chose curriculum development and training vendors to produce and deliver the Care Coordinator and Nurse Care Management Supervisor trainings. Each cohort of 15-20 participants will receive approximately 60 hours of Care Coordinator training over a three-month period, with the first session to launch in early DY2 Q2. This will include 44 hours of Comprehensive Care Coordinator training, designed and delivered by the Primary Care Development Corporation (PCDC); eight hours of Motivational Interviewing training, designed and delivered by the National Council for Behavioral Health; and eight hours of training on Care Management for SMI/Substance Users delivered by various subject matter experts. Nurse Care Management Supervisors will participate in the training with the Care Coordinators and receive an additional two day training on supervision, delivered by the National Council for Behavioral Health. Extensive work was undertaken throughout the reporting period to develop a Care Coordination Management System (CCMS) that will meet the needs of the PPS. This included mapping existing systems used by PPS partners to ensure BPHC's chosen solution will provide sufficient interface capabilities to capture all required information for network-wide interoperability and information sharing, regardless of if each partner documents directly in the tool. Business and system requirements were documented, in addition to building out detailed workflow and data flow charts between EHRs, Bronx RHIO, and the CCMS. Contracting with a CCMS vendor did not take place as planned during this quarter, but is expected during DY2 Q2 (one task has been pushed out to reflect this delay). This milestone remains on track for completion.
Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.	BPHC has convened a cross-Health Home group for collaboration around provider and community education, bottom-up referral processes, minimum standards for PCP-Health Home communications, Health Home At-Risk service provision, and other topics. The first meeting of the group was held in June 2016 with participation from the three organizations serving the vast majority of BPHC attributed Health Home enrolled patients: Bronx Accountable Healthcare Network (BAHN), Community Care Management Partners (CCMP), and Coordinated Behavioral Care (CBC). During the meeting the Health Home representatives agreed that focus groups should be conducted with Primary Care Providers and Health Home Care Managers to capture each group's requests regarding the content, frequency and format of communications between parties. The eventual output would be basic processes and basic templates for communications and data exchange. It was also determined that the BPHC Central

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Milestone Name	Narrative Text
	Services Organization (CSO) and the Health Homes will undergo a process to match small/solo practices with designated Care Management Agencies (CMAs) to build relationships and ensure consistency of care coordination service provision. Health Homes will also consider whether they would like their CMAs to identify Care Managers for participation in BPHC-organized care coordination trainings. Finally, Health Home representatives will report back to the CSO regarding what sort of data they would find useful in guiding their work and the CSO will determine BPHC's ability to access and compile the requested data into meaningful reports for the Health Homes. BPHC-affiliated Health Home representatives will continue to meet regularly and collaborate in this fashion going forward. Additionally, BPHC has begun engagement with the Community Healthcare Network (CHN) Health Home, upon determining that the Health Home provides services to a significant number of patients attributed to the PPS. The CSO also developed a request for proposals that will be released in early DY2 Q2, for Health Homes interested in providing Critical Time Intervention (CTI) services to seriously mentally ill (SMI) patients who are homeless/precariously housed. This milestone remains on track for completion.
Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).	BPHC's Community Engagement and Communications Group convened during DY2 Q1 to finalize the development of an electronic Community Resources Directory, accessible to providers across the network, in order build a bridge between clinical and social services. The directory is searchable by service type and zip code and is connected to the PPS Salesforce platform, allowing partners to keep their information consistently up to date. The Central Services Organization (CSO) worked with partners to define their referral procedures, with particular attention to closed loop referral tracking on all referrals to social services. BPHC considered various approaches to ensuring bi-directional information exchange between the referral-making and referral-receiving organizations, aiming to implement a simple solution that will have buy-in from both clinical and social service providers. The CSO also prepared to release a request for proposals (RFP) to CBOs on health literacy training for patients, which will include connecting patients to needed PCP, Health Home At-Risk, and Health Home services. This milestone remains on track for completion.
Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.	The Health Home At-Risk Implementation Work Group (IWG) identified various evidence-based guidelines on care coordination. After conducting an in-depth review of the Agency for Healthcare Research and Quality (AHRQ) guidelines entitled, Designing and Implementing Medicaid Disease and Care Management Programs, the group voted to recommend Section 8: The Care Management Evidence Base to the Quality and Care Innovation Subcommittee (QCIS) to serve as BPHC's evidence-based guidelines on care coordination. The group also chose to recommend the full eight-section document to serve as an implementation reference guide for practices engaged in the Health Home At-Risk Intervention Program. The QCIS reviewed the recommendation and will vote to approve or reject the guidelines during DY2 Q2. The QCIS also examined the patient education materials currently used by BPHC organizations and determined that BPHC patients have sufficient access to culturally and linguistically appropriate resources. The CSO was asked to develop a workflow intended to conduct consistent evaluations as DSRIP progresses, in order to identify any emerging needs for the development of additional materials for particular programs or populations. This milestone remains on track for completion.

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Mid-Point Assessment	Completed	Mid-Point Assessment			06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Mid-Point Assessment	zstopak	Templates	36_DY2Q1_PROJ2aiii_MDL2aiii4_PPS1538_TEMPL_2a_Mid-Point_Assessment_Project_Narrative_2aiii_FINAL_4782.docx	Mid-Point Assessment Project Narrative (2.a.iii - Health Home At-Risk)	08/02/2016 12:59 PM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment	

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

Instructions :

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

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

Instructions :

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

(1) A key risk associated with BPHC's strategy for 2.b.iii includes the possibility of delayed expansion of the Emergency Department (ED) Navigator program due to recruitment and training challenges. To mitigate this risk, BPHC will stagger the DSRIP program expansion, beginning in the SBH ED and Montefiore's Moses EDs and then moving to other Montefiore EDs. BPHC has contracted with the CMO to help lead program development and training, and other programmatic functions to minimize delays and ensure proper programmatic oversight.
(2) Patients with BH conditions are more likely to overutilize the ED and may impact DSRIP's goal of reduction in avoidable ED use. CBOs can help mitigate this risk: Parachute NYC is an effective program that provides an alternative to the ED and inpatient admissions through peer-run respite centers and mobile crisis intervention. The program has been challenged by low use. It reaches the end of its funding on June 30, 2016. Discussions with MCOs regarding a payment mechanism to sustain the program are still in progress. To mitigate these risks, BPHC will work with NYCDOHMH, Riverdale Mental Health Association, and the Visiting Nurse Service of New York to develop an approach, negotiate with MCOs regarding program payments and "market" the program more intensively to ED physicians, psychiatrists, Health Homes (HH), and CBOs.
(3) Many of the targeted patients for this project are in need of social as well as medical services. However, many arrive at the ED during off-hours, limiting the time in which staff can connect patients with PCPs, urgent care centers, HHs and social service providers. In addition, ED providers often lack the knowledge and time to connect patients with social service agencies and Parachute NYC program. To mitigate these risks, BPHC will expand hours of CMO's ED Navigator program to 12-hour days with weekend hours to better account for individuals who arrive at the ED and need support services during off-hours. BPHC will train staff to provide warm hand-offs to social services the next business day as well as track referrals to completion. BPHC is also developing a web-based directory of CBO providers that will provide comprehensive information on the scope of social services provided across the PPS.
(4) IT challenges across providers present additional barriers to 2.b.iii and care coordination efforts. Many of the alternatives to the ED, including urgent care centers, Parachute NYC, PCPs, and CBOs do not have EMR data-sharing capabilities and are not connected to Bronx RHIO. Without these capabilities, patient information is not accessible at the point of care and cannot be shared electronically with patients' existing PCPs. BPHC will expand RHIO connectivity to more PPS providers and increase the use of RHIO alerts to inform PCPs of the patients' ED admission. BPHC will implement an electronic care management and referral management tool to be shared across BPHC providers. BPHC will support a communication plan to make ED and community-based staff aware of the value of the tool for patients through transitions from ED to other settings (SNF, HH, CBO, or other PPS provider).
(5) Another risk is the ability for ED navigators to identify patients' PCPs and make real-time appointments, especially if patients arrive in ED at off-hours. To mitigate this risk, PPS is investigating means of identifying patient PCPs using RHIO and use of open access scheduling to make appointments without having to call PCP offices.

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY3,Q4	13,720

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	2,573	5,145	7,718	10,290
	Quarterly Update	2,916	0	0	0
	Percent(%) of Commitment	113.33%	0.00%	0.00%	0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment	0.00%	0.00%	0.00%	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
zstopak	Report(s)	36_DY2Q1_PROJ2biii_MDL2biii2_PES_RPT_BPHC-PATIENTLIST-2biii-DY2Q1_2916pts_FINAL_5445.xlsx	Patient Engagement - ED Care Triage (2.b.iii)	08/04/2016 03:48 PM

Narrative Text :

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

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Establish ED care triage program for at-risk populations	DY3 Q4	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Stand up program based on project requirements		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify key stakeholders and initiate regular ED care triage task force meetings		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Conduct preliminary site visits to participating EDs		Project		Completed	08/15/2015	12/31/2015	08/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish workflow triage model with input from task force and participating ED site-specific implementation teams		Project		Completed	08/15/2015	12/31/2015	08/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task Draft job descriptions, staffing and recruitment plan, in consultation with the Workforce Subcommittee		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify a documentation platform for templates and tools developed for ED care triage		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop guidelines and assessment template/tool for use by Patient Navigator, including mechanisms to identify patients who are already engaged in HHs and those who are eligible for HHs		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop guidelines and assessment template/tool for assisting patient in selecting a PCP		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop guidelines and assessment template for scheduling follow-up PCP/BH provider/Other provider		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop guidelines and assessment template to be used in identifying patient's need for social supports and the process of referral to CBOs, with particular attention to the complex needs of patients with co-occurring disorders, homelessness and SUD		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Develop standard procedures for notifying and sharing information with PCP / HH care manager / other provider										
Task Develop standard procedures for referral to behavioral health support services for eligible patients, with particular attention to the complex needs of patients with co-occurring disorders, homelessness and SUD		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop specifications to generate alerts for patients to be targeted in ED care triage; specify criteria for intervention		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop training curriculum for Patient Navigators and ED staff using evidence-based care management principles and project specific procedures and tools		Project		Completed	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Finalize compilation of all documentation into a Clinical Operations Plan (COP) for ED Care Triage for At-Risk Populations		Project		Completed	03/01/2016	06/30/2016	03/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Finalize budget for ED Care Triage for At-Risk Populations		Project		Completed	03/01/2016	06/30/2016	03/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Submit elements of the COP to Quality and Care Innovation Sub-Committee (QCIS) for approval		Project		In Progress	04/01/2016	08/31/2016	04/01/2016	08/31/2016	09/30/2016	DY2 Q2
Task Establish plan for data exchange and systems for documenting ED Care Triage activities across the PPS		Project		In Progress	04/01/2016	08/31/2016	04/01/2016	08/31/2016	09/30/2016	DY2 Q2
Task Identify and catalogue available community resources, using the CNA as a starting point to create a Community Resources Database		Project		In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Survey participating providers to identify gaps in services and identify additional potential community organization partners		Project		Completed	07/15/2015	03/31/2016	07/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Define processes for referral, and access to information among providers, and feedback processes to the practices electronically with interim manual processes as needed in conjunction with IT subcommittee		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish and document referral and follow-up procedures for the sites, with a mechanism for sites to audit adherence and report to		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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QCIS										
Task Identify community organizations for inclusion in the initial iteration of the Community Resource Database, sign agreements with with community based organizations and establish process to facilitate feedback to and from community organizations		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Perform regular checks of Community Resource Database to ensure data is up to date and accurate and to identify additional resources to consider including		Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Establish the schedule and materials for periodic staff training on the warm transfer and referral tracking		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Orient hospital staff and community-based partners on the project		Project		Completed	10/15/2015	03/31/2016	10/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop and implement registry reporting capabilities to track and intervene on patients to be targeted by ED care triage		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Recruit and hire Patient Navigators		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Train Patient Navigators, their supervisors, and ED staff using the curriculum developed including use of Community Resource Database, with particular attention to the complex needs of patients with co-occurring disorders, homelessness and SUD		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable	DY3 Q4	Project	N/A	In Progress	06/30/2015	03/31/2018	06/30/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	06/30/2015	03/31/2018	06/30/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)		Project		In Progress	06/30/2015	03/31/2018	06/30/2015	03/31/2018	03/31/2018	DY3 Q4
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs		Provider	Safety Net Hospital	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices		Project		Completed	06/30/2015	12/31/2015	06/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recruit or contract for PCMH practice certification resources as needed		Project		Completed	06/30/2015	12/31/2015	06/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition		Project		Completed	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Perform gap analysis by practice and identify key priorities.		Project		Completed	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.		Project		Completed	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition		Project		In Progress	01/01/2016	11/30/2016	01/01/2016	11/30/2016	12/31/2016	DY2 Q3
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS wide PCMH sub-committee as needed.		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Assess eligible participating partner EHR use relative to		Project		Completed	06/30/2015	08/30/2015	06/30/2015	08/30/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Meaningful Use and PCMH 2014 Level 3 standards										
Task Establish BPHC program to educate, encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, including potential use of incentive-based payments for implementation		Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Recruit or contract for EHR implementation resources as needed		Project		Completed	11/01/2015	04/01/2016	11/01/2015	04/01/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner EHR implementation and progress towards Meaningful Use and PCMH standards		Project		Not Started	08/01/2016	12/31/2016	08/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Track status and manage support to ensure all eligible safety net providers are using certified EHR systems that meet Meaningful Use and PCMH 2014 Level 3 standards		Project		In Progress	10/15/2015	03/15/2018	10/15/2015	03/15/2018	03/31/2018	DY3 Q4
Task Identify safety net provider data sharing requirements and ENS capabilities and assess partner and QE data sharing capabilities and current HIE participation		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Coordinate with Bronx RHIO to develop comprehensive HIE adoption program to encourage and support partner participation and integration		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Begin coordinated interface and service development with Bronx RHIO		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish BPHC program to manage support for safety net providers to ensure that all are actively sharing health information, coordinating with Bronx RHIO to encourage, track and support partner participation and integration/data sharing		Project		Completed	03/01/2016	04/25/2016	03/01/2016	04/25/2016	06/30/2016	DY2 Q1
Task Track status and manage support to ensure that all PPS safety net providers are actively sharing health information through Bronx RHIO/ENS/alternative health information exchange		Project		In Progress	03/01/2016	03/31/2018	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor the use of ENS for communications related to ED Care Triage		Project		In Progress	03/01/2016	03/31/2018	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor practice transformation sustainability after receiving 2014		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
NCQA level 3 PCMH certification, and provide support as needed.										
Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	DY3 Q4	Project	N/A	Not Started	09/01/2016	03/31/2018	09/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task A defined process for triage of patients from patient navigators to non-emergency PCP and needed community support resources is in place.		Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Implement ED care triage protocols, as outlined in Milestone 1		Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provide technical assistance to site-specific implementation teams		Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Monitor the speed with which patients receive an appointment with PCP/specialist/BH. Troubleshoot with PCPs/others as necessary		Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Patient Navigation Team conducts telephonic follow-up with patient and PCP/HH/behavioral health/appropriate specilaty service/CBO/other support service to ensure access to care, community support resources and to track appointment completion.		Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Modify Clinical Operations Plan procedures to reflect lessons learned, in conjunction with task force		Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is	DY2 Q4	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
optional.)										
Task PPS has protocols and operations in place to transport non-acute patients to appropriate care site. (Optional).		Provider	Safety Net Hospital	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	DY2 Q4	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 Perform gap analysis and identify priories to achieving integration of patient record.		Project		Completed	04/01/2015	01/01/2016	04/01/2015	01/01/2016	03/31/2016	DY1 Q4
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.		Project		Completed	04/01/2015	01/01/2016	04/01/2015	01/01/2016	03/31/2016	DY1 Q4
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)		Project		Completed	04/01/2015	01/01/2016	04/01/2015	01/01/2016	03/31/2016	DY1 Q4
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget to build registry and acquire necessary resources		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.										
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish ED care triage program for at-risk populations	BPHC, with the assistance of Montefiore's Care Management Organization (CMO) as vendor and a joint SBH-Montefiore implementation team, is implementing the ED Care Triage project. Activities of the Site-Specific Implementation Team/Project task forces for DY2Q1 including completing the Clinical Operation Plan (COP), finalizing the ED Care Triage budget, and developing the training for ED Navigators. Collaboration with Bronx Lebanon and One City Health (HHC) PPS in geographical proximity has also begun. The COP includes detailed work flows and descriptions of the program. Activities during DY2Q1 have also involved creating more detail around processes to be developed into the ED Navigator training. BPHC will augment the training curriculum with overviews of behavioral health respite providers and home-based asthma services which were described in the COP. SBH and Montefiore – the two hospital systems in BPHC – have developed rollout plans for estimated completion of hiring and training starting in the SBH and Montefiore Moses ED in September 2016 and then to the other Montefiore EDs including the Children's Hospital by March of 2017. SBH and Montefiore have begun recruiting staff. Templates of documentation ED Navigators will use to document project activities were shared with both Montefiore IT and SBH IT departments during DY2Q1 in order to build the documentation within their respective EMRs. Lastly, BPHC has been defining the business requirements for the ED Care Triage project with the Bronx RHIO in efforts to create project specific registry and analytics tools. Implementation of central registries to track and intervene on patients will be delayed and is set for DY2Q3. Milestone is on track for completion.
Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS	We are executing a comprehensive plan to support our safety net providers in Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) which includes EHR support and connectivity of data captured therein. A process has been started to ensure all applicable providers meet PCMH recognition and MU accreditation where possible and that we meet our obligation to the previously agreed tasks. Consultants have been deployed to perform detailed gap analyses with about 115 practices, with 80 locations already evaluated thus far. Of those, 21 practices have already submitted their PCMH 2014 attestations, with all achieving level 3, which accounts for 30% of

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable	the PCPs identified by SDOH in the PPS. Of note is SDOH's latest guidelines which will decrease the number of physicians identified as PCMH eligible and thus drastically increase the share of eligible physicians which have already completed this process. Contracting is complete with six consulting groups for the work on the remaining practices. We are starting to also discuss Advance Primary Care and Transforming Clinical Practice Initiative with SDOH-certified consultants and are identifying locations which would be good candidates for the programs. These six consulting groups are part of a Community of Practice ("CoP") we are organizing to build/establish best practices, share and collaborate with experts on PCMH transformation, and possibly transfer the experience and knowledge to other population health initiatives. PCMH progress is tracked and reported on at every Executive Committee meeting. BPHC continues to actively work with its partners by leveraging best practices and workflows from primary care sites that already utilize RHIO alerts to ensure real-time notification to PCP and/or Health Home Care Manager. As well, alerts will signal to the providers that ED visit documentation is available in the RHIO. Meetings with the Bronx RHIO and seven largest primary care organization partners occurred in DY2Q1 and will continue in DY2Q2 to further define workflow for utilizing alerts and communicating ED Navigator recommendations to PCPs and CBOs. The milestone is on track for completion.
For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	
Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)	
Use EHRs and other technical platforms to track all patients engaged in the project.	We are executing a comprehensive plan to support our safety net providers in obtaining Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) certification, which includes the use of targeted patient registries in conjunctions with our clinical projects. We have a strategy in place for care management which includes the uses of registries, EHRs, Care Coordination Management Systems, and referral tracking systems. Our major partners which account for 87% of BPHC PCPs and 81% of non-PCPs, are already sharing clinical data to varying degrees with the Bronx RHIO and anticipate the quality and quantity of this data to increase. We reviewed DSRIP performance measures and Quality and Care Innovations Subcommittee recommended registry fields, and have been working with BxRHIO to further define which are most feasible to build out and release to our largest partners in DY2. Bronx RHIO has conducted a gap analysis on data currently in the RHIO and identified missing and other data quality issues relevant to those initial proxy measures and registries. Bronx RHIO had already begun development of Spectrum, its population health management (PHM) and analytics tool, which the PPS will utilize as part of our PHM solution. Though still in development this quarter, we obtained accounts and initial training on Spectrum for key staff in the CSO to begin understanding it. We are also simultaneously exploring potentials to utilize the MAPP/Salient resources to use as additional PHM source to understand the population we serve and their utilization patterns. Furthermore, we are actively pursuing to improve consent rates for Bronx RHIO and initiated a data use agreement (DUA) where each partner allows the Bronx RHIO to share their data with BPHC to create an environment where PHM will be more comprehensively implemented. We are confident that we are also close to securing a Care Coordination and Management System (CCMS) for the PPS. BPHC also deployed a rapid cycle evaluation (RCE) process and selected initial set of key process measures to support our implementation progress. We have fully executed a contract in DY1Q4 with the Bronx RHIO to support registry development and PHM. However, we continue to negotiate with our leading CCMS vendor, Acupera. Delays on their part have contributed to our inability to fully execute a contract to acquire their CCMS. We will likely sign a contract for a CCMS by

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	September 30, 2016 (end of DY2Q2). As registries and CCMS platforms are deployed, we will execute our registry testing plan and training programs for providers and care managers. Given that we have yet to contract for/acquire a CCMS platform, and our registries are still in build for Spectrum, the Bronx RHIO's data analytics tool, we cannot yet execute our training plan for providers and care managers. We expect that training on registry use for PHM will begin by September 30, 2016, but that training on our CCMS platform won't begin until January 2017. As registries and CCMS platforms are deployed, we will issue CCMS user credentials and train partner providers and care managers in the use of the integrated solution. Given that we have yet to contract for/acquire a CCMS platform, we cannot yet issue user credentials nor disseminate standardized IT protocols and data security requirements across the system. We expect that training on our CCMS platform won't begin until January 2017, at which point we will issue user credentials, IT protocols and data security requirements. The milestone is on track for completion.

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Mid-Point Assessment	Completed	Mid-Point Assessment			06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Mid-Point Assessment	zstopak	Templates	36_DY2Q1_PROJ2biii_MDL2biii4_PPS1540_TEMPL_2a_Mid-Point_Assessment_Project_Narrative_2biii_FINAL_4817.docx	Mid-Point Assessment Project Narrative (2.b.iii - ED Care Triage)	08/02/2016 02:06 PM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment	

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

Instructions :

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

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

Instructions :

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

(1) There is often inadequate coordination and communication between hospital-based teams, outpatient care managers (CM), PCPs, SNFs, and home-health care agencies that are key to effective hand-offs among providers. In addition, hospital staff does not always recognize the value of CBOs in managing Care Transitions (CT). To mitigate these risks, Clinical Coordinators (CTCCs), post-discharge care coordinators (PDCCs) and outpatient CMs will have access to an electronic care and referral management tool that can be shared across all BPHC providers. BPHC will assure that partners across multiple settings can use this tool to find and refer to various services needed during transitions of care. Sharing transitional care plans (TCP) through BxRHIO will be instrumental to CT hand offs, as will telephonic follow up to fill gaps and close-loop referral. BPHC will develop training to address cultural competency, language barriers, and detail elements of CT model and roles of each CT team member, including hospital-based staff, outpatient CMs, and CBOs providing social services, with particular attention to warm handoffs, coordination and communication across roles and settings.
(2) Unstable housing and Behavioral Health (BH) diagnoses including substance use disorder (SUD) may impact readmissions; CBO partners will be engaged to assist in mitigating these risks. To prevent readmissions among SMI patients who are at risk for homelessness, BPHC will fund Health Homes (HH) to provide Critical Time Interventions, an evidence-based, time-limited CT program. In efforts to prevent readmissions and overutilization of the ED among patients with BH diagnoses, SBH Health System (SBH) has partnered with two CBOs through the Medicaid Accelerated eXchange (MAX) Series. BronxWorks and Bronx Crisis Respite Center, CBOs who provide homeless services and crisis respite services respectively, have started to engage SBH BH patients. ED and readmission rates among BH patients have dropped over the six months since the CBO partnerships began. Efforts will be made to expand these CBO partnerships to all BPHC facilities and to develop the CTI program to compliment these services.
(3) Recruiting and hiring CT staff, particularly Spanish-speaking staff, presents a challenge to readmission reduction efforts. Hospitals may also experience unexpected delays in hiring due to issues with the unions. BPHC is working with local community colleges, CBOs, 1199 Training and Education Fund and NYSNA to help recruit and train care management staff, offer competitive salaries, flexible hours, and job sharing, as feasible, to improve recruitment and retention.
(4) Existing policies and procedures for early notification of planned discharges differ among hospitals. Notification of HH CMs when patients are being discharged varies, particularly if patients are discharged earlier than expected or from a hospital not subscribed to RHIO alerts. BPHC will require hospitals and PCPs to have RHIO connectivity, to use alerts, and to establish protocols requiring timely notification of discharges to HH CMs. TCPs will be shared with PCPs and HH CMs through RHIO alerts and telephone calls. HHs will be provided with one point of contact in the hospital so that CMs can easily receive relevant updates from the hospital-CT team.

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY3,Q4	10,290

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	1,672	3,345	5,016	6,689
	Quarterly Update	2,141	0	0	0
	Percent(%) of Commitment	128.05%	0.00%	0.00%	0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment	0.00%	0.00%	0.00%	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
zstopak	Report(s)	36_DY2Q1_PROJ2biv_MDL2biv2_PES_RPT_BPHC-PATIENTLIST-2biv-DY2Q1_2141pts_FINAL_4821.xlsx	Patient engagement - 2.b.iv (Care Transitions) DY2 Q1	08/02/2016 02:13 PM

Narrative Text :

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

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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)	Prescribed Due Date	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.	DY2 Q4	Project	N/A	In Progress	09/01/2015	03/31/2017	09/01/2015	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	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Engage partners, including health homes (HH), to promote project understanding and partner alignment.		Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify key stakeholders and initiate Care Transitions (CT) work group		Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Conduct preliminary site visits to participating in-patient settings		Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Orient hospital staff to the project		Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop job description and staffing plan, in consultation with the Workforce Subcommittee		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Map comprehensive list of care and social services used by patients in the home or other non-medical setting		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop criteria for identifying and targeting patients most at risk for readmission, to facilitate the creation of patient registries and alerts		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify electronic patient stratification tool or algorithm to identify the 'at risk' population		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish workflow triage model with input from CT work group and participating site-specific implementation teams		Project		Completed	11/15/2015	02/01/2016	11/15/2015	02/01/2016	03/31/2016	DY1 Q4
Task		Project		Completed	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4

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Establish plan for data exchange and systems for documenting CT program activities across the PPS										
Task Develop guidelines and assessment template/tools for the determination of HH and CT eligibility by CT team		Project		Completed	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop guidelines and assessment template/tools for assisting patient in selecting a PCP		Project		Completed	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop guidelines and assessment template/tools for scheduling follow-up PCP appointment, specialty care, CBO care, and/or a medical visit in a non-traditional setting (e.g. house call, telehealth)		Project		Completed	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop guidelines and assessment template/tools to be used in identifying patient's need for social supports and the process of referral to CBOs		Project		Completed	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop standard procedures for notifying and sharing information with PCP / HH care manager / or other provider, as needed		Project		Completed	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop standard procedures for referral to behavioral health support services for eligible patients		Project		Completed	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize compilation of all documentation into a Clinical Operations Plan (COP) for CT intervention		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Finalize budget for CT intervention		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Submit elements of COP to Quality and Care Innovation Sub-Committee (QCIS) for approval		Project		Completed	03/01/2016	05/31/2016	03/01/2016	05/31/2016	06/30/2016	DY2 Q1
Task Develop training curriculum for CT staff using evidence-based care management principles and project specific procedures and tools. Training curriculum will emphasize cultural competence and health literacy		Project		Completed	03/01/2016	06/30/2016	03/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Convene representative group of PPS members to form CT work group, including hospitals, BH and SUD SMEs to review Critical Time Intervention strategies and to create workplan.		Project		Completed	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4

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Task Define the population to be targeted by Critical Time Intervention strategies		Project		Completed	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task In conjunction with the Workforce subcommittee, define a Critical Time Intervention staffing model, to address the needs of the target population including staff qualifications, roles, functions, and panel size of team members		Project		Completed	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop financial model to cost out Critical Time Intervention team		Project		Completed	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop and document the COP to define the elements of the Critical Time Intervention program including the roles of PCPs, BH specialists, HHs, HIE and technology requirements, and evidence-based guidelines		Project		Completed	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Working with Workforce Subcommittee, design training and recruitment strategy for Critical Time Intervention staffing		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Develop Critical Time Intervention implementation budget		Project		Completed	03/01/2016	06/30/2016	03/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Submit elements of Critical Time Intervention COP to QCIS for approval		Project		Completed	03/01/2016	05/31/2016	03/01/2016	05/31/2016	06/30/2016	DY2 Q1
Task Prepare/disseminate gap analysis tool based on COP to participating providers to determine Critical Time Intervention resource needs against project plan and care management team staffing model		Project		Completed	02/01/2016	06/30/2016	02/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Complete assessment of Critical Time Intervention staffing needs across the PPS in conjunction with the Workforce Subcommittee		Project		Completed	02/01/2016	05/31/2016	02/01/2016	05/31/2016	06/30/2016	DY2 Q1
Task Develop a registry of patients to be targeted for intervention		Project		Completed	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Establish technology interfaces to ensure frequent automated updates of registry data		Project		Completed	04/04/2016	06/30/2016	04/04/2016	06/30/2016	06/30/2016	DY2 Q1
Task Implement CCMS and/or other systems and services with patient registries and other features required for PHM		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Recruit and hire needed CT staff										
Task Train CT staff and their supervisors		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify implementation teams for Critical Time Intervention		Project		In Progress	03/01/2016	03/31/2017	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Launch recruitment and training programs with Critical Time Intervention participating providers		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Establish mechanisms for feedback and monitoring for Continuous Quality Improvement (CQI)		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task CT staff implement Care Transitions interventions, using project-specific templates, tools and procedures		Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task CT staff conduct telephonic follow-up with patient and PCP/HH/BH/other support service to ensure access to care and all follow up appointments were completed.		Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Modify COP procedures to reflect lessons learned, in conjunction with task force		Project		Not Started	06/30/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	DY3 Q2	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.		Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Meet with payers to identify triggers and processes for payer care coordination and chronic care services to ensure coordination and prevent gaps in care and/or redundant services, as part of a value-based payment strategy, outlined below.		Project		In Progress	01/01/2016	06/30/2016	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Task Develop partnership agreements with payers affirming coverage and coordination of service benefits. Include HHs in the development of this payment strategy.		Project		In Progress	03/01/2016	03/31/2017	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Review final State value-based payment roadmap and PPS value-based payment plan		Project		Completed	07/01/2015	08/31/2015	07/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task Identify Medicaid MCOs engaged with our attributed patients and actively engage them in developing new and strengthening existing value-based payment arrangements through a structured stakeholder engagement process.		Project		Completed	09/01/2015	11/15/2015	09/01/2015	11/15/2015	12/31/2015	DY1 Q3
Task Establish partner value-based payment reporting requirements and procedures to enable ongoing monitoring of value-based payments and care transitions.		Project		In Progress	03/01/2016	09/30/2016	03/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Develop detailed analysis of PPS partners' existing value-based payment arrangements with Medicaid MCOs and other payers by reviewing claims-level data, with attention to HHs		Project		Completed	09/30/2015	12/31/2015	09/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Engage MCOs in defining PPS MCO contracting strategy and organizational requirements necessary to support the development of contracts with Medicaid MCOs		Project		Completed	09/15/2015	12/01/2015	09/15/2015	12/01/2015	12/31/2015	DY1 Q3
Task Engage PPS partners, especially HHs, to assist in defining PPS MCO contracting strategy and organizational requirements necessary to support the development of contracts with Medicaid MCOs		Project		In Progress	11/15/2015	09/15/2016	11/15/2015	09/15/2016	09/30/2016	DY2 Q2
Task Develop or contract with an organizational structure (e.g. HH) or multiple organizational structures to support contracting with Medicaid MCOs and other payers as an integrated system		Project		Completed	11/15/2015	02/15/2016	11/15/2015	02/15/2016	03/31/2016	DY1 Q4
Task Develop value-based payment arrangements for presentation to Medicaid MCOs and other payers		Project		Completed	02/15/2016	03/31/2016	02/15/2016	03/31/2016	03/31/2016	DY1 Q4
Task Develop PPS plan, overseen by Finance and Sustainability Sub-committee, to achieve 90% value based payments by DY5 and present to the Executive Committee for review and signoff		Project		In Progress	07/15/2015	12/31/2016	07/15/2015	12/31/2016	12/31/2016	DY2 Q3
Task		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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PPS has agreement in place with MCOs and HHs related to coordination of CT intervention for populations at-risk for re-admission										
Task Monitor use of assessment tool to identify HH-eligible patients		Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Ensure eligibility is noted in patient's EHR		Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Monitor rates of referrals to HH services based on eligibility		Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Ensure required social services participate in the project.	DY3 Q2	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Required network social services, including medically tailored home food services, are provided in care transitions.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop a web-based directory of preferred CBO/social service providers, including medically tailored home food services, that will provide a comprehensive source of information on the scope of social services provided across the PPS.		Project		Completed	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Analyze Community Needs Assessment data, Medicaid data base/MAPP, and PPS partner data for 30 day hospital readmissions over the past 12 months		Project		Completed	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Identify and catalog available community resources, using the CNA as a starting point to create a Community Resources Database		Project		In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Survey participating providers to identify gaps in services and identify additional potential community organization partners		Project		Completed	07/15/2015	03/31/2016	07/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Define processes for referral, and access to information among providers, and feedback processes to the practices electronically with interim manual processes as needed in conjunction with IT subcommittee		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish and document referral and follow-up procedures for the sites, with a mechanism for sites to audit adherence and report to QCIS		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify community organizations for inclusion in the initial		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

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iteration of the Community Resource Database, sign agreements with with community based organizations and establish process to facilitate feedback to and from community organizations										
Task Perform regular checks of Community Resource Database to ensure data is up to date and accurate and to identify additional resources to consider including		Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Establish the schedule and materials for periodic staff training on the warm transfer and referral tracking		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	DY2 Q4	Project	N/A	In Progress	04/01/2016	03/31/2017	04/01/2016	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	04/01/2016	03/31/2017	04/01/2016	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	04/01/2016	03/31/2017	04/01/2016	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	04/01/2016	03/31/2017	04/01/2016	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	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop and implement policies and procedures for early notification of planned discharges.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop communications plan between in-patient and CT staff		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Monitor early notification of planned discharge and modify procedures as necessary, using CQI		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Provide pre-discharge visits that educate patients and caregivers about their conditions and how to manage them, review discharge summaries and care plans, and perform medication reconciliation										
Task Ensure hospital policies and procedures allow access by care managers for patients identified for CT intervention		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	DY2 Q4	Project	N/A	In Progress	08/15/2015	03/31/2017	08/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.		Project		Not Started	06/30/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Ensure that transition plans include the following elements: a. Flag patients at if high-risk for readmission b. Medication reconciliation c. Methods to identify and respond to worsening condition d. Interdisciplinary team approach e. Engaged primary provider f. Information dissemination		Project		Not Started	06/30/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop and implement policies and procedures for including care transitions plans in the patient's medical record		Project		Not Started	06/30/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify and document required clinical and care management protocols for priority programs, projects and interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data		Project		Completed	08/15/2015	10/15/2015	08/15/2015	10/15/2015	12/31/2015	DY1 Q3
Task Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations for how interventions will be logged, tracked and reported		Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Deploy systems to improve and promote effective care transitions, include protocols for tracking and follow-up		Project		Completed	01/15/2016	02/28/2016	01/15/2016	02/28/2016	03/31/2016	DY1 Q4

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Task Operationalize partner and workforce roles by providing gap analysis and appropriate training to clinicians and care management staff (including licensed care managers, care coordinators, patient navigators/community health workers, medical assistants and front-office staff)		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Establish data collection, survey and reporting mechanisms to enable BPHC monitoring to ensure that patients are receiving appropriate health care and community support in priority projects, based on needs identified in prior planning activities		Project		Completed	02/01/2016	06/15/2016	02/01/2016	06/15/2016	06/30/2016	DY2 Q1
Task Review process for rapid cycle evaluation and continuous improvement of data collection, survey and reporting methods based on priority project experience and modify process as needed to ensure patients receive appropriate health care and community support		Project		Not Started	08/01/2016	09/01/2016	08/01/2016	09/01/2016	09/30/2016	DY2 Q2
Task Monitor record of transition plan in the interoperable EHR, as well as whether PCP has accessed the plan (if feasible)		Project		Not Started	06/30/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Convene providers from different care settings to define specific information and clinical data to include in the care transition record shared between sending and receiving providers, as patient goes from one care setting to another. Resources designed by the National Transition of Care Coalition will be considered.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #6 Ensure that a 30-day transition of care period is established.	DY2 Q4	Project	N/A	Not Started	06/30/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.		Project		Not Started	06/30/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Establish a process and structure to conduct a detailed review of all discharges leading to readmission within 30 days.		Project		Not Started	06/30/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Use the analysis and the ongoing review data to inform services to involve in this project.		Project		Not Started	06/30/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Work with partners to define how to document and communicate 30-day transition period of care.		Project		Not Started	06/30/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Task Incorporate the 30 day care transition period into payer agreements.		Project		Not Started	06/30/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	DY2 Q4	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 Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform gap analysis and identify priories to achieving integration of patient record.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.		Project		Completed	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget to build registry and acquire necessary resources		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care										
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2

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.	BPHC has made progress in designing the training for implementation of the 30-day care transitions intervention on BPHC inpatient units and on a post-discharge basis. Hospital partners have developed a staffing rollout beginning at SBH and Montefiore Wakefield by September 2016 and rolling out to other Montefiore sites between October and March of 2017. BPHC partners have started to engage IT departments to build and test work lists of patients to be targeted for the intervention. The Montefiore Care Management Organization (CMO), our vendor, has provided updated drafts of both the training curriculum and presentations and has been actively editing the materials based on input from the joint Montefiore-SBH project task force. Meetings with the Bronx RHIO and seven largest primary care organization partners in the PPS have occurred over DY2Q1 and will continue in DY2Q2 to further define workflow for utilizing alerts and communicating care transitions to PCPs and CBOs. During the quarter, BPHC has also made significant progress toward establishing a Critical Time Intervention (CTI) program to address the transitions of care for behavioral health patients. BPHC has sent out a request for proposal (RFP) to all of our Health Home partners and behavioral health members – mental health services (Article 31) and substance abuse programs (Article 32) who may be interested in operating a CTI program. BPHC has already begun to engage inpatient behavioral health providers and discharge planners to identify patients who meet the criteria of the target population to engage patients and provide a warm handoff to the CTI team while the patient is still

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Milestone Name	Narrative Text
	in the hospital. Lastly, BPHC has been defining the business requirements for the Care Transitions project with the Bronx RHIO in efforts to create project specific registry and analytics tools. As registries and CCMS platforms are deployed, we will execute our registry testing plan and training programs for providers and care managers. Given that we have yet to contract for/acquire a CCMS platform, and our registries are still in build for Spectrum, the Bronx RHIO's data analytics tool, we cannot yet execute our training plan for providers and care managers. We expect that training on registry use for PHM will begin by September 30, 2016, but that training on our CCMS platform won't begin until January 2017. Milestone is on track for completion.
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.	As noted in the prior quarter and in the IDS milestone 8 subtasks (to which nearly all of this milestone's tasks are linked), contracting with Medicaid Managed Care Organizations, as an integrated delivery system, is contingent upon developing a larger VBP plan and determining the most appropriate governance structure given existing and / or emerging arrangements. Subtasks within this milestone section are being deferred until after the baseline assessment is completed and after the VBP plan towards achieving 90% value-based payments across the PPS network by year 5 which is due DY2 Q4 (3/31/17). As outlined in the Finance section under Milestone 4 of the IDS PIP, BPHC engaged Manatt to assist with VBP planning efforts. The engagement's objective is to assist BPHC with VBP modeling and understanding the various contractual arrangements that may be used. The engagement also focuses on the current structures and capabilities of the Montefiore ACO and analyzing the features of the VBP Innovator Pilot program with which Montefiore and St. Barnabas Hospital are pursuing together. This will serve as the foundation of a potential IDS and VBP plan which can then be leveraged to this milestone that addresses contracting. Although no contracts are achievable under an IDS without first achieving an IDS structure, there has been open communication with BPHC and the MCOs through the Equity Infrastructure Program ("EIP") and Equity Performance Program ("EPP") reporting requirements. In addition, through relationships between MCO and PPS providers, the dialogue has shifted from individual arrangements to a prospective focus on a larger arrangement through an ACO or IPA. The issue, however, continues to remain the ability and infrastructure of the MCOs to administer VBP arrangements and accommodate the data needs of an IDS given their existing business model of fee-for-service schedules, denials and other back-office hurdles to process a claim payment.
Ensure required social services participate in the project.	Efforts have been made over the quarter to review MAPP, the Community Needs Assessment (CNA) and hospital readmission data to identify trends and prioritize work lists for patients to be targeted in the intervention. Also a root cause analysis for any readmission will be considered as part of ongoing continuous quality improvement (CQI) and discussed at IWG meetings as the projects kickoff. General readmission trends will be aggregated and communicated as programs develop and community partnerships continue to mature. BPHC has established formal partnerships with Health Home Care Management Agencies (CMAs) and Skilled Nursing Facilities to whom many transitioning patients will likely be referred. CBOs that provide supportive housing, respite services as well as behavioral health services have been engaged to provide specific transition assistance. In addition, as explained in Milestone 1 update, the Critical Time Intervention (CTI) model will also engage Health Homes and other CBOs in this project. Milestone is on track for completion.
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.	Hospital policies and procedures as laid out in the Clinical Operations Plan (COP) will be updated to allow access for care managers (CMs), both hospital-based and outpatient. BPHC is also working to help partners develop workflows to start using RHIO alerts so that outpatient CMs will have knowledge when patients are in the hospital and determine appropriate courses of action including contacting care transition staff, visiting patients in the hospital as well as taking part in the development of the Transitional Care Plan. Conversations will continue over the next few quarters as how to strengthen communication between hospital and outpatient settings regarding care coordination of patients in the 30-day period following discharge. Milestone is on track for completion.
Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Providers from different settings have been part of the SBH-Montefiore implementation task force and reviewed the Transitional Care Plan (TCP) in considering resources designed by National Transition of Care Coalition. The TCP was briefly discussed at the May Implementation Work Group (IWG) where nursing home and home care providers were present and those providers gave input as to information that would be useful to them such as medication reconciliation and problems, goals and interventions (PGI) to be addressed during the 30-day period following discharge. The July IWG will involve a further discussion of these elements. BPHC has decided to use the Bronx RHIO for exchange of discharge summaries and/or TCPs. Alerts will be attached to these documents to ensure physicians receive them. IT departments are developing infrastructure for program rollout per staffing/training schedule laid out in Milestone 1 narrative. Criteria for Critical Time Intervention (CTI) have been finalized and were approved by the IWG and QCIS in May. Conversations have continued with a subgroup of CTI subject matter experts at the hospitals and Health Homes who will identify and refer individuals meeting criteria for the target population in DY2Q2. As mentioned in Milestone 1, an RFI for the CTI program operation has been developed and will be disseminated to behavioral-health providers within our PPS. Milestone is on track for completion.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Ensure that a 30-day transition of care period is established.	Milestone progress to begin in DY2 Q2
Use EHRs and other technical platforms to track all patients engaged in the project.	We are executing a comprehensive plan to support our safety net providers in obtaining Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) certification, which includes the use of targeted patient registries in conjunctions with our clinical projects. We have a strategy in place for care management which includes the uses of registries, EHRs, Care Coordination Management Systems, and referral tracking systems. Our major partners which account for 87% of BPHC PCPs and 81% of non-PCPs, are already sharing clinical data to varying degrees with the Bronx RHIO and anticipate the quality and quantity of this data to increase. We reviewed DSRIP performance measures and Quality and Care Innovations Subcommittee recommended registry fields, and have been working with BxRHIO to further define which are most feasible to build out and release to our largest partners in DY2. Bronx RHIO has conducted a gap analysis on data currently in the RHIO and identified missing and other data quality issues relevant to those initial proxy measures and registries. Bronx RHIO had already begun development of Spectrum, its population health management (PHM) and analytics tool, which the PPS will utilize as part of our PHM solution. Though still in development this quarter, we obtained accounts and initial training on Spectrum for key staff in the CSO to begin understanding it. We are also simultaneously exploring potentials to utilize the MAPP/Salient resources to use as additional PHM source to understand the population we serve and their utilization patterns. Furthermore, we are actively pursuing to improve consent rates for Bronx RHIO and initiated a data use agreement (DUA) where each partner allows the Bronx RHIO to share their data with BPHC to create an environment where PHM will be more comprehensively implemented. We are confident that we are also close to securing a Care Coordination and Management System (CCMS) for the PPS. BPHC also deployed a rapid cycle evaluation (RCE) process and selected initial set of key process measures to support our implementation progress. We have fully executed a contract in DY1Q4 with the Bronx RHIO to support registry development and PHM. However, we continue to negotiate with our leading CCMS vendor, Acupera. Delays on their part have contributed to our inability to fully execute a contract to acquire their CCMS. We will likely sign a contract for a CCMS by September 30, 2016 (end of DY2Q2). As registries and CCMS platforms are deployed, we will execute our registry testing plan and training programs for providers and care managers. Given that we have yet to contract for/acquire a CCMS platform, and our registries are still in build for Spectrum, the Bronx RHIO's data analytics tool, we cannot yet execute our training plan for providers and care managers. We expect that training on registry use for PHM will begin by September 30, 2016, but that training on our CCMS platform won't begin until January 2017. As registries and CCMS platforms are deployed, we will issue CCMS user credentials and train partner providers and care managers in the use of the integrated solution. Given that we have yet to contract for/acquire a CCMS platform, we cannot yet issue user credentials nor disseminate standardized IT protocols and data security requirements across the system. We expect that training on our CCMS platform won't begin until January 2017, at which point we will issue user credentials, IT protocols and data security requirements. The milestone is on track for completion.

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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
Milestone Mid-Point Assessment	Completed	Mid-Point Assessment			06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Mid-Point Assessment	zstopak	Report(s)	36_DY2Q1_PROJ2biv_MDL2biv4_PPS1541_RPT_2a_Mid-Point_Assessment_Project_Narrative_2biv_FINAL_4863.docx	Mid-Point Assessment Project Narrative (2.b.iv - Care Transitions)	08/02/2016 03:51 PM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment	

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

Instructions :

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

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

Instructions :

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

This project marks a significant cultural shift in how care is delivered to and experienced by patients. Lack of provider buy-in is a risk for successful implementation. To mitigate this risk, BPHC will: (a) provide project-specific training and technical assistance (TA) on the IMPACT model processes and protocols to primary care providers (PCPs) and their care teams through an experienced training consultant over a 6-month training period. Training and TA will assess and provide guidance on building an effective care team. In addition, the training and TA will place an emphasis on providing culturally competent care for depression, including an understanding of cultural barriers to care and health literacy and stigma among the patient population; (b) provide technical assistance for those organizations seeking to introduce primary care (PC) into behavioral health (BH) sites or BH into PC sites. BPHC will connect organizations implementing co-location with peers that have successfully co-located PC and BH. BPHC will also seek ways to incentivize physician participation, e.g., offering access to tools for population health management, including registries and care coordination. TA will include an emphasis on providing culturally competent care for BH issues.
Regulatory and reimbursement barriers currently in place discourage effective integration of PC and BH through co-location due to cost, paperwork, and length of approval process. To mitigate this risk, BPHC requested and received the following waivers from the State: Article 28 facilities may provide mental health or substance abuse services provided those services comprise no more than 49% of a facility's annual visits and the facility complies with various provisions of the new integrated services regulations; Articles 31 and 32 facilities may provide physical health services provided those services comprise no more than 49% of a facility's annual visits and the facility complies with various provisions of the new integrated services regulations.
Article 28 and Article 32 facilities may treat their patients in the home, but there is no system yet for reimbursement for such visits. SDOH, OMH, and OASAS have yet to grant any waivers that would allow two different providers licensed by different agencies to share space, e.g., a common waiting room used by an Article 28 and Article 31 facility. To mitigate this risk, BPHC will continue to advocate to the State for these waivers to ensure project goals and milestones are met.
The shortage of psychiatrists in our PPS, as noted by our CNA, poses a sizable risk to the success of this project. BPHC will mitigate this risk by exploring the use of tele-psychiatry to increase BPHC's psychiatric capacity as implementation begins. Staff recruitment efforts will focus on identifying additional psychiatrists, and we will also launch a recruitment program targeted towards attracting and retaining nurses, licensed clinical social workers (LCSWs), psychologists, and psychiatric NPs and physician assistants (PAs) to perform the roles of therapist and depression care managers at participating sites. We will also consider recruiting for licensed master social workers (LMSWs) with the expectation that they pass the LCSW exam within a year of hire, and contract with 1199 Training and Employment Funds to provide training. BPHC will also reach out to other PPSs in the region to collaborate on workforce issues that may impact recruitment strategies, including compensation.

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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 "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY3,Q4	64,260

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	10,681	21,362	32,043	42,724
	Quarterly Update	22,273	0	0	0
	Percent(%) of Commitment	208.53%	0.00%	0.00%	0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment	0.00%	0.00%	0.00%	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
zstopak	Report(s)	36_DY2Q1_PROJ3ai_MDL3ai2_PES_RPT_BPHC-PATIENTLIST-3ai-DY2Q1_22273pts_FINAL_4873.xlsx	Patient Engagement - 3.a.i (PC/BH Integration)	08/02/2016 04:07 PM

Narrative Text :

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

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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)	Prescribed Due Date	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.	DY3 Q4	Model 1	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.			Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Behavioral health services are co-located within PCMH/APC practices and are available.			Provider	Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Finalize contract with vendor			Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Finalize contracts with Primary Care and Behavioral Health Providers engaged in project.			Project		Completed	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Assess current state, including physical health services , current PCMH level if applicable, IT infrastructure, interoperability, staffing, etc.			Project		Completed	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recruit or contract for PCMH practice certification resources as needed			Project		Completed	05/01/2015	12/31/2015	05/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Assess current state of PCPs engaged in project, including behavioral health service delivery capabilities, work flow, IT infrastructure, interoperability, staffing, etc			Project		Completed	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	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 Develop best practice policies and procedures, by PCBH workgroup to be reviewed by the Quality & Care Innovation Sub-committee (QCIS)			Project		Completed	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Educate leadership within each organization participating in project of the benefits of co located behavioral health services within a primary care setting.			Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Perform gap analysis and identify key priorities to successful completion of co-located services.			Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition			Project		Completed	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Perform gap analysis by practice and identify key priorities			Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.			Project		Completed	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Develop mechanisms to monitor progress towards completion and sustainability of co-located services, evaluate barriers, and develop mechanisms for continuous quality improvement			Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition			Project		In Progress	01/01/2016	11/30/2016	01/01/2016	11/30/2016	12/31/2016	DY2 Q3
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed			Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and			Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	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
provide support as needed											
Task Provide support, trainings, resources and education to participating providers as needed to ensure successful completion of co-located and integrated behavioral health services.			Project		In Progress	12/01/2015	03/31/2018	12/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	DY2 Q4	Model 1	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.			Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.			Project		In Progress	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Establish regularly scheduled meetings with vendor and PCBH workgroup to choose evidence based guidelines and protocols including medication management, care engagement and processes for collaborative care meetings.			Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task In collaboration with BPHC Workforce Sub-committee, assign roles and responsibilities for practice specific implementation of evidence based guidelines and protocols and action plans to engage PCPs with behavioral health specialists			Project		Completed	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize collaborative care practices, reviewed and approved by the QCIS			Project		Completed	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Assess current participating providers practice models with vendors and PCBH workgroup. The PPS will begin working with approximately 60 sites and their staff, including administrators, providers, and care team staff.			Project		Completed	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Complete best practice care protocols draft, including			Project		Completed	12/01/2015	06/30/2016	12/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	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
those needed for specific conditions, for QCIS review											
Task Finalize PPS wide evidence- based protocols with approval by QCIS			Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Perform Gap analysis to identify key priorities for participating providers to meet best practice standards			Project		Completed	09/30/2015	03/31/2016	09/30/2015	03/31/2016	03/31/2016	DY1 Q4
Task Provide vendor and CSO support as needed for successful implementation of protocols.			Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Finalize and implement evidence- based practice guidelines			Project		In Progress	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Finalize and implement evidence- based practice guidelines			Project		In Progress	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Develop mechanisms for evaluation, accountability, and continuous quality improvement			Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop mechanisms for regular review of project-selected Evidence Based Guidelines (by project quality councils) to assure our PPS is utilizing the most up-to-date tools and that those upadated guidelines/protocols continue to be clinically integrated across the PPS			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	DY4 Q2	Model 1	Project	N/A	In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Policies and procedures are in place to facilitate and document completion of screenings.			Project		Completed	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Screenings are documented in Electronic Health Record.			Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as			Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).											
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.			Provider	Practitioner - Primary Care Provider (PCP)	In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Assess participating providers current rates of patient assessments			Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Educate leadership within each participating organization around benefits of providing preventative care screenings using industry standard questionnaires regularly.			Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Assess participating providers current process for identifying unmet needs			Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize draft policies and procedures to facilitate and document behavioral health screenings by PCBH workgroup, and approval by QCIS			Project		Completed	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Perform gap analysis,including provider capability for documenting screenings in EMR, and identify steps to meet standards.			Project		Completed	09/30/2015	03/31/2016	09/30/2015	03/31/2016	03/31/2016	DY1 Q4
Task Provide education/trainings needed to ensure success in conjunction with Workforce Sub-committee			Project		Completed	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize policy around timely documentation of screenings in the electronic health record.			Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Develop process to monitor progress towards completing screenings on 90% of patient population using approved screenings			Project		Completed	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Assess participating providers current procedures for patients who receive a positive screening, as well as for completion of referrals.			Project		Completed	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task			Project		In Progress	03/01/2016	12/31/2016	03/01/2016	12/31/2016	12/31/2016	DY2 Q3

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Create and Finalize policies on implementing "warm transfers" for patients who have a positive screening.											
Task Provide education/training as needed to ensure successful implementation.			Project		In Progress	12/01/2015	03/31/2018	12/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Implement "warm transfer" policies and procedures, as well as instructions on appropriate documentation in the electronic health record.			Project		In Progress	03/01/2016	12/31/2016	03/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Monitor success and sustainability of implemented "warm transfer" protocols and engage sites in continuous quality improvement			Project		In Progress	03/01/2016	03/31/2018	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor success and sustainability of implemented screening protocols			Project		In Progress	03/01/2016	03/31/2018	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor success with timely and accurate documentation in the electronic health record.			Project		In Progress	03/01/2016	03/31/2018	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor success towards completion of screenings on 90% of eligible patients engaged in project, engage sites with continuous quality improvement as needed to ensure success.			Project		In Progress	03/01/2016	03/31/2018	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Provide education and training as needed to achieve goal			Project		In Progress	12/01/2015	03/31/2018	12/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	DY2 Q4	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 Define business requirements and data elements for			Project		Completed	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3

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patient registry to stratify and track all patients engaged in this project.											
Task Develop a project specific strategy for tracking patient engagement, employing PHM tools and processes outlined below.			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform gap analysis and identify priories to achieving integration of patient record.			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)			Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.			Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget to build registry and acquire necessary resources			Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries			Project		In Progress	04/01/2016	06/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data			Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop training plan and curriculum to deploy risk			Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1

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assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care											
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.			Project		In Progress	04/01/2016	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.			Project		In Progress	04/01/2016	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.			Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Milestone #5 Co-locate primary care services at behavioral health sites.	DY4 Q2	Model 2	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.			Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care services are co-located within behavioral Health practices and are available.			Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care services are co-located within behavioral Health practices and are available.			Provider	Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Finalize contract with vendor			Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Finalize contracts with Behavioral Health and Primary Care Providers engaged in project.			Project		Completed	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Assess current state, including physical health and			Project		Completed	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1

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behavioral health services , current PCMH level if applicable, IT infrastructure, interoperability, staffing, etc.											
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recruit or contract for PCMH practice certification resources as needed			Project		Completed	05/01/2015	12/31/2015	05/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Educate leadership within each organization participating in project of the benefits of co located primary care services within a behavioral health setting.			Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Perform gap analysis and identify key priorities to successful completion of co-located services.			Project		Completed	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition			Project		Completed	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Perform gap analysis by practice and identify key priorities.			Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.			Project		Completed	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition			Project		In Progress	01/01/2016	11/30/2016	01/01/2016	11/30/2016	12/31/2016	DY2 Q3
Task Develop best practice policies and procedures by PCBH workgroup, send for review and approval by QCIS			Project		In Progress	03/31/2016	12/31/2016	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Provide support, trainings, resources and education to			Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4

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participating providers as needed to ensure successful completion of co-located and integrated primary care services.											
Task Develop mechanisms to monitor progress towards completion and sustainability of co-located services, evaluate barriers, and develop mechanisms for continuous quality improvement			Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed.			Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.			Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Assess current state of BH practices engaged in project, including Primary care service delivery capabilities, (e.g.exam room structure) work flow, IT infrastructure, interoperability, staffing, etc.			Project		Not Started	09/01/2016	03/31/2018	09/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	DY2 Q4	Model 2	Project	N/A	In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.			Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.			Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Assess current participating providers practice models with vendors and PCBH workgroup			Project		Completed	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task In collaboration with BPHC Workforce Sub-committee, assign roles and responsibilities for practice specific implementation of evidence based guidelines and protocols and action plans to engage PCPs with			Project		Completed	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4

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behavioral health specialists											
Task Finalize PPS wide evidence- based protocols with approval by QCIS.			Project		Completed	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Perform Gap analysis to identify key priorities for participating providers to meet best practice standards.			Project		Completed	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize and implement evidence- based practice guidelines.			Project		Completed	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish regularly scheduled meetings with vendor and PCBH workgroup to choose evidence based guidelines and protocols including medication management, care engagement and processes for collaborative care meetings.			Project		In Progress	03/31/2016	12/31/2016	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Finalization of collaborative care practices, reviewed and approved by the QCIS			Project		In Progress	03/31/2016	12/31/2016	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Complete best practice care protocols draft, including those needed for specific conditions, for QCIS review			Project		In Progress	03/31/2016	12/31/2016	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Develop mechanisms for evaluation, accountability, and continuous quality improvement			Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop mechanisms for regular review of project-selected Evidence Based Guidelines (by project quality councils) to assure our PPS is utilizing the most up-to-date tools and that those upadated guidelines/protocols continue to be clinically integrated across the PPS.			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provide vendor and CSO support as needed for successful implementation of protocols.			Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients	DY4 Q2	Model 2	Project	N/A	In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4

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to identify unmet needs.											
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.			Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Screenings are documented in Electronic Health Record.			Project		In Progress	03/31/2016	03/31/2018	03/31/2016	03/31/2018	03/31/2018	DY3 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).			Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.			Provider	Practitioner - Primary Care Provider (PCP)	In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Educate leadership within each participating organization around benefits of providing preventative care screenings using industry standard questionnaires regularly. Recognize that BH patients with conditions other than depression still require depression screening with industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT. In this colocation model also educate around Primary Care preventive screenings including: age appropriate cancer screenings, alcohol, tobacco and substance use screenings, CVD and DM screenings, vaccinations, etc.			Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Assess participating providers current process for identifying unmet physical needs of patients, The PPS will begin working with approximately 50 sites and their staff, including administrators, providers, and care team staff.			Project		In Progress	03/31/2016	12/31/2016	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Develop process to monitor progress towards completing industry standard questionnaires/screening (such as PHQ-2 or 9 for			Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3

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those screening positive, SBIRT) on 90% of patient population.											
Task Assess participating providers' current procedures for patients who receive a positive screening, as well as for completion of referrals, and adapt to include screenings performed by PCP.			Project		Completed	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize draft policies and procedures to facilitate and document behavioral health and primary care screenings by PCBH workgroup, approval by QCIS			Project		Completed	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Perform gap analysis,including provider capability for documenting screenings in EMR, and identify steps to meet standards.			Project		Completed	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize policy around timely documentation of screenings in the electronic health record.			Project		Completed	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Monitor success with timely and accurate documentation in the electronic health record.			Project		In Progress	03/01/2016	03/31/2018	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor success and sustainability of implemented screening protocols.			Project		In Progress	03/01/2016	03/31/2018	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Assess participating providers current rates of patient assessments.			Project		Completed	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Monitor success towards completion of screenings on 90% of patients engaged in project, as needed to ensure success.			Project		In Progress	03/01/2016	03/31/2018	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Create and Finalize policies on implementing "warm transfers" back to BH specialist for patients who have a positive screening.			Project		In Progress	03/01/2016	12/31/2016	03/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Implement "warm transfer" policies and procedures, as well as instructions on appropriate documentation in the electronic health record.			Project		Not Started	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task			Project		Not Started	12/31/2016	12/31/2017	12/31/2016	12/31/2017	12/31/2017	DY3 Q3

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Monitor success and sustainability of implemented "warm transfer" protocols and engage sites in continuous quality improvement											
Task Provide education/training as needed to ensure success in conjunction with Workforce Sub-committee			Project		In Progress	12/01/2015	03/31/2018	12/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Provide education and training as needed to achieve goal.			Project		In Progress	12/01/2015	03/31/2018	12/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Provide education/training as needed to ensure successful implementation.			Project		In Progress	12/01/2015	03/31/2018	12/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	DY2 Q4	Model 2	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively 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 Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.			Project		Completed	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Develop a project specific strategy for tracking patient engagement, employing PHM tools and processes outlined below.			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform gap analysis and identify priories to achieving			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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integration of patient record.											
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)			Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.			Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget to build registry and acquire necessary resources			Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries			Project		In Progress	04/01/2016	06/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data			Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care			Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.			Project		In Progress	04/01/2016	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.			Project		In Progress	04/01/2016	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.			Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Milestone #9 Implement IMPACT Model at Primary Care Sites.	DY4 Q2	Model 3	Project	N/A	In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has implemented IMPACT Model at Primary Care Sites.			Provider	Practitioner - Primary Care Provider (PCP)	In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Asses the current state of participating primary care sites, including behavioral health service delivery capabilities, IT infrastructure, staffing, etc.			Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Educate senior leadership of participating providers regarding IMPACT Model and requirements.			Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Finalize contracts with providers participating in IMPACT collaborative care model and vendor			Project		Completed	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Perform gap analysis by practice to identify key changes required for successful transition to an IMPACT collaborative care model incorporating behavioral health.			Project		Completed	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize and implement strategy for moving provider networks towards an IMPACT Model.			Project		Completed	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish PCBH workgroup to integrate IMPACT model standards into best practice protocol design. Utilize the IMPACT manual.			Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Monitor provider transformation sustainability and success with implementation of IMPACT Model through continuous quality improvement			Project		In Progress	03/31/2016	03/31/2018	03/31/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care	DY2 Q4	Model 3	Project	N/A	In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4

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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.			Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures include process for consulting with Psychiatrist.			Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Assess current participating providers practice models with vendors and PCBH workgroup, The PPS will begin working with approximately 75 sites and their staff, including administrators, providers, and care team staff.			Project		Completed	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop best practice care protocols draft, integrating IMPACT model standards into best practice protocol design. Utilize the IMPACT manual.			Project		Completed	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize PPS wide evidence- based protocols with approval by QCIS			Project		Completed	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Perform Gap analysis to identify key priorities for participating providers to meeting best practice standards.			Project		In Progress	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provide support as needed to ensure successful implementation.			Project		In Progress	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Finalize and implement evidence- based practice guidelines.			Project		In Progress	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Monitor success of developed protocols, updates made as needed with approval by QCIS			Project		In Progress	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Assess current participating providers' practice to begin to formulate implementable policies and procedures for psychiatric consultation.			Project		In Progress	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task			Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Develop draft evidence-based policies and procedures for consulting with a psychiatrist case review											
Task Finalize policies, procedures and protocols with approval by the QCIS.			Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provide education, training and resources as needed for successful implementation of policies and procedures.			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Implement policies, procedures and protocols for successful consultation with psychiatrist.			Project		In Progress	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Monitor success of developed policies, procedures and protocol, as well as sustainability for consulting with psychiatrist.			Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Establish mechanisms for continuous quality improvement			Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	DY2 Q4	Model 3	Project	N/A	In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.			Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.			Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Determine the type of DCM needed for each participating provider to meet the DCM role requirements, in conjunction with Workforce Sub-Committee, .			Project		Completed	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Update policies, protocols, procedures, and organizational structure as necessary to implement			Project		In Progress	03/31/2016	12/31/2016	03/31/2016	12/31/2016	12/31/2016	DY2 Q3

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and/or formally create the role of DCM with Workforce Sub-committee											
Task Finalize the formal hiring and creation of DCM role with Workforce Sub-committee			Project		In Progress	03/31/2016	12/31/2016	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Ensure that this staff member is identified as such in the Electronic Health Record (E.H.R.).			Project		In Progress	03/31/2016	12/31/2016	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Establish requirements of IMPACT Model DCM role by PCBH workgroup and approval by QCIS			Project		In Progress	03/31/2016	12/31/2016	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Perform gap analysis to identify key priorities for participating providers to be successful with implementation of the role for the DCM with the IMPACT model with Workforce Sub-committee			Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Create/provide training protocols and procedures for DCM role to ensure they are proficient in all required IMPACT interventions			Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Implement IMPACT model policies, procedures and protocols.			Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provide resources, training, education as needed, assuring that DCM meets role requirements according to the IMPACT model.			Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Continuously monitor and re-evaluate the effectiveness of the individual/individuals in the DCM position to ensure that the requirements of IMPACT model continue to be met into the future.			Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Establish continuous quality improvement. Develop mechanisms for evaluation, accountability, and continuous quality improvement			Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	DY2 Q4	Model 3	Project	N/A	In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task			Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4

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All IMPACT participants in PPS have a designated Psychiatrist.											
Task Draft policies and procedures regarding the psychiatrists' responsibilities around treatment and follow-up care with patients.			Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Finalize job-related policies and procedures regarding psychiatrists' responsibilities for approval by QCIS			Project		Completed	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Provide assistance with resources for hiring designated psychiatrists, as needed.			Project		Completed	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop mechanisms for evaluation, accountability, and continuous quality improvement			Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provide training of designated psychiatrists to ensure they are able to adequately perform the requirements of the position			Project		In Progress	12/31/2015	06/30/2016	12/31/2015	09/30/2016	09/30/2016	DY2 Q2
Task Provide training for IMPACT collaborative care teams, including collaborative care case consultation			Project		In Progress	12/31/2015	06/30/2016	12/31/2015	09/30/2016	09/30/2016	DY2 Q2
Task Provide training for care teams on IMPACT model and designated psychiatrist's role.			Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #13 Measure outcomes as required in the IMPACT Model.	DY4 Q2	Model 3	Project	N/A	In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).			Project		In Progress	12/31/2015	03/31/2018	12/31/2015	03/31/2018	03/31/2018	DY3 Q4
Task Assess participating providers current rates of patient assessments.			Project		Completed	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Provide education and training as needed to achieve goal.			Project		In Progress	12/31/2015	03/31/2018	12/31/2015	03/31/2018	03/31/2018	DY3 Q4
Task Develop process to monitor, via EHRs/RHIO/CCMS,			Project		In Progress	12/31/2015	03/31/2018	12/31/2015	03/31/2018	03/31/2018	DY3 Q4

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progress towards completing screenings on 90% of patient population using approved screenings											
Task Monitor success towards completion of screenings on 90% of patients engaged in project, engage sites with continuous quality improvement as needed to ensure success.			Project		In Progress	03/01/2016	03/31/2018	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #14 Provide "stepped care" as required by the IMPACT Model.	DY4 Q2	Model 3	Project	N/A	In Progress	12/31/2015	03/31/2018	12/31/2015	03/31/2018	03/31/2018	DY3 Q4
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.			Project		In Progress	12/31/2015	03/31/2018	12/31/2015	03/31/2018	03/31/2018	DY3 Q4
Task Draft protocols to adjust treatment according to evidence-based algorithm if a patient is not improving, within 10-12 weeks of the start of the treatment plan. Align with IMPACT model.			Project		Completed	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Evidence Based Protocols for stepped care, as aligned with IMPACT model, are approved by QCIS			Project		Completed	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task Implement IMPACT model aligned protocols related to stepped care across practices using the IMPACT model			Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop mechanisms for evaluating successful stepped care, accountability, and continuous quality improvement			Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	DY2 Q4	Model 3	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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actively engaged patients for project milestone reporting.											
Task Develop a project specific strategy for tracking patient engagement, employing PHM tools and processes outlined below.			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform gap analysis and identify priories to achieving integration of patient record.			Project		Completed	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.			Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)			Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.			Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget to build registry and acquire necessary resources			Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries			Project		In Progress	04/01/2016	06/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Develop project implementation and testing plan for building registry as required for PHM, including			Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1

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technical support, ensure frequent automated updates of registry data											
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care			Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.			Project		Not Started	07/01/2016	12/31/2016	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.			Project		In Progress	04/01/2016	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, with an emphasis on tracking patient engagement with primary care.			Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2

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.	Bronx Partners for Healthy Communities (BPHC) continues to collaborate with the Institute for Family Health (IFH) to provide ongoing trainings and technical assistance around integration of primary care and behavioral health services. The Clinical Operations Plan (COP) was approved by the Implementation Work Group (IWG) and the Quality and Care Innovations Subcommittee (QCIS) in the previous quarter, since then the COP has been disbursed to BPHC's partners to support adoption of revised policies and procedures at the organizational level. IFH and Bronx Partners for Healthy Communities (BPHC) are working closely with partner organization leadership to

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	ensure that training plans are being implemented and the COP adopted. Also in the previous quarter Training and Technical Assistance Plans were developed for each organization and their respective sites (53 overall). The plans include details on the trainings identified as needed for each organization through consult with IFH. Standard training topics include: Behavioral Activation; Billable Practices; Depression 101 for non-prescribers; Introduction to Collaborative Care; Motivational Interviewing; PHQ Screening; Problem Solving Treatment; Psychiatric Consultation; Psychopharmacology; SafeTALK; SBIRT; Treatment Planning; and Working with Seriously Mentally Ill and Substance Abusing Populations. This is not an exhaustive list of the trainings that can be provided, and our vendor has been flexible in meeting the needs identified through consistent check-ins with participating organizations. At the end of DY2Q1, check-ins were scheduled with each major organization representing the 38 sites participating in Model 1 of this project to assess whether their training and technical assistance needs have been met and revise plans accordingly. This has proven to be an effective way to recalibrate training plans. We are executing a comprehensive plan to support our safety net providers in Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) which includes EHR support and connectivity of data captured therein. A process has been started to ensure all applicable providers meet PCMH recognition and MU accreditation where possible and that we meet our obligation to the previously agreed tasks. Consultants have been deployed to perform detailed gap analyses with about 115 practices, with 80 locations already evaluated thus far. Of those, 21 practices have already submitted their PCMH 2014 attestations, with all achieving level 3, which accounts for 30% of the PCPs identified by SDOH in the PPS. Of note is SDOH's latest guidelines which will decrease the number of physicians identified as PCMH eligible and thus drastically increase the share of eligible physicians which have already completed this process. Contracting is complete with six consulting groups for the work on the remaining practices. We are starting to also discuss Advance Primary Care and Transforming Clinical Practice Initiative with SDOH-certified consultants and are identifying locations which would be good candidates for the programs. These six consulting groups are part of a Community of Practice ("CoP") we are organizing to build/establish best practices, share and collaborate with experts on PCMH transformation, and possibly transfer the experience and knowledge to other population health initiatives. PCMH progress is tracked and reported on at every Executive Committee meeting. The milestone is on track for completion.
Develop collaborative evidence-based standards of care including medication management and care engagement process.	In the previous quarter, the Clinical Operation Plan (COP) outlining policies and procedures for effective implementation of Primary Care/Behavioral Health co-location model has been reviewed and approved by the Primary Care/Behavioral Health Implementation Work Group (IWG), Quality and Care Innovation Subcommittee, and the CSO Chief Medical Officer. Best practices for care in an integrated setting are captured in the COP, with specific guidance around medication management for depression and anxiety. Trainings on psychopharmacology and medication management are being delivered to participating providers. Additionally, Bronx Partners for Healthy Communities (BPHC) in collaboration with the Institute for Family Health (IFH) and the New York City Department of Health and Mental Hygiene (NYCDOHMH) to develop trainings around Screening, Brief intervention, and Referral to Treatment (SBIRT) methodology. This milestone is on track for completion.
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 Clinical Operations Plan (COP) for project 3ai, Primary Care/Behavioral Health Integration (PCBH), provides guidance for workflows around screening and documentation. The COP has been published and distributed to the sites implementing PCBH. Currently trainings on screenings, including PHQ and SBIRT) are being provided to implementing sites. The vendor overseeing trainings through the Institute for Family Health is aware of existing workflows that may hinder effective screening and how each site can improve the workflows. This milestone is on track for completion.
Use EHRs or other technical platforms to track all patients engaged in this project.	We are executing a comprehensive plan to support our safety net providers in Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) which includes EHR support and connectivity of data captured therein. Our agreement with Bronx RHIO will continue to serve as the foundation to achieve next quarter's tasks and those of the future to support this Milestone. Our MU plan will be part of a package of IT interventions for those providers which have yet to achieve connectivity. With the help of NYC DOHMH's Primary Care Information Project (PCIP) we performed a gap assessment of all BPHC providers and using an existing network map we attributed them to organizations. The gap assessment looked at eligibility of physicians, and if eligible, where they are in the MU process. Based on this process a work plan is being developed for each individual organization, prioritizing those physicians which have yet to start the program. As part of the work plan, we are including other IT infrastructure improvements, such as EHR implementation and RHIO connectivity and encounter notification systems deployment. We estimate a maximum MU opportunity of ~$60 million which will help fund this work. Part of this plan will also be RHIO incentive funding and other revenue streams. The milestone is on track for completion.
Co-locate primary care services at behavioral health sites.	Bronx Partners for Healthy Communities (BPHC) continues to collaborate with the Institute for Family Health (IFH) to provide ongoing trainings and technical assistance around integration of primary care and behavioral health services. The Clinical Operations Plan (COP) was approved by the Implementation Work Group (IWG) and the Quality and Care Innovations Subcommittee (QCIS) in the previous quarter, since then the COP has been disbursed to BPHC's partners to support adoption of revised

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Milestone Name	Narrative Text
	policies and procedures at the organizational level. IFH and Bronx Partners for Healthy Communities (BPHC) are working closely with partner organization leadership to ensure that training plans are being implemented and the COP adopted. Also in the previous quarter Training and Technical Assistance Plans were developed for each organization and their respective sites (53 overall). The plans include details on the trainings identified as needed for each organization through consult with IFH. Standard training topics include: Behavioral Activation; Billable Practices; Depression 101 for non-prescribers; Introduction to Collaborative Care; Motivational Interviewing; PHQ Screening; Problem Solving Treatment; Psychiatric Consultation; Psychopharmacology; SafeTALK; SBIRT; Treatment Planning; and Working with Seriously Mentally Ill and Substance Abusing Populations. This is not an exhaustive list of the trainings that can be provided, and our vendor has been flexible in meeting the needs identified through consistent check-ins with participating organizations. At the end of DY2Q1, check-ins were scheduled with each major organization representing the 53 sites participating in the project to assess whether their training and technical assistance needs have been met and revise plans accordingly. The majority of the 14 sites that have committed to Model 2 have an existing primary care practice physically co-located, but will need assistance through training to adopt the new workflows and the overall transformations laid out in project 3ai. In some cases, sites are seeking assistance with identifying primary care services to be co-located. The COP is now being distributed to the DSRIP Program Directors, CSO liaison/operational lead embedded within the seven largest primary care partner organizations, to assist them with guiding on-the-ground implementation. We anticipate additional organizations and sites will be interested in participating in this project. This milestone is on track for completion. It should be noted that per the guidance issued by the Independent Assessor in June 2016, the PCMH requirements no longer apply to model 2 projects. PCMH tasks were not able to be deleted, and so they were marked "complete".
Develop collaborative evidence-based standards of care including medication management and care engagement process.	In the previous quarter, the Clinical Operation Plan (COP) outlining policies and procedures for effective implementation of Primary Care/Behavioral Health co-location model has been reviewed and approved by the Primary Care/Behavioral Health Implementation Work Group (IWG), Quality and Care Innovation Subcommittee, and the CSO Chief Medical Officer. Best practices for care in an integrated setting are captured in the COP, with specific guidance around medication management for depression and anxiety. Trainings on psychopharmacology and medication management are being delivered to participating providers. Additionally, Bronx Partners for Healthy Communities (BPHC) in collaboration with the Institute for Family Health (IFH) and the New York City Department of Health and Mental Hygiene (NYCDOHMH) to develop trainings around Screening, Brief intervention, and Referral to Treatment (SBIRT) methodology. This milestone is on track for completion. It should be noted that per the guidance issued by the Independent Assessor in June 2016, the PCMH requirements no longer apply to model 2 projects. PCMH tasks were not able to be deleted, and so they were marked "complete".
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 Clinical Operations Plan (COP) for project 3ai, Primary Care/Behavioral Health Integration (PCBH), provides guidance for workflows around screening and documentation. The COP has been published and distributed to the sites implementing PCBH. Currently trainings on screenings, including PHQ and SBIRT) are being provided to implementing sites. The vendor overseeing trainings through the Institute from Family Health is aware of existing workflows that may hinder effective screening and how each site can improve the workflows. Additionally, guidance around physical health screenings for Model 2 sites is pending further details from NYSDOH per the changes distributed by the Independent Assessor. This milestone is on track for completion.
Use EHRs or other technical platforms to track all patients engaged in this project.	We are executing a comprehensive plan to support our safety net providers in obtaining Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) certification, which includes the use of targeted patient registries in conjunctions with our clinical projects. We have a strategy in place for care management which includes the uses of registries, EHRs, Care Coordination Management Systems, and referral tracking systems.. Our major partners which account for 87% of BPHC PCPs and 81% of non-PCPs, are already sharing clinical data to varying degrees with the Bronx RHIO and anticipate the quality and quantity of this data to increase. We reviewed DSRIP performance measures and Quality and Care Innovations Subcommittee recommended registry fields, and have been working with BxRHIO to further define which are most feasible to build out and release to our largest partners in DY2. Bronx RHIO has conducted a gap analysis on data currently in the RHIO and identified missing and other data quality issues relevant to those initial proxy measures and registries. Bronx RHIO had already begun development of Spectrum, its population health management (PHM) and analytics tool, which the PPS will utilize as part of our PHM solution. Though still in development this quarter, we obtained accounts and initial training on Spectrum for key staff in the CSO to begin understanding it. We are also simultaneously exploring potentials to utilize the MAPP/Salient resources to use as additional PHM source to understand the population we serve and their utilization patterns. Furthermore, we are actively pursuing to improve consent rates for Bronx RHIO and initiated a data use agreement (DUA) where each partner allows the Bronx RHIO to share their data with BPHC to create an environment where PHM will be more comprehensively implemented. We are confident that we are also close to securing a Care Coordination and Management System (CCMS) for the PPS. BPHC also deployed a rapid cycle evaluation (RCE) process and selected initial set of key process measures to support our implementation progress. The milestone is on track for

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	completion.
Implement IMPACT Model at Primary Care Sites.	Bronx Partners for Healthy Communities (BPHC) continues to collaborate with the Institute for Family Health (IFH) to provide ongoing trainings and technical assistance around integration of primary care and behavioral health services. The Clinical Operations Plan (COP) was approved by the Implementation Work Group (IWG) and the Quality and Care Innovations Subcommittee (QCIS) in the previous quarter, since then the COP has been disbursed to BPHC's partners to support adoption of revised policies and procedures at the organizational level. IFH and Bronx Partners for Healthy Communities (BPHC) are working closely with partner organization leadership to ensure that training plans are being implemented and the COP adopted. Also in the previous quarter Training and Technical Assistance Plans were developed for each organization and their respective sites (53 overall, 28 enrolled in IMPACT Model 3). The plans include details on the trainings identified as needed for each organization through consult with IFH. Standard training topics include: Behavioral Activation; Billable Practices; Depression 101 for non-prescribers; Introduction to Collaborative Care; Motivational Interviewing; PHQ Screening; Problem Solving Treatment; Psychiatric Consultation; Psychopharmacology; SafeTALK; SBIRT; Treatment Planning; and Working with Seriously Mentally Ill and Substance Abusing Populations. This is not an exhaustive list of the trainings that can be provided, and our vendor has been flexible in meeting the needs identified through consistent check-ins with participating organizations. At the end of DY2Q1, check-ins were scheduled with each major organization representing the 53 sites participating in the project to assess whether their training and technical assistance needs have been met and revise plans accordingly. This milestone is on track for completion.
Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	The Clinical Operations Plan (COP), outlining policies and procedures for effective implementation of the IMPACT Model, has been created and finalized by the CSO and the vendor, Institute for Family Health. The COP chapters include: 'Adoption of the IMPACT Model, evidence-based guidelines, and Intake-Assessment-Management,' 'IMPACT Staffing Plan P&P,' and 'Common Assessment Tools.' The COP was vetted with the Primary Care/Behavioral Health Implementation Workgroup (IWG). These chapters were approved in the previous quarter, published, and distributed to all implementing sites. This milestone is on track for completion.
Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	In the previous quarter, the CSO solicited the partners' startup funding needs through a Request for Information (RFI) process to partners who have a signed Master Services Agreement with the CSO. Responses were reviewed and analyzed by CSO leadership to determine support to be provided for staffing, IT, population health management, and other needs. Sites are experiencing challenges with identifying and hiring qualified staff. The vendor, Institute for Family Health (IFH), is assisting through technical assistance and other resources with challenges related to hiring. The role requirements were also defined in collaboration with the Workforce Subcommittee and a job description has been developed. It was noted that many behavioral health providers will be supporting patients with behavioral health needs apart from depression. Additionally, many organizations have reported that the title, "Depression Care Manager" is a problematic one and will be opting for, "Behavioral Health Specialist", which better reflects the versatility needed for an individual providing depression care. This milestone is on track for completion.
Designate a Psychiatrist meeting requirements of the IMPACT Model.	The role of the psychiatrist has been defined in the Clinical Operations Plan and a job description has been developed, both of which were approved by the Primary Care/Behavioral health Implementation Work Group and the Quality and Care Innovations Subcommittee. During the Training and Technical Assistance Needs Assessments, resources were provided to aid in the hiring of the psychiatrist, a key component of the IMPACT Model. The Institute for Family Health, in addition to conducting the trainings, provides assistance in identifying consulting Psychiatrists through a database that the organization maintains with behavioral health providers and consultants. Identifying Consulting Psychiatrists is posing a challenge for some sites and the vendor is addressing this through training and technical assistance. This milestone is on track for completion. Two tasks related to training of the consulting psychiatrists and IMPACT collaborative care trainings were pushed back to the next quarter to allow participating practices to complete the hiring of staff for new teams.
Measure outcomes as required in the IMPACT Model.	The Training and Technical Assistance Needs Assessment specifically addressed the providers' current rates of patient assessment, with the focus PHQ 2/9. The CSO has continued to work closely with the DSRIP Program Directors, CSO liaison/operational lead embedded at each of the largest seven primary care organization partners, to create strategies for tracking important data via EHR's. Necessary changes to the EHR are being made across the sites to track screening rates. The depression registry will monitor the depression care status, screening, and improvement rates. This will also include integration of patient records between the primary care and behavioral health providers. This milestone is on track for completion.
Provide "stepped care" as required by the IMPACT Model.	The Clinical Operations Plan (COP) includes evidence-based guidelines on "stepped care" for sites implementing the IMPACT Model. The Training and Technical

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	Assistance Needs Assessments informed the type of technical assistance and training required by each site to achieve the new workflows. "Stepped care" guidance was obtained through the Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington. As a component of the COP, the evidence-based protocols for providing "stepped care" were approved by the Primary Care/Behavioral Health Implementation Work Group and the Quality and Care Innovations Subcommittee. This milestone is on track for completion.
Use EHRs or other technical platforms to track all patients engaged in this project.	We are executing a comprehensive plan to support our safety net providers in obtaining Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) certification, which includes the use of targeted patient registries in conjunctions with our clinical projects. We have a strategy in place for care management which includes the uses of registries, EHRs, Care Coordination Management Systems, and referral tracking systems.. Our major partners which account for 87% of BPHC PCPs and 81% of non-PCPs, are already sharing clinical data to varying degrees with the Bronx RHIO and anticipate the quality and quantity of this data to increase. We reviewed DSRIP performance measures and Quality and Care Innovations Subcommittee recommended registry fields, and have been working with BxRHIO to further define which are most feasible to build out and release to our largest partners in DY2. Bronx RHIO has conducted a gap analysis on data currently in the RHIO and identified missing and other data quality issues relevant to those initial proxy measures and registries. Bronx RHIO had already begun development of Spectrum, its population health management (PHM) and analytics tool, which the PPS will utilize as part of our PHM solution. Though still in development this quarter, we obtained accounts and initial training on Spectrum for key staff in the CSO to begin understanding it. We are also simultaneously exploring potentials to utilize the MAPP/Salient resources to use as additional PHM source to understand the population we serve and their utilization patterns. Furthermore, we are actively pursuing to improve consent rates for Bronx RHIO and initiated a data use agreement (DUA) where each partner allows the Bronx RHIO to share their data with BPHC to create an environment where PHM will be more comprehensively implemented. We are confident that we are also close to securing a Care Coordination and Management System (CCMS) for the PPS. BPHC also deployed a rapid cycle evaluation (RCE) process and selected initial set of key process measures to support our implementation progress. The milestone is on track for completion.

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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
Milestone Mid-Point Assessment	Completed	Mid-Point Assessment			06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Mid-Point Assessment	zstopak	Templates	36_DY2Q1_PROJ3ai_MDL3ai4_PPS1545_TEMPL_2a_Mid-Point_Assessment_Project_Narrative_3ai_FINAL_4905.docx	Mid-Point Assessment Project Narrative - 3.a.i PC/BH Integration	08/02/2016 06:40 PM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment	

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

Instructions :

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

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

Instructions :

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

(1) Some primary care physicians (PCPs) may resist the imposition of standard treatment protocols and new workflows. To mitigate this risk, our disease management work groups bring PCPs and other project participants together to review and develop consensus on evidence-based (EB) guidelines and workflows for each disease-specific intervention. Members have recommended these EB protocols to the PPS Quality & Care Innovation Subcommittee and the Executive Committee for approval to deploy across the PPS. Implementation of these protocols is part of contractual agreements between partners and the PPS. BPHC is allocating the necessary resources to provide online and in-person training, support and follow-up with PCPs and other care team members at times that accommodate their clinical schedules to encourage adoption of program elements.

(2) Not all physicians and other PCMH care team members currently document self-management goals (SMG) in the medical record in a way that is conducive to demonstrating completion for reporting purposes. The CSO is working closely with providers to provide them with the necessary IT support to ensure such documentation is possible. We are also working with the Bronx RHIO to collect this data from all partners. This will allow the Bronx RHIO to create tool which will allow the monitoring of this requirement in close to real-time for reporting purposes and allow the CSO to address challenges quickly.

(3) It will be challenging to recruit and train sufficient care management staff to serve the needs of the Bronx population. Recruiting Spanish-speaking care management staff will be a particular risk. BPHC's workforce strategy mitigates this risk through work with community colleges and coordination with the 1199 Training and Education Fund, Montefiore CMO, and NYSNA. BPHC recently committed to funding a recruiter to support its partners with its workforce recruiting goals, including for care management staff.

(4) Attaining PCMH 2014 Level 3 recognition is difficult and resource-intensive, particularly for smaller primary care practices. The CSO is providing technical and financial assistance, including IT support and training, to primary care practices as they work to attain the recognition. BPHC has been recognized by NYS for its approach to PCMH support of its network – further discussion of this approach can be found in the narrative for project 2.a.i.

(5) Medication adherence is a chronic problem for individuals with CVD. Organizations that could be instrumental in helping patients with medication adherence such as home care agencies and MCOs are handicapped by policies and/or regulations. To mitigate these risks, BPHC formed and began convening a Pharmacy Workgroup. The kickoff was held on February 25th and included representatives from 7 of the 10 BPHC pharmacies. This workgroup is brainstorming strategies to support medication adherence of BPHC patients, and is exploring best practices of its workgroup members – including opt-in care management services provided by pharmacies, whereby patients will be alerted by the pharmacy in the event of a missed prescription refill and may elect to have the pharmacy contact the prescribing physician to resolve medication prescription issues.

(6) Providers may not implement EHR systems that meet MU and PCMH 2014 Level 3 standards, interoperability challenges may present and/or

providers may resist participating in the IDS. BPHC used gap analyses to develop a program to monitor and deploy assistance to providers at risk, support practices by deploying internal community, external consulting resources and provide customized technical assistance, coaching, and training modules. Two team members have recently joined the BPHC CSO team to specifically focus on MU.

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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 "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY3,Q4	21,560

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	3,504	7,007	10,511	14,014
	Quarterly Update	5,588	0	0	0
	Percent(%) of Commitment	159.47%	0.00%	0.00%	0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment	0.00%	0.00%	0.00%	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
zstopak	Report(s)	36_DY2Q1_PROJ3bi_MDL3bi2_PES_RPT_BPHC-PATIENTLIST-3bi-DY2Q1_5588pts_FINAL_4907.xlsx	Patient Engagement - 3.b.i Disease Management CVD	08/02/2016 06:47 PM

Narrative Text :

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

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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)	Prescribed Due Date	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.	DY3 Q4	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	06/30/2015	03/31/2018	06/30/2015	03/31/2018	03/31/2018	DY3 Q4
Task Create a Transitional Work Group (CVD/DM TWG) comprised of representatives from partner organizations to support development of and approve elements of the COP		Project		Completed	04/01/2015	06/01/2015	04/01/2015	06/01/2015	06/30/2015	DY1 Q1
Task Identify DSRIP project requirements which are related to PCMH elements and incorporate into PCMH strategy and project planning documents		Project		Completed	05/15/2015	09/30/2015	05/15/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify relevant evidence-based guidelines for HTN and hyperlipidemia in conjunction with the CVD/DM TWG		Project		Completed	05/04/2015	09/30/2015	05/04/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify patient criteria for smoking cessation interventions (counsel to quit, smoking cessation medication, non-medication smoking cessation strategy)		Project		Completed	06/11/2015	09/30/2015	06/11/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify partner organizations participating in project (sites and CBOs)		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop a workplan and timeline to develop the clinical operations plan (COPs) and implement a strategy for the CV population that aligns with the patient engagement speed and scale application submission		Project		Completed	04/01/2015	10/31/2015	04/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Develop the COP to define the program elements, define the required and suggested components of those elements, and		Project		Completed	05/04/2015	10/31/2015	05/04/2015	10/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
identify relevant resources to achieve them. Elements include health information exchange and technology requirements, and evidence-based guidelines and high-value treatment protocols										
Task Develop the project implementation budget		Project		Completed	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Design training and recruitment strategy in conjunction with workforce team and CVD/DM TWG		Project		Completed	07/28/2015	03/31/2016	07/28/2015	03/31/2016	03/31/2016	DY1 Q4
Task Submit elements of the COP to Quality and Care Innovation Sub-Committee (QCIS) for approval		Project		Completed	07/23/2015	10/31/2015	07/23/2015	10/31/2015	12/31/2015	DY1 Q3
Task Identify clinical champions and operational leaders in each participating organization to develop and lead implementation of the program at each of their providers/sites. These facility-based champions/leaders form the Site-Specific Implementation Team		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Prepare/disseminate gap analysis tool based on COP to participating providers to determine implementaton support needs		Project		Completed	01/15/2016	06/30/2016	01/15/2016	06/30/2016	06/30/2016	DY2 Q1
Task Hold webinar for participating partner organizations		Project		Completed	01/15/2016	03/31/2016	01/15/2016	03/31/2016	03/31/2016	DY1 Q4
Task Create rapid deployment collaborative, comprised of representatives from partner organizations to support implementation of the COP. This group replaces the TWG and will be the implementation work group.		Project		Completed	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop mechanisms for regular review of project-selected evidence-based guidelines (EBGs) by implementation work group to assure our PPS is utilizing the most up-to-date tools and that those upadated guidelines/protocols continue to be clinically integrated across the PPS		Project		Completed	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
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.	DY3 Q4	Project	N/A	In Progress	06/30/2015	03/31/2018	06/30/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY		Provider	Safety Net Practitioner - Primary Care Provider	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
requirements.			(PCP)							
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	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	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.		Project		In Progress	09/30/2015	03/31/2018	09/30/2015	03/31/2018	03/31/2018	DY3 Q4
Task Identify safety net provider data sharing requirements and assess partner and QE data sharing capabilities and current HIE participation		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Coordinate with Bronx RHIO to develop comprehensive HIE adoption program to encourage and support partner participation and integration		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Begin coordinated interface and service development with Bronx RHIO, including connectivity to the SHIN-NY.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish BPHC program to manage support for safety net providers to ensure that all are actively sharing health information, coordinating with Bronx RHIO to encourage, track and support partner participation and integration/data sharing		Project		Completed	03/01/2016	04/25/2016	03/01/2016	04/25/2016	06/30/2016	DY2 Q1
Task Track status and manage support to ensure that all PPS safety net providers are actively sharing health information through Bronx RHIO or alternative health information exchange		Project		In Progress	03/01/2016	03/31/2018	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	DY3 Q4	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).		Project		Not Started	01/01/2018	03/31/2018	01/01/2018	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	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Assess eligible participating partner EHR use relative to Meaningful Use and PCMH 2014 Level 3 standards										
Task Establish BPHC program to educate, encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, including potential use of incentive-based payments for implementation		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Recruit or contract for EHR implementation resources as needed		Project		Completed	11/01/2015	06/30/2016	11/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner EHR implementation and progress towards Meaningful Use and PCMH standards		Project		Not Started	08/01/2016	12/31/2016	08/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Track status and manage support to ensure all eligible safety net providers are using certified EHR systems that meet Meaningful Use and PCMH 2014 Level 3 standards		Project		In Progress	10/15/2015	03/15/2018	10/15/2015	03/15/2018	03/31/2018	DY3 Q4
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recruit or contract for PCMH practice certification resources as needed		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition		Project		Completed	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Perform gap analysis by practice and identify key priorities.		Project		Completed	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.		Project		Completed	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition		Project		In Progress	01/01/2016	11/30/2016	01/01/2016	11/30/2016	12/31/2016	DY2 Q3
Task Monitor progress with achieving 2014 NCQA level 3 PCMH		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4

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certification, support provided by PPS as needed.										
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	DY2 Q4	Project	N/A	In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform gap analysis and identify priories to achieving integration of patient record.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.		Project		Completed	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget to build registry and acquire necessary resources		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1

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frequent automated updates of registry data										
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	DY2 Q4	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate tobacco control protocols.		Project		In Progress	03/31/2016	03/31/2017	03/31/2016	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	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify/establish the protocols for the 5A's of tobacco control and services/programs to incorporate into COP		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify/develop member educational material and smoking cessation support tools for inclusion in COP		Project		Completed	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Survey participants to determine capability of sites' EHR systems for providing point of care reminders		Project		In Progress	05/01/2016	09/30/2016	05/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Site-Specific Implementation Teams work with their IT teams to		Project		In Progress	05/01/2016	03/31/2017	05/01/2016	03/31/2017	03/31/2017	DY2 Q4

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implement point-of-care prompts to facilitate tobacco control protocols into EHR workflows, including documentation										
Task Site-specific Implementation Teams establish and map interim manual processes to fulfill protocols in COP		Project		In Progress	05/01/2016	09/30/2016	05/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Establish the schedule and materials for periodic staff training to incorporate the use of the EHR to prompt the use of 5 A's of tobacco control.		Project		Not Started	08/01/2016	03/31/2017	08/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provide guidance for ongoing assesment to ensure that practices are following training requirements and protocols		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop feedback mechansims for accountability and continuous quality improvement		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	DY2 Q4	Project	N/A	In Progress	05/04/2015	03/31/2017	05/04/2015	03/31/2017	03/31/2017	DY2 Q4
Task Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).		Project		In Progress	06/30/2015	03/31/2017	06/30/2015	03/31/2017	03/31/2017	DY2 Q4
Task Define target population, select EBGs for target population and present recommmendation to Quality & Care Innovation Sub-Committee (QCIS)		Project		Completed	05/04/2015	12/31/2015	05/04/2015	12/31/2015	12/31/2015	DY1 Q3
Task QCIS reviews and recommends EBGs for adoption and implementation across the PPS		Project		Completed	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develops educational materials suitable to the needs, culture and language of the target populations in conjunction with select CBOs, PCPs, and SMEs		Project		Completed	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Present educational materials to QCIS for review		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Identify clinical champions to drive adoption of guidelines		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Implement EBG and educational material dissemination plan across the PPS with support of RDC and site-specific implementation teams		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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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.	DY2 Q4	Project	N/A	In Progress	06/30/2015	03/31/2017	06/30/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.		Project		Not Started	01/01/2017	03/31/2017	01/01/2017	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	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination processes are in place.		Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinate across project specific workgroups to establish the care management model/organizational structure and processes most appropriate for achieving project outcomes; include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers		Project		Completed	06/30/2015	10/31/2015	06/30/2015	10/31/2015	12/31/2015	DY1 Q3
Task Present care management model to QCIS for review and approval		Project		Completed	06/30/2015	10/31/2015	06/30/2015	10/31/2015	12/31/2015	DY1 Q3
Task Working with Workforce Subcommittee, design training and recruitment strategy for care managers and care teams		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Begin to recruit, hire and train new and existing staff as needed.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Site-specific implementation teams, with support from CSO and in coordination with PCMH work, establish care coordination team and implement care coordination processes (e.g., community service/program referrals and tracking, communication, PCP alerts, education materials, coordination among team members, frequency and purpose of patient contact.) Ensure these include coordination with the Health Home care manager, where applicable.		Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Develop a mechanism to gather feedback and share best practices		Project		Completed	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task		Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4

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Provide guidance for ongoing assesment to ensure that practices are following requirements and protocols										
Task Identify and document required clinical and care management protocols for priority programs, projects and interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data		Project		Completed	08/15/2015	10/15/2015	08/15/2015	10/15/2015	12/31/2015	DY1 Q3
Task Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations for how interventions will be logged, tracked and reported.		Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Deploy systems to improve and promote effective care transitions		Project		Completed	01/15/2016	02/28/2016	01/15/2016	02/28/2016	03/31/2016	DY1 Q4
Task Operationalize partner and workforce roles by providing gap analysis and appropriate training.		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Establish data collection, survey and reporting mechanisms to enable BPHC monitoring to ensure that patients are receiving appropriate health care and community support in priority projects, based on needs identified in prior planning activities		Project		Completed	02/01/2016	06/15/2016	02/01/2016	06/15/2016	06/30/2016	DY2 Q1
Task Review process for rapid cycle evaluation and continuous improvement of data collection, survey and reporting methods based on priority project experience and modify process as needed to ensure patients receive appropriate health care and community support		Project		Not Started	08/01/2016	09/01/2016	08/01/2016	09/01/2016	09/30/2016	DY2 Q2
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	DY3 Q4	Project	N/A	In Progress	05/19/2015	03/31/2019	05/19/2015	03/31/2019	03/31/2019	DY4 Q4
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	12/31/2015	03/31/2019	12/31/2015	03/31/2019	03/31/2019	DY4 Q4
Task Review Million Hearts resources and other relevant literature related to implementation of similar programs and identify documents most relevant for PPS, including strategies to ensure that Medicaid patients are not charged a co-pay for blood pressure checks		Project		Completed	05/19/2015	03/31/2016	05/19/2015	03/31/2016	03/31/2016	DY1 Q4

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Task Conduct research into current coverage for such visits by Medicaid and coding for non-billable visits, etc.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Conduct gap analysis to assess resources required to meet this requirement		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Meet with other PPSs to consider lobbying MCOs to cover such visit copays (make providers whole)		Project		In Progress	10/15/2015	03/31/2019	10/15/2015	03/31/2019	03/31/2019	DY4 Q4
Task Conduct periodic meetings/learning collaboratives with PCP practice partners to gather feedback and share best practices		Project		Not Started	09/30/2016	03/31/2019	09/30/2016	03/31/2019	03/31/2019	DY4 Q4
Task Provide guidance for ongoing assesment to ensure that practices are providing access for such visits		Project		Not Started	09/30/2016	03/31/2019	09/30/2016	03/31/2019	03/31/2019	DY4 Q4
Task Develop feedback mechansims for accountability and continuous quality improvement		Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	DY2 Q4	Project	N/A	In Progress	06/30/2015	03/31/2017	06/30/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.		Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task In conjunction with Workforce Subcommittee, identify relevant training resources and nursing competencies to create protocols (standardized across PPS) for inclusion in the COP		Project		Completed	07/28/2015	03/31/2016	07/28/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify site-specific staff members responsible for BP measurement training and documenting training has occurred		Project		Completed	10/15/2015	03/31/2016	10/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Provide guidance for ongoing assesment of staff competencies to ensure that practices are following training requirements and protocols		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop feedback mechansims for accountability and continuous quality improvement		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #10 Identify patients who have repeated elevated blood pressure	DY3 Q4	Project	N/A	In Progress	07/07/2015	03/31/2017	07/07/2015	03/31/2017	03/31/2017	DY2 Q4

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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.		Project		In Progress	03/31/2016	03/31/2017	03/31/2016	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	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.		Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Using EBGs identified in the COP, determine blood pressure program parameters and stratification levels for identification, enrollment and hypertension visit frequency		Project		Completed	07/07/2015	06/30/2016	07/07/2015	06/30/2016	06/30/2016	DY2 Q1
Task Establish processes to use registry (see requirement 4), to reach out to patients and establish the process and person responsible for staff training on such processes.		Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Support site-specific implementation teams to ensure that scheduling resources/technology fulfills project requirements.		Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Conduct periodic meetings/learning collaboratives with PCP practice partners to gather feedback and share best practices		Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provide guidance for ongoing assesment of competencies to ensure that practices are following training requirements and protocols		Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop feedback mechansims for accountability and continuous quality improvement		Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	DY2 Q4	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has 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	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task		Project		Completed	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Determine criteria/limitations for use of once-daily and single dose medication regimens based on feedback from partners, review of MCO formularies and review of clinicial literature; include recommendations in COP										
Task Determine current status of the above regimens in payor and provider formularies, ease of prescribing in various EHRs		Project		Completed	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish protocols for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors for inclusion in COP		Project		Completed	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop mechanisms for regular review of medication recommondations to assure our PPS is utilizing the most up-to-date tools and that any updated guidelines/protocols continue to be clinically integrated across the PPS		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	DY3 Q4	Project	N/A	In Progress	05/04/2015	03/31/2017	05/04/2015	03/31/2017	03/31/2017	DY2 Q4
Task Self-management goals are documented in the clinical record.		Project		In Progress	06/30/2015	03/31/2017	06/30/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.		Project		In Progress	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify best practices for identification and follow-up of self-management goals into COP		Project		Completed	05/04/2015	12/31/2015	05/04/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify relevant training resources /competencies in conjuction with workforce subcommittee		Project		Completed	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish plan to integrate self-management goals into the EHR with interim manual processes as needed		Project		Completed	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish requirements and processes to ensure documentation of the goals		Project		In Progress	01/15/2016	03/31/2017	01/15/2016	03/31/2017	03/31/2017	DY2 Q4
Task Establish the schedule and materials for periodic staff training on person-centered methods that include documentation of self-management goals		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Provide guidance for ongoing assesment of competencies to ensure that practices are following training requirements and protocols										
Task Develop feedback mechansims for accountability, and continuous quality improvement, including assessment of patient adherence to self-management plan and opportunities to increase adherence.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	DY3 Q4	Project	N/A	In Progress	05/15/2015	03/31/2017	05/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed referral and follow-up process and adheres to process.		Project		In Progress	06/30/2015	03/31/2017	06/30/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff on warm referral and follow-up process.		Project		In Progress	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.		Project		In Progress	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Define processes for referral, and access to information among providers, and feedback processes to the practices electronically with interim manual processes as needed in conjunction with IT subcommittee		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish and document referral and follow-up procedures for the sites, with a mechanism for sites to audit adherence		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify community organizations for inclusion in the initial iteration of the Community Resource Database, sign agreements with with community based organizations and establish process to facilitate feedback to and from community organizations		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Perform regular checks of Community Resource Database to ensure data is up to date and accurate and to identify additional resources to consider including		Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Conduct periodic meetings/learning collaboratives with		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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community organization partners to gather feedback and share best practices										
Task Establish the schedule and materials for periodic staff training on the warm transfer and referral tracking		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	DY2 Q4	Project	N/A	In Progress	06/11/2015	03/31/2017	06/11/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed and implemented protocols for home blood pressure monitoring.		Project		In Progress	06/30/2015	03/31/2017	06/30/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.		Project		In Progress	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff on warm referral and follow-up process.		Project		In Progress	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify minimal and recommended SBPM protocols needed to satisfy project requirements, including identification of patients' needs and linkage to support		Project		Completed	06/11/2015	12/18/2015	06/11/2015	12/18/2015	12/31/2015	DY1 Q3
Task Conduct gap analysis with partners to identify implementation support needs		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Individual sites adopt protocols for at-home BP monitoring		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Identify staff member(s) at each site responsible for training patients in self-blood pressure monitoring, including equipment evaluation		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Establish workflow at each site to address patient-reported BP values that are out of range, including how are values reported and staff member(s) responsible for following up		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Conduct webinars/conference calls to ensure that all practices have protocols in place and are adhering to them		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Define training requirements in conjuction with Workforce Subcommittee		Project		In Progress	07/28/2015	09/30/2016	07/28/2015	09/30/2016	09/30/2016	DY2 Q2

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Task Identify nursing competencies and training resources to support SBPM in conjuction with Workforce Subcommittee		Project		In Progress	08/15/2015	09/30/2016	08/15/2015	09/30/2016	09/30/2016	DY2 Q2
Task Create patient communication materials in coordination with the Cultural Competency/Health Literacy orkstream		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Establish schedule and materials for periodic staff training on the warm transfer and referral follow-up process		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop feedback mechansims for accountability and continuous quality improvement		Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	DY2 Q4	Project	N/A	In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Using EBGs identified in the COP, determine parameters for patient stratification, identification, and hypertension visit frequency		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Establish processes to use registry (see requirement 4), to reach out to patients and establish processes and person responbile for staff training on such processes.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Support site-specific implementation teams to ensure that scheduling resources/technology fulfills projecct requirements.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Conduct periodic meetings/learning collaboratives with sites to gather feedback and share best practices		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provide guidance for ongoing assesment of competencies to ensure that sites are following training requirements and protocols		Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task		Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4

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Develop feedback mechansims for accountability and continuous quality improvement										
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	DY2 Q4	Project	N/A	In Progress	07/07/2015	03/31/2017	07/07/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed referral and follow-up process and adheres to process.		Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Define criteria for referral to Quitline		Project		Completed	07/07/2015	12/31/2015	07/07/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish and document process for referral to Quitline and patient follow-up		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Create culturally-competent communication materials at appropriate health literacy levels materials with the Quitline telephone number and website		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop feedback mechansims for accountability and continuous quality improvement		Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	DY3 Q4	Project	N/A	In Progress	12/31/2015	03/31/2020	12/31/2015	03/31/2020	03/31/2020	DY5 Q4
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.		Project		Not Started	06/30/2017	03/31/2020	06/30/2017	03/31/2020	03/31/2020	DY5 Q4
Task If applicable, PPS has established linkages to health homes for targeted patient populations.		Project		Completed	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.		Project		In Progress	01/15/2016	09/30/2017	01/15/2016	09/30/2017	09/30/2017	DY3 Q2
Task Using claims data to identify "hotspot" areas/patient groups for outreach		Project		Not Started	07/01/2016	03/31/2020	07/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task Identify and mitigate service shortages to address these		Project		Not Started	09/30/2017	03/31/2018	09/30/2017	03/31/2018	03/31/2018	DY3 Q4

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"hotspots" which can include mobile services and use of churches and community centers for education and blood pressure screening.										
Task Implement 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, if feasible.		Project		Not Started	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Establish linkages to health homes for targeted patient populations		Project		Not Started	07/01/2016	06/30/2017	07/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task Implement the Stanford Model through partnerships with community based organizations, including Health People		Project		Not Started	07/01/2016	03/31/2020	07/01/2016	03/31/2020	03/31/2020	DY5 Q4
Milestone #18 Adopt strategies from the Million Hearts Campaign.	DY2 Q4	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.		Provider	Practitioner - Primary Care Provider (PCP)	Not Started	12/31/2016	03/31/2017	12/31/2016	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)	Not Started	12/31/2016	03/31/2017	12/31/2016	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	Not Started	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify relevant resources and protocols earmarked as useful by Million Hearts to incorporate into COP, including noting relevance by provider type (PCP, non-PCP and behavioral health providers)		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify relevant patient tools for inclusion in COP		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Review Action Guide related to HTN and SBPM and incorporate into guidelines/protocols in COP		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify clinical champions from the Site-Specific Implementation Team in each participating organization (PCP, non-PCP and behavioral health providers) to drive adoption of Million Hearts		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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strategies and materials identified in COP										
Task Develop mechanisms for regular review of Million Hearts resources to assure our PPS is utilizing the most up-to-date tools and that any updates are clinically integrated across the PPS.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	DY3 Q4	Project	N/A	In Progress	07/01/2015	03/31/2020	07/01/2015	03/31/2020	03/31/2020	DY5 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	06/30/2016	03/31/2020	06/30/2016	03/31/2020	03/31/2020	DY5 Q4
Task Identify current tools and services available to members for relevant MCOs across the PPS, including telehealth, care management, and stipends for completing recommended preventive screenings.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Distribute materials regarding extant services and benefits available to members to providers participting in project		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Build prompts to these tools and services into provider EHRs		Project		Not Started	04/01/2017	03/31/2020	04/01/2017	03/31/2020	03/31/2020	DY5 Q4
Task Where feasible, make agreements with MCO related to coordination of services for high risk populations, including smoking cessation services, weight management, and other preventive services relevant to this project.		Project		Not Started	04/01/2017	03/31/2018	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task Communicate payor information and include information on availability/how to access in training programs		Project		Not Started	04/01/2017	03/31/2018	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has engaged at least 80% of their PCPs in this activity.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify sites participating in project		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Ensure that all participating practices have signed MSA		Project		Completed	09/30/2015	03/31/2016	09/30/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Identify opportunities to coordinate processes, education and communication including incorporation of increased blood pressure identification for screening checks into PCMH workflow processes.		Project		Completed	05/15/2015	03/31/2016	05/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Ensure that hypertension program training is incoporated/included in other care coordination training sessions.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Monitor activity/engagement and make periodic reports to QCIS / EC		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop feedback mechansims for accountability and continuous quality improvement for Site-Specific Implementation Teams.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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.	The CVD Clinical Operations Plan (COP) is the foundational document for implementation. It was first distributed in December 2015 and the second edition was released in June 2016. The COP is based on the DSRIP Domain 1 and 3 requirements and measures, using input from the CVD-Diabetes Transitional Work Group (TWG). It includes chapters on target population, evidence-based guidelines, guidance for at-home blood pressure monitoring, aspirin use, flu shots, patient-driven self-management goals, preferred drugs, referral protocols, patient flows, care team roles, patient/caregiver education and engagement, and practitioner engagement tools. This milestone is on track for completion by DY3Q4.
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.	We are executing a comprehensive plan to support our safety net providers in Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) which includes EHR support and connectivity of data captured therein. Our agreement with Bronx RHIO will continue to serve as the foundation to achieve next quarter's tasks and those of the future to support this Milestone. Our MU plan will be part of a package of IT interventions for those providers which have yet to achieve connectivity. With the help of NYC DOHMH's Primary Care Information Project (PCIP) we performed a gap assessment of all BPHC providers and using an existing network map we attributed them to organizations. The gap assessment looked at eligibility of physicians, and if eligible, where they are in the MU process. Based on this process a work plan is being developed for each individual organization, prioritizing those physicians which have yet to start the program. As part of the work plan, we are including other IT infrastructure improvements, such as EHR implementation and RHIO connectivity and encounter notification systems deployment. We estimate a maximum MU opportunity of ~$60 million which will help fund this work. Part of this plan will also be RHIO incentive funding and other revenue streams. The milestone is on track for completion.
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	We are executing a comprehensive plan to support our safety net providers in Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) which includes EHR support and connectivity of data captured therein. A process has been started already to ensure all applicable providers meet PCMH recognition and MU accreditation and

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Demonstration Year 3.	that we meet our obligation to the previously agreed tasks. We have hired and deployed expert PCMH consultants to perform detailed gap analyses with about 111 practices, with 80 locations already evaluated thus far. Of the provider locations in the PPS, 95% are compliant with this milestone. Funding has been earmarked for IT expansion and process for this funding's distribution have been developed and communicated to the member organizations. Schedule As (i.e., contracts) have been developed to distribute some of this funding as a result of the process. Our MU plan will be part of a package of IT interventions for those providers which have yet to achieve connectivity. With the help of Primary Care Information Project (PCIP) we performed a gap assessment of all BPHC providers and using an existing network map we attributed them to organizations. The gap assessment looked at eligibility of physicians, and if eligible, where they are in the MU process. Based on this process a work plan is being developed for each individual organization, prioritizing those physicians which have yet to start the program. As part of the work plan, we are including other IT infrastructure improvements, such as EHR implementation and RHIO connectivity and encounter notification systems deployment. In conjunction with PCIP, the PPS is tracking providers' IT infrastructure, developing training materials, and other types of support for EHR use and deployment. The milestone is on track for completion. We are executing a comprehensive plan to support our safety net providers in Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) which includes EHR support and connectivity of data captured therein. A process has been started to ensure all applicable providers meet PCMH recognition and MU accreditation where possible and that we meet our obligation to the previously agreed tasks. Consultants have been deployed to perform detailed gap analyses with about 115 practices, with 80 locations already evaluated thus far. Of those, 21 practices have already submitted their PCMH 2014 attestations, with all achieving level 3, which accounts for 30% of the PCPs identified by SDOH in the PPS. Of note is SDOH's latest guidelines which will decrease the number of physicians identified as PCMH eligible and thus drastically increase the share of eligible physicians which have already completed this process. Contracting is complete with six consulting groups for the work on the remaining practices. We are starting to also discuss Advance Primary Care and Transforming Clinical Practice Initiative with SDOH-certified consultants and are identifying locations which would be good candidates for the programs. These six consulting groups are part of a Community of Practice ("CoP") we are organizing to build/establish best practices, share and collaborate with experts on PCMH transformation, and possibly transfer the experience and knowledge to other population health initiatives. PCMH progress is tracked and reported on at every Executive Committee meeting. The milestone is on track for completion.
Use EHRs or other technical platforms to track all patients engaged in this project.	We are executing a comprehensive plan to support our safety net providers in obtaining Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) certification, which includes the use of targeted patient registries in conjunctions with our clinical projects. We have a strategy in place for care management which includes the uses of registries, EHRs, Care Coordination Management Systems, and referral tracking systems. Our major partners which account for 87% of BPHC PCPs and 81% of non-PCPs, are already sharing clinical data to varying degrees with the Bronx RHIO and anticipate the quality and quantity of this data to increase. We reviewed DSRIP performance measures and Quality and Care Innovations Subcommittee recommended registry fields, and have been working with BxRHIO to further define which are most feasible to build out and release to our largest partners in DY2. Bronx RHIO has conducted a gap analysis on data currently in the RHIO and identified missing and other data quality issues relevant to those initial proxy measures and registries. Bronx RHIO had already begun development of Spectrum, its population health management (PHM) and analytics tool, which the PPS will utilize as part of our PHM solution. Though still in development this quarter, we obtained accounts and initial training on Spectrum for key staff in the CSO to begin understanding it. We are also simultaneously exploring potentials to utilize the MAPP/Salient resources to use as additional PHM source to understand the population we serve and their utilization patterns. Furthermore, we are actively pursuing to improve consent rates for Bronx RHIO and initiated a data use agreement (DUA) where each partner allows the Bronx RHIO to share their data with BPHC to create an environment where PHM will be more comprehensively implemented. We are confident that we are also close to securing a Care Coordination and Management System (CCMS) for the PPS. BPHC also deployed a rapid cycle evaluation (RCE) process and selected initial set of key process measures to support our implementation progress. The milestone is on track for completion. Completion dates for three tasks under this milestone have been altered to reflect BPHC's current implementation timeline: We have fully executed a contract in DY1Q4 with the Bronx RHIO to support registry development and PHM. However, we continue to negotiate with our leading CCMS vendor, Acupera. Delays on their part have contributed to our inability to fully execute a contract to acquire their CCMS. We will likely sign a contract for a CCMS by September 30, 2016 (end of DY2Q2).

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	As registries and CCMS platforms are deployed, we will execute our registry testing plan and training programs for providers and care managers. Given that we have yet to contract for/acquire a CCMS platform, and our registries are still in build for Spectrum, the Bronx RHIO's data analytics tool, we cannot yet execute our training plan for providers and care managers. We expect that training on registry use for PHM will begin by September 30, 2016, but that training on our CCMS platform won't begin until January 2017. As registries and CCMS platforms are deployed, we will issue CCMS user credentials and train partner providers and care managers in the use of the integrated solution. Given that we have yet to contract for/acquire a CCMS platform, we cannot yet issue user credentials nor disseminate standardized IT protocols and data security requirements across the system. We expect that training on our CCMS platform won't begin until January 2017, at which point we will issue user credentials, IT protocols and data security requirements.
Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	The CVD Clinical Operations Plan (COP) includes a chapter on this topic, written in Policy & Procedure (P&P) format as well as suggested resources. BPHC policy states that PCPs should ask about tobacco use and willingness to quit for all patients 12 years and up at every visit while pediatricians should ask about the tobacco use status of adolescent patients and family members. Patients who indicate they smoke or use tobacco some days or every day should be advised to quit and the PCP (or another designated member of staff) should discuss and/or provide cessation methods or strategies with patients who indicate a willingness to quit. To link to other project initiatives, the COP recommends referrals to the NYS Smoker's Quitline (documented in the EHR) be offered to all eligible patients and recommends that smoking cessation should be added as a patient self-management goal where appropriate. Sites are working to assess the current state of any such referrals and implement a workflow meeting the COP requirements; this work will continue through DY2Q2, with EHR updates being implemented as part of a coordinated strategy beginning by DY2Q3. This topic was included in the current state assessment/ gap analysis that the CSO (Central Services Organization) conducted with sites in April. This milestone is on track for completion by DY2Q4.
Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	The CVD Clinical Operations Plan (COP) includes chapters on this topic, written in Policy & Procedure (P&P) format as well as suggested resources. BPHC did not define a single set of guidelines for hypertension, but the COP states required elements for guidelines selected, and recommends JNC-7 with modifications to age range control recommendations and shorter follow up. For management of cholesterol, BPHC selected 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. Our partners are continuing working their organization-specific processes to adopt evidence-based guidelines from the COP. The development of mechanisms for regular review of the evidence-based guidelines (EBGs) was approved by our BPHC Quality and Care Innovation Subcommittee in March 2016. This milestone is on track for completion by DY2Q4.
Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	The model for care coordination teams was finalized in DY1Q2 and included in the Clinical Operations Plan (COP) for the Health Home At-Risk project (referenced in other project sections). This model includes the opportunity to add additional members of the care management team needed to fulfill the care coordination requirements of the CVD project, including community health workers and clinical pharmacists, the funding for which is assessed and offered through our "Request for Information" (RFI) process, BPHC's comprehensive partners funding needs assessment for clinical integration. The requirements of the Diabetes (and other primary care projects) were included in the assessment of need for additional staff members to prevent silo-ing and to build capacity for PCMH and Domain 3 DSRIP requirements. This quarter (DY2Q1), partner organizations continued to incorporate the COP into the protocols and implementation by the medical care providers and care teams of the sites of the participating organizations began. This milestone is on track for completion by DY2Q4.
Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	The Clinical Operations Plan (COP) includes a chapter on this topic, written in Policy & Procedure (P&P) format. It also includes Million Hearts resources, case studies of successful implementation and strategies to ensure that Medicaid patients are not charged a co-payment for blood pressure checks. The work has continued into the current demonstration year (DY2), as part of the work of the CVD/Diabetes Implementation Work Group which met for the first time in April 2016. This milestone is on track for completion by DY3Q4.
Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	The Clinical Operations Plan (COP) includes a chapter on this topic. Education in correct blood pressure measurement has been included in the Medical Assistant (MA) training curriculum developed by the Workforce Subcommittee as measuring and recording blood pressure is an important job responsibility for these individuals. The first class of MA completed the training this quarter (DY2Q1) and another class is scheduled for DY2Q2. Training for all types of staff was also a topic of the cross-PPS CVD learning consortium, which is a monthly call with members of seven PPSs participating in the CVD project, including Advocate Community Providers, Care Compass Network, Nassau Queens Performing Provider System, OneCity Health, Montefiore Hudson Valley Collaborative, Suffolk Care Collaborative and Catholic Medical Partners.

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	Following the meeting selected resources were exchanged and the PPSs continue to provide updates on this work during the subsequent calls. This milestone is on track for completion by DY2Q4.
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.	The Clinical Operations Plan (COP) includes a chapter on this specific activity (which should be fulfilled with the cross-project registry), written in Policy & Procedure (P&P) format. We held several meetings with the Bronx RHIO this quarter (DY2Q1) to identify workflows and data elements to ensure that this task is able to be fulfilled by the cross-project population health resources being developed by the Bronx RHIO. This topic was included in the current state assessment that the CSO (Central Services Organization) conducted with the seven largest primary care organizations in April, focusing on the near-term solutions to fulfill this requirement while the RHIO-based resource is being developed. Partners have been tasked this quarter (DY2Q1) with identifying a point person(s) responsible for population health management activities including the activities specified in this milestone, which they all successfully did. This milestone is on track for completion by DY2Q4.
Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	The Clinical Operations Plan (COP) includes a chapter on this topic, written in Policy & Procedure (P&P) format, that where patients' insurance status allows and it is medically appropriate, PCPs will preferentially prescribe combination drugs, once-daily formulations, and 90-day supplies. Additionally, the COP included the recommendation that where adherence is an issue, BPHC will assist patients in finding pharmacies that offer blister packs, and pill boxes, etc. Quality and Care Innovation Subcommittee (QCIS) approved this for adoption this quarter (DY2, Q1). This topic has been an area of focus for the BPHC pharmacy workgroup, which launched in February and met most recently on June 16. The group decided that pharmacies could potentially help the PPS identify which members are missing services or not taking advantage of preferred formulations. This milestone is on track for completion by DY2Q4.
Document patient driven self-management goals in the medical record and review with patients at each visit.	The Clinical Operations Plan (COP) includes a chapter on this topic, written in Policy & Procedure (P&P). The recommendations were based on and aligned with the NCQA PCMH 2013 guidance on patient self-management goals. This topic was included in the current state assessment that the CSO (Central Services Organization) conducted with sites in April and was identified as an area of focus for DY2Q3. As part of patient engagement data collection, BPHC also conducted focused meetings with SBH, Union Community Health Center, Morris Heights Health Center and Montefiore to identify the current documentation for such goals and identify methods to allow for structured, consistent data collection in the future. The COP was presented and distributed to all partners at the CVD/Diabetes Project Launch in February. This milestone is on track for completion by DY2Q4.
Follow up with referrals to community based programs to document participation and behavioral and health status changes.	The Clinical Operations Plan (COP) includes a chapter on this topic in the project "cross-cutting" section. Operationalizing this requirement will be a key activity for the CSO this demonstration year (DY2). The Community-based organizations (CBOs) engagement task force and BPHC CBO staff have been in the process of developing a web-based directory of CBO/Social service providers. In coordination with these partners, the PPS is creating a directory of available services that will be searchable by zip code and service to be shared throughout the network. BPHC in coordination with its partners continues to identify and compile a list of most frequently referred organizations to that will be shared with the CBO task force. Documentation and workflows for making closed loop referrals to CBOs have been created as part of the COP. BPHC is developing relationship and moving towards establishing formal partnerships with our Health Homes' Care Management Agencies (CMAs). CBOs that provide supportive housing, respite services as well as behavioral health services have been engaged to provide specific transition assistance as part of Project 2.b.iv. More formal partnerships are in progress with those organizations as well. In particular, an effort is being made to provide assistance to seriously mentally ill and homeless/precariously housed patients and those experiencing a behavioral health crisis. BPHC is leveraging best practices developed by a SBH team participating in the Medicaid Accelerated eXchange (MAX) series to establish more formal referral partnerships with providers of behavioral health respite providers and transitional housing. Milestone is on track for completion in DY2Q4.
Develop and implement protocols for home blood pressure monitoring with follow up support.	The Clinical Operations Plan (COP) includes a chapter on this topic, written in Policy & Procedure (P&P). The COP identifies the Million Hearts guidelines for Self-Measured Blood Pressure Monitoring as the minimum self-blood pressure monitor (SBPM) program. All patients with hypertension must be prescribed a SBPM. Practices are also strongly recommended to carry out telephonic titration of blood pressure medications by a non-traditional provider (RN or Pharmacist) via standing orders or titration algorithms, which can be standardized for the practice or customized by the PCP for the specific patient. This topic was included in the current state assessment that the Central Services Organization (CSO) conducted with the seven largest primary care organizations in April, and BPHC's Chief Medical Officer has also focused on the topic as part of her physician engagement work. Additionally, this topic has been an area of focus for the BPHC pharmacy workgroup, which launched in February. The group is working to develop a resource for prescribers to support prescribing of home blood-pressure cuffs. This milestone is on track for completion by DY2Q4.
Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	The Clinical Operations Plan (COP) includes a chapter on this specific activity (which should be fulfilled with the cross-project registry), written in Policy & Procedure (P&P) format. We held several meetings with the Bronx RHIO this quarter (DY2Q1) to identify workflows and data elements to ensure that this task is able to be fulfilled by the

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Milestone Name	Narrative Text
	cross-project population health resources being developed by the RHIO. This topic was included in the current state assessment/ gap analysis that the Central Services Organization (CSO) conducted with the largest primary care organizations in April, focusing on the near-term solutions to fulfill this requirement while the RHIO-based resource is being developed. Beginning this quarter (DY2Q1), participating organizations must identify the individual(s) responsible at each organization responsible for performing such work, and to identify a workflow to identify and outreach to such patients in line with the COP. This milestone is on track for completion by DY2Q4.
Facilitate referrals to NYS Smoker's Quitline.	The Clinical Operations Plan (COP) includes a chapter on this topic. BPHC policy states that PCPs should ask about tobacco use and willingness to quit for all patients 12 years and up at every visit while pediatricians should ask about the tobacco use status of adolescent patients and family members. Patients who indicate they smoke or use tobacco some days or every day should be advised to quit and the PCP (or another designated member of staff) should discuss and/or provide cessation methods or strategies with patients who indicate a willingness to quit, including a referral to the NYS Smoker's Quitline (documented in EMR). Sites are continuing to work to assess the current state of any such referral sand implement a workflow meeting the COP requirements; this work will continue through DY2Q2, with EHR updates being implemented as part of a coordinated strategy beginning by DY2Q3. This milestone is on track for completion by DY2Q4.
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.	The Clinical Operations Plan (COP) includes a chapter on this topic, written in Policy & Procedure (P&P) format, based on the CVD/Diabetes Transitional Work Group (TWG)'s recommendation. The COP was presented and distributed to all the participating member organizations of our PPS at the CVD/Diabetes Project Launch in February. BPHC has continued to contract with Health People to provide training and implementation of the Stanford Model for chronic diseases and we are exploring the possibility of 'hot-spotting' to identify and host classes in high-need areas, as well as hosting them at or near our provider sites. Health People is working with our member organizations as part of Project 3.c.i. to identify patients with diabetes to receive training to become peer educators, and lead the Diabetes self-management courses. Recruiting is currently occurring, continuing from DY2Q1, and training is expected to begin in July, with classes beginning in August. Based on the success of this undertaking, BPHC is considering offering or partnering with another organization to provide the Chronic Disease Self-Management Program as well. This milestone is on track for completion by DY5Q4.
Adopt strategies from the Million Hearts Campaign.	The Central Services Organization (CSO) has written and finalized the Clinical Operations Plan (COP) based on the CVD/Diabetes Transitional Work Group (TWG)'s approved selected patient educational materials and provider tools from the Million Hearts Patient Tools and Educational materials for inclusion as recommended resources. These tools include algorithms for BP treatment, non-traditional visits, self-management and motivational interviewing. Million Hearts resources were also included in the COP chapters on home blood pressure monitoring, and No Co-Payment Drop-In BP Checks. These recommendations have been approved by Quality and Care Innovation Subcommittee (QCIS). This topic was included in the current state assessment that the CSO conducted with the seven largest primary care organizations in April. This milestone is on track for completion by DY5Q4.
Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	BPHC's Chief Medical Officer has continued to make the topic of partnership/agreements with Medicaid Managed Care Organizations (MCOs) a priority topic at the regularly-scheduled cross-PPS Clinical Leadership Forum series hosted by Greater New York Hospital Association (GNYHA). BPHC plans to collect information on selected initiatives (e.g., self-blood pressure monitoring programs) to potentially support coverage of such programs/equipment by MCOs in the future. We are also working to align and prioritize our activities, particularly around outcome measures, with the HealthFirst performance measures. This milestone is on track for completion by DY5Q4.
Engage a majority (at least 80%) of primary care providers in this project.	Last demonstration year (DY1), BPHC confirmed participation in the CVD project for its seven largest primary care organization partners, who encompass the majority of our PCPs and more than 90% of our primary care visits. Practices must commit to participating in the CVD project in order to qualify for the Patient-Centered Medical Home (PCMH) transformation support funding (in receiving the expert PCMH consultants). In our second wave of provider engagement with smaller organizations, project participation materials continue to emphasize that 3.b.i is required for all adult primary care practices. This quarter (DY2Q1), BPHC developed guidance outlining the links between the DSRIP projects to the PCMH requirements, emphasizing that PCMH implementation is the foundation for the disease-management DSRIP work. This milestone is on track for completion by DY2Q4.

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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
Milestone Mid-Point Assessment	Completed	Mid-Point Assessment			06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Mid-Point Assessment	zstopak	Templates	36_DY2Q1_PROJ3bi_MDL3bi4_PPS1546_TEMPL_2a_Mid-Point_Assessment_Project_Narrative_3bi_FINAL_4906.docx	Mid-Point Assessment - 3.b.i Disease Management CVD	08/02/2016 06:44 PM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment	

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

Instructions :

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

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

Instructions :

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

(1) Some primary care physicians (PCPs) may resist the imposition of standard treatment protocols and new workflows. To mitigate this risk, our disease management work groups bring PCPs and other project participants together to review and develop a consensus on evidence-based (EB) guidelines and workflows for each disease-specific intervention. Members recommend these EB protocols to the PPS Quality & Care Innovation Subcommittee and the Executive Committee for approval to deploy across the PPS. Implementation of these protocols is part of contractual agreements between partners and the PPS. BPHC is allocating the necessary resources to provide online and in-person training, support and follow up with physicians and other care team members at times that accommodate their clinical schedules to encourage adoption of program elements.

(2) It will be challenging to recruit and train sufficient care management staff to serve the needs of the Bronx population. Recruiting Spanish-speaking care management staff will be a particular risk. BPHC's workforce strategy mitigates this risk, through work with community colleges and coordination with the 1199 Training & Education Fund, Montefiore CMO, and NYSNA to identify capable workers and provide training in Spanish when needed. BPHC is also using alternative employment tactics, such as flexible hours and job sharing where feasible, to attract a broader pool of workers. BPHC recently committed to funding a recruiter to support its partners with its workforce recruiting goals, including for care management staff.

(3) Medication adherence is a chronic problem for individuals with diabetes. Organizations that could be instrumental in helping patients with medication adherence, such as home care agencies and MCOs are handicapped by policies and/or regulations. To mitigate these risks, BPHC is working with MCOs to institute policy changes that will promote medication adherence. Additionally, this year, BPHC formed and began convening a Pharmacy Workgroup. The kickoff was held on February 25th and included representatives from 7 of the 10 BPHC pharmacies. This workgroup is brainstorming strategies to support medication adherence of BPHC patients, and is exploring best practices of its workgroup members – including opt-in care management services provided by pharmacies, whereby patients will be alerted by the pharmacy in the event of a missed prescription refill and may elect to have the pharmacy contact the prescribing physician to resolve medication prescription issues.

(4) Enhancing patient self-management and self-efficacy is anticipated to be a particular risk to the project's success. It is challenging to effectively motivate and engage chronically ill patients over the long term to embrace changes in behavior and self-manage their condition. Many patients do not appreciate the effects of uncontrolled diabetes, risks that are compounded in the Bronx population by low health literacy and educational attainment. These challenges are exacerbated by the complex, multi-organ nature of diabetes, requiring an interdisciplinary treatment approach. Among its mitigation tactics, BPHC is implementing the Stanford Model across the PPS to address this risk. BPHC has contracted with Health People, a CBO that is a certified Stanford Model trainer.

(5) Providers may not implement EHR systems that meet MU and PCMH 2014 Level 3 standards, interoperability challenges may present and/or providers may resist participating in the IDS. BPHC is using gap analyses to develop a program to monitor and deploy assistance to providers at risk, support practices by deploying internal community, external consulting resources and provide customized technical assistance, coaching, and

training modules. Two team members have recently joined the BPHC CSO team to specifically focus on MU.

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY2,Q4	18,060

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	4,515	9,030	13,545	18,060
	Quarterly Update	9,197	0	0	0
	Percent(%) of Commitment	203.70%	0.00%	0.00%	0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment	0.00%	0.00%	0.00%	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
zstopak	Report(s)	36_DY2Q1_PROJ3ci_MDL3ci2_PES_RPT_BPHC-PATIENTLIST-3ci-DY2Q1_9197pts_FINAL_4908.xlsx	Patient Engagement - 3.c.i Disease Management Diabetes	08/02/2016 07:05 PM

Narrative Text :

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

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Evidence-based strategies for the management and control of diabetes in the PPS designated area are developed and implemented for all participating providers. Protocols for disease management are developed and training of staff is completed.		Project		In Progress	06/30/2015	03/31/2018	06/30/2015	03/31/2018	03/31/2018	DY3 Q4
Task Create a Transitional Work Group (CVD/Diabetes TWG) comprised of representatives from partner organizations to support development of and approve elements of the COP		Project		Completed	04/01/2015	06/01/2015	04/01/2015	06/01/2015	06/30/2015	DY1 Q1
Task Identify DSRIP project requirements which are related to PCMH elements and incorporate into PCMH strategy and project planning documents		Project		Completed	05/15/2015	09/30/2015	05/15/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify relevant evidence-based guidelines for diabetes		Project		Completed	05/04/2015	09/30/2015	05/04/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify partner organizations participating in project (sites and CBOs)		Project		Completed	04/01/2015	11/01/2015	04/01/2015	11/01/2015	12/31/2015	DY1 Q3
Task Develop a workplan and timeline to develop the clinical operations plan (COPs) and implement a strategy for the diabetes population that aligns with the patient engagement speed and scale application submission		Project		Completed	04/01/2015	10/31/2015	04/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Develop the COP to define the program elements, define the required and suggested components of those elements, and identify relevant resources to achieve them. Elements include health information exchange and technology requirements, and evidence-based guidelines and high-value treatment protocols		Project		Completed	05/04/2015	10/31/2015	05/04/2015	10/31/2015	12/31/2015	DY1 Q3
Task		Project		Completed	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Develop the project implementation budget										
Task Design training and recruitment strategy in conjunction with workforce team and CVD/DM TWG		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Submit elements of the COP to Quality and Care Innovation Sub-Committee (QCIS) for approval		Project		Completed	07/23/2015	10/31/2015	07/23/2015	10/31/2015	12/31/2015	DY1 Q3
Task Identify clinical champions and operational leaders in each participating organization to develop and lead implementation of the program at each of their providers/sites. These facility-based champions/leaders form the Site-Specific Implementation Team		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Prepare/disseminate gap analysis tool based on COP to participating providers to determine implementaton support needs		Project		Completed	01/15/2016	06/30/2016	01/15/2016	06/30/2016	06/30/2016	DY2 Q1
Task Hold webinar for participating partner organizations		Project		Completed	01/15/2016	03/31/2016	01/15/2016	03/31/2016	03/31/2016	DY1 Q4
Task Create a rapid deployment collaborative, comprised of representatives from partner organizations to support implementation of the COP and to provide updates to QCIS. and to update the COP annually.		Project		Completed	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop mechanisms for regular review of project-selected Evidence Based Guidelines (by project quality councils) to assure our PPS is utilizing the most up-to-date tools and that those updated guidelines/protocols continue to be clinically integrated across the PPS.		Project		Completed	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone #2 Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has engaged at least 80% of their PCPs in this activity.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify sites participating in project. In order to meet the 80% participation rate target, project participation materials distributed to sites indicate that 3.c.i is required for all adult primary care practices.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task		Project		Completed	09/30/2015	03/31/2016	09/30/2015	03/31/2016	03/31/2016	DY1 Q4

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Ensure that all participating practices have signed MSA										
Task Identify opportunities to coordinate processes, education and communication into PCMH workflow processes.		Project		Completed	05/15/2015	03/31/2016	05/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Collaborate with other BPHC project-specific workgroups and teams to ensure that diabetes management training is incoporated/included in other care coordination training sessions.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Monitor acitivity/engagement and make periodic reports to QCIS / EC		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop methodology for evaluation, feedback and Continuous Quality Improvement.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.	DY2 Q4	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		Not Started	01/01/2017	03/31/2017	01/01/2017	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	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination processes are established and implemented.		Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinate to establish the care team and care coordination/management framework/organizational structure and processes most appropriate for achieving project outcome, including nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.		Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Present care management model to QCIS for review and approval		Project		Completed	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish care coordination teams and processes; include community service and program referrals and tracking,		Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
communication, PCP alerts, education materials, coordination among team members, frequency and purpose of patient contact. Ensure these include coordination with the Health Home care manager, where applicable.										
Task Working with Workforce Subcommittee, design training and recruitment strategy for care coordinators/managers and care teams with a training focus on improving health literacy, patient self-efficacy.		Project		Completed	06/30/2015	12/31/2015	06/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify site-specific implementation teams.		Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Launch recruitment and training programs with participating providers		Project		In Progress	04/01/2016	10/31/2016	04/01/2016	10/31/2016	12/31/2016	DY2 Q3
Task Identify and document required clinical and care management protocols for priority programs, projects and interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data		Project		Completed	08/15/2015	10/15/2015	08/15/2015	10/15/2015	12/31/2015	DY1 Q3
Task Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations for how interventions will be logged, tracked and reported.		Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Deploy systems to improve and promote effective care transitions, include protocols for tracking and follow-up		Project		Completed	01/15/2016	02/28/2016	01/15/2016	02/28/2016	03/31/2016	DY1 Q4
Task Operationalize partner and workforce roles by providing gap analysis and appropriate training.		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Establish data collection, survey and reporting mechanisms to enable BPHC monitoring to ensure that patients are receiving appropriate health care and community support in priority projects, based on needs identified in prior planning activities		Project		Completed	02/01/2016	06/15/2016	02/01/2016	06/15/2016	06/30/2016	DY2 Q1
Task Review process for rapid cycle evaluation and continuous improvement of data collection, survey and reporting methods based on priority project experience and modify process as		Project		Not Started	08/01/2016	09/01/2016	08/01/2016	09/01/2016	09/30/2016	DY2 Q2

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SBH Health System (PPS ID:36)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
needed to ensure patients receive appropriate health care and community support										
Milestone #4 Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.	DY2 Q4	Project	N/A	In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.		Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task If applicable, PPS has established linkages to health homes for targeted patient populations.		Project		Completed	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.		Project		In Progress	01/15/2016	03/31/2017	01/15/2016	03/31/2017	03/31/2017	DY2 Q4
Task Using claims data identify "hotspot" areas/patient groups for outreach		Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify and mitigate service shortages to address these "hotspots" which can include mobile services and use of churches and community centers for education and blood pressure screening.		Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Implement 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, if feasible.		Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Establish linkages to health homes for targeted patient populations		Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Implement the Stanford Model through partnerships with community based organizations, including Health People		Project		In Progress	01/15/2016	03/31/2017	01/15/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Ensure coordination with the Medicaid Managed Care organizations serving the target population.	DY3 Q4	Project	N/A	In Progress	07/01/2015	03/31/2020	07/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has agreement in place with MCO related to coordination of		Project		In Progress	06/30/2016	03/31/2020	06/30/2016	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.										
Task Identify current tools and services available to members for relevant MCOs across the PPS, including telehealth, care management, stipend for completing recommended preventive screenings.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Distribute materials regarding extant services and benefits available to members to providers participting in project		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Build prompts to these tools and services into provider EHRs		Project		Not Started	04/01/2017	03/31/2020	04/01/2017	03/31/2020	03/31/2020	DY5 Q4
Task Where feasible, make agreements with MCO related to coordination of services for high risk populations, including smoking cessation services, weight management, and other preventive services relevant to this project.		Project		Not Started	04/01/2017	03/31/2018	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task Communicate payor information and include information on availability/how to access in training programs		Project		Not Started	04/01/2017	03/31/2018	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Use EHRs or other technical platforms to track all patients engaged in this project.	DY2 Q4	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	06/30/2015	03/31/2017	06/30/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS uses a recall system that allows staff to report which patients are overdue for which preventive services and to track when and how patients were notified of needed services.		Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform gap analysis and identify priories to achieving integration of patient record.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task		Project		Completed	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.										
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget to build registry and acquire necessary resources		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Site-specific implementation teams establish processes to use PHM tools/registry, to identify, reach out and track patients due for preventive services.		Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Ensure that IT solutions (within registry or other) allow for "closed loop processing" e.g., tracking of patient through completion of any given preventive service.		Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Conduct training around closed loop processing/referral and preventive service tracking.		Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Provide guidance for ongoing assesment to ensure that practices are following requirements and protocols, and offer guidance to develop mechanisms for continuous quality improvement.		Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify safety net provider data sharing requirements and assess partner and QE data sharing capabilities and current HIE participation		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Coordinate with Bronx RHIO to develop comprehensive HIE adoption program to encourage and support partner participation and integration		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Begin coordinated interface and service development with Bronx RHIO		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish BPHC program to manage support for safety net providers to ensure that all are actively sharing health information, coordinating with Bronx RHIO to encourage, track and support partner participation and integration/data sharing		Project		Completed	03/01/2016	04/25/2016	03/01/2016	04/25/2016	06/30/2016	DY2 Q1
Task Track status and manage support to ensure that all PPS safety net providers are actively sharing health information through Bronx RHIO or alternative health information exchange		Project		In Progress	03/01/2016	03/31/2017	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify community organizations for inclusion in the initial iteration of the Community Resource Database, sign agreements with with community based organizations and establish process to facilitate feedback to and from community organizations		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task		Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Perform regular checks of Community Resource Database to ensure data is up to date and accurate and to identify additional resources to consider including										
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices		Project		In Progress	11/02/2015	03/31/2017	11/02/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.	DY3 Q4	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		Not Started	01/01/2018	03/31/2018	01/01/2018	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	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.		Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.		Provider	Safety Net Mental Health	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Assess eligible participating partner EHR use relative to Meaningful Use and PCMH 2014 Level 3 standards		Project		Completed	06/30/2015	12/31/2015	06/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish BPHC program to educate, encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, including potential use of incentive-based payments for implementation		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Recruit or contract for EHR implementation resources as needed		Project		Completed	11/01/2015	06/30/2016	11/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner EHR implementation and progress towards Meaningful Use and PCMH standards		Project		Not Started	08/01/2016	12/31/2016	08/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task		Project		In Progress	10/15/2015	03/15/2018	10/15/2015	03/15/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Track status and manage support to ensure all eligible safety net providers are using certified EHR systems that meet Meaningful Use and PCMH 2014 Level 3 standards										
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recruit or contract for PCMH practice certification resources as needed		Project		Completed	05/01/2015	12/31/2015	05/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition		Project		Completed	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Perform gap analysis by practice and identify key priorities.		Project		Completed	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.		Project		Completed	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition		Project		In Progress	01/01/2016	11/30/2016	01/01/2016	11/30/2016	12/31/2016	DY2 Q3
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed.		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.	The Diabetes Clinical Operations Plan (COP) is the foundational document for implementation. It was first distributed in December 2015 and the second edition was released in June 2016. The COP is based on the DSRIP Domain 1 and 3 requirements and measures, using input from the CVD-Diabetes Transitional Work Group (TWG). It includes chapters on target population, evidence-based guidelines (EBGs), referral protocols, patient flows, care team roles, and patient/caregiver education and engagement. DSRIP Program Directors (DPDs), our embedded liaison/program lead at the largest 7 primary care organization partners, are beginning organization-specific processes to adopt evidence-based guidelines from the COP. The development of mechanisms for regular review of the EBGs is was approved by our BPHC Quality and Care Innovation Subcommittee in March. This milestone is on track for completion by DY3, Q4.
Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.	Last demonstration year (DY1), BPHC confirmed participation in the Diabetes project for its seven largest primary care organization partners, who encompass the majority of our PCPs and more than 90% of our primary care visits. Practices must commit to participating in the Diabetes project in order to qualify for the Patient-Centered Medical Home (PCMH) transformation support funding (in receiving the expert PCMH consultants). In our second wave of provider engagement with smaller organizations, project participation materials continue to emphasize that 3.b.i is required for all adult primary care practices. This quarter (DY2Q1), BPHC developed guidance outlining the links between the DSRIP projects to the PCMH requirements, emphasizing that PCMH implementation is the foundation for the disease-management DSRIP work. This milestone is on track for completion by DY2Q4.
Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.	The model for care coordination teams was finalized in DY1Q2 and included in the Clinical Operations Plan (COP) for the Health Home At-Risk project (referenced in other project sections). This model includes the opportunity to add additional members of the care management team needed to fulfill the care coordination requirements of the diabetes project, including certified diabetes educators (CDEs), the funding for which is assessed and offered through our "Request for Information" (RFI) process, BPHC's comprehensive partners funding needs assessment for clinical integration. The requirements of the Diabetes (and other primary care projects) were included in the assessment of need for additional staff members to prevent silo-ing and to build capacity for PCMH and Domain 3 DSRIP requirements. This quarter (DY2Q1), partner organizations continued to incorporate the COP into the protocols and implementation by the medical care providers and care teams of the sites of the participating organizations began. This milestone is on track for completion by DY2Q4.
Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.	The Clinical Operations Plan (COP) includes a chapter on this topic, written in Policy & Procedure (P&P) format, based on the CVD/Diabetes Transitional Work Group (TWG)'s recommendation. The COP was presented and distributed to all the participating member organizations of our PPS at the CVD/Diabetes Project Launch in February. BPHC has contracted with Health People to provide training and implementation of the Stanford Model for chronic diseases and we are exploring the possibility of 'hot-spotting' to identify and host classes in high-need areas, as well as hosting them at or near our provider sites. Health People is currently working with our member organizations to identify patients with diabetes to receive training to become peer educators, and lead the Diabetes self-management courses. Recruiting is currently occurring, continuing from DY2Q1, and training is expected to begin in July, with classes beginning in August. We plan to train 20 peer coaches, who are compensated for their training and teaching, and we have a planned capacity for up to 800 students in the DSMP courses. We have also been successful in collaborating with our CBO partners to identify coach candidates, and look forward to continued collaboration (hosting classes, referring students) when the classes begin. This milestone is on track for completion by DY5, Q4.
Ensure coordination with the Medicaid Managed Care organizations serving the target population.	BPHC's Chief Medical Officer has continued to make the topic of partnership/agreements with Medicaid Managed Care Organizations (MCOs) a priority topic at the regularly-scheduled cross-PPS Clinical Leadership Forum series hosted by Greater New York Hospital Association (GNYHA). BPHC plans to collect information on selected initiatives (e.g., self-blood pressure monitoring programs) to potentially support coverage of such programs/equipment by MCOs in the future. We are also working to align and prioritize our activities, particularly around outcome measures, with the HealthFirst performance measures. This milestone is on track for completion by DY5Q4.
Use EHRs or other technical platforms to track all patients engaged in this project.	We are executing a comprehensive plan to support our safety net providers in Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) which includes EHR support and connectivity of data captured therein. Our agreement with Bronx RHIO will continue to serve as the foundation to achieve next quarter's tasks and those of the future to support this Milestone. Our MU plan will be part of a package of IT interventions for those providers which have yet to achieve connectivity. With the help of NYC DOHMH's Primary Care Information Project (PCIP) we performed a gap assessment of all BPHC providers and using an existing network map we attributed them to organizations. The gap assessment looked at eligibility of physicians, and if eligible, where they are in the MU process. Based on this process a work plan is being developed for each individual organization, prioritizing those physicians which have yet to start the program. As part of the work plan, we are including other IT infrastructure improvements, such as EHR implementation and RHIO connectivity and encounter notification systems deployment. We estimate a maximum MU opportunity

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	of ~$60 million which will help fund this work. Part of this plan will also be RHIO incentive funding and other revenue streams. The milestone is on track for completion.
Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.	We are executing a comprehensive plan to support our safety net providers in Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) which includes EHR support and connectivity of data captured therein. A process has been started already to ensure all applicable providers meet PCMH recognition and MU accreditation and that we meet our obligation to the previously agreed tasks. We have hired and deployed expert PCMH consultants to perform detailed gap analyses with about 111 practices, with 80 locations already evaluated thus far. Of the provider locations in the PPS, 95% are compliant with this milestone. Funding has been earmarked for IT expansion and process for this funding's distribution have been developed and communicated to the member organizations. Schedule As (i.e., contracts) have been developed to distribute some of this funding as a result of the process. Our MU plan will be part of a package of IT interventions for those providers which have yet to achieve connectivity. With the help of Primary Care Information Project (PCIP) we performed a gap assessment of all BPHC providers and using an existing network map we attributed them to organizations. The gap assessment looked at eligibility of physicians, and if eligible, where they are in the MU process. Based on this process a work plan is being developed for each individual organization, prioritizing those physicians which have yet to start the program. As part of the work plan, we are including other IT infrastructure improvements, such as EHR implementation and RHIO connectivity and encounter notification systems deployment. In conjunction with PCIP, the PPS is tracking providers' IT infrastructure, developing training materials, and other types of support for EHR use and deployment. The milestone is on track for completion.

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Mid-Point Assessment	Completed	Mid-Point Assessment			06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Mid-Point Assessment	zstopak	Templates	36_DY2Q1_PROJ3ci_MDL3ci4_PPS1547_TEMPL_2a_Mid-Point_Assessment_Project_Narrative_3ci_FINAL_4909.DOCX	Mid-Point Assessment Project Narrative - 3.c.i Disease Management Diabetes	08/02/2016 07:13 PM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment	

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

Instructions :

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

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

Instructions :

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

(1) BPHC may be unable to significantly impact the number of asthma-related ED visits if parents and caregivers are unaware of symptoms that can lead to exacerbations and may not act fast enough to prevent an incident resulting in an ED visit. To mitigate this risk, community health workers (CHWs) from a.i.r. nyc will emphasize the importance of consistent medication use to control asthma and will demonstrate use of medication delivery devices during home visits.

(2) This project is heavily reliant on CHWs being able to conduct home visits to inspect homes and engage and educate the target population. The experience of our primary vendor for this project, a.i.r nyc, indicates that 50% of affected individuals that they reach out to do not initially accept a home visit. Trust building will require time, persistence, and tactics that are culturally sensitive and address the specific concerns of each family. To tackle this challenge, a.i.r nyc recruits CHWs from the geographic and ethnic communities to be served. CHW training focuses on building client trust, cultural competency, and positive impact of persistence as key to overcoming patients' fears. Additionally, we plan to "market" a.i.r. nyc services and to elevate their "brand" as a trusted partner to physicians, schools, and community organizations that have earned a high degree of community trust. As part of establishing this link, a.i.r. nyc has conducted an orientation on its services for sites identified as key referral sources to the project. A tactic includes incorporating logos of trusted PPS partners, possibly including CBOs, on outreach and educational materials disseminated to patients. We are also including an article about a.i.r. nyc in the July issue of a patient-targeted health magazine distributed by SBH which reaches 6500 households.

(3) Another challenge this project will face is integrating referrals to our home-based asthma program into two critical asthma patient contact points: hospital emergency departments (EDs) and discharge planning (DP) units. To address this, BPHC has included training on the home-based asthma program for staff involved in the ED Care Triage and 30-day Care Transitions programs. This includes a clinician orientation, to educate ED and DP staff on the goals, strategies, tactics and proven value of the intervention, and workflows for referring patients to a.i.r. nyc. We have included these sites in our project planning for the project and have an initial roll-out meeting schedule with stakeholders from ED and Care Transitions in June.

(4) We may face the challenge of demand for services outpacing capacity for this project, but we have established a monthly reporting schedule to monitor referrals and capacity to mitigate this risk.

(5) Most providers do not have asthma registries or electronic care plan tools and some do not participate in the RHIO to permit information sharing across providers. BPHC's CSO is addressing these issues by adding new IT capabilities, including a care planning and management platform and patient registries, and promoting RHIO participation. Until we have a fully running care coordination system, we are working with PPS partners and a.i.r. nyc to find mutually convenient interim solutions for referrals management, including a single-referral webform and a multiple-referral option through partners' EHRs.

(6) Lifestyle choices could pose a challenge to patient compliance (e.g., passive smoking, environmental factors acting as asthma triggers such as

pests, molds, etc.). Mitigation will include CHWs referring patients and families to needed services, including the Quitline and integrated pest management (IPM) services. Smoking cessation is also an important component of our CVD program.

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY4,Q4	10,850

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	678	1,357	2,034	2,713
	Quarterly Update	70	0	0	0
	Percent(%) of Commitment	10.32%	0.00%	0.00%	0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment	0.00%	0.00%	0.00%	0.00%

Warning: PPS Reported - Please note that your patients engaged to date (70) does not meet your committed amount (678) for 'DY2,Q1'

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
zstopak	Report(s)	36_DY2Q1_PROJ3dii_MDL3dii2_PES_RPT_BPHC-PATIENTLIST-3dii-DY2Q1_70pts_FINAL_4911.xlsx	Patient Engagement - 3.d.ii Asthma	08/02/2016 07:22 PM

Narrative Text :

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

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	DY3 Q2	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 developed a strategy for the collaboration of community medical and social services providers to assess a patient's home and provide self-management education for the appropriate control of asthma.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Contract with a.i.r. nyc to provide home-based services for clients/families with asthma to develop and disseminate patient education materials and create rosters demonstrating that patients have received home-based interventions.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Contract with a.i.r. nyc to perform home environment assessment for environmental factors acting as asthma triggers, e.g., pests, molds, etc.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify key stakeholders and subject matter experts (SMEs) among PPS members and convene representative individuals to establish work group to develop Clinical Operations Plan (COP) for participating members to use as project implementation manual.		Project		Completed	04/01/2015	06/01/2015	04/01/2015	06/01/2015	06/30/2015	DY1 Q1
Task Develop workplan and time line to develop COP.		Project		Completed	06/01/2015	08/03/2015	06/01/2015	08/03/2015	09/30/2015	DY1 Q2
Task Develop comprehensive provider/participant engagement, education and communication plan to engage community medical and social services providers in the project and establish productive collaborative relationships and linkages among them.		Project		Completed	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Develop and finalize Asthma Action Plan form		Project		Completed	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Develop systems to populate Asthma Actions Plans for dissemination to patients and PCPs.										
Task Identify and establish relationship(s) with legal services in the community that provide pro bono legal services for community members, including dealing with landlords who fail to address/mitigate building environment factors that are known triggers of asthma problems		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Identify PPS members who will participate in project.		Project		Completed	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Use Master Services Agreement (MSA) to contract with PPS members who participate in the project and receive DSRIP funds		Project		Completed	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define target population.		Project		Completed	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify Site-Specific Implementation Teams to facilitate referrals to a.i.r. nyc and coordinate Asthma Action Plan and report distribution to care teams.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Develop methodology evaluation, feedback and Continuous Quality Improvement (CQI) for Site-Specific Implementation Teams.		Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	DY2 Q4	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence-based trigger reduction interventions.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify integrated pest management (IPM) vendors who provide services in the Bronx.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop policies, procedures and workflows for engaging IPM vendors when needed, including responsible resources at each stage of the workflow.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3

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a.i.r. nyc has partnership with NYCDOHMH's Healthy Homes programs for linking patients to IPM vendors. Meet with a.i.r. nyc and Healthy Homes Program adminstrator to develop plan for scaling up linking patients with IPM vendors/resources and other community based services as needed.										
Task Establish a.i.r nyc's Action Plan for Remediation as tool for monitoring and tracking delivery of IPM services to patients to ensure services are delivered.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task In conjunction with the Workforce Subcommittee, develop training materials for Community Health Workers (CHWs) on 1) how to conduct home environmental assessmentswith establishment of asthma action plan for remediation; and 2) the protocols for engaging IPM vendors for trigger reduction interventions.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop patient educational materials on indoor asthma triggers and availability of IPM resources to reduce exposure to the triggers.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #3 Develop and implement evidence-based asthma management guidelines.	DY2 Q4	Project	N/A	In Progress	06/29/2015	03/31/2017	06/29/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS incorporates evidence-based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management.		Project		In Progress	06/29/2015	03/31/2017	06/29/2015	03/31/2017	03/31/2017	DY2 Q4
Task Global Initiative for Asthma (GINA) guidelines for Asthma Management and Prevention in combination with EPR 3 national guidelines will serve as basis for implementing evidence-based asthma management care together with The Community Preventative Service Task Force evidence-based recommendations for Home-Based Multi-Trigger, Multicomponent Environmental Interventions for Asthma Control: http://www.thecommunityguide.org/asthma/multicomponent.html		Project		Completed	06/29/2015	08/03/2015	06/29/2015	08/03/2015	09/30/2015	DY1 Q2
Task Quality and Care Innovation Sub-Committee (QCIS) will review and revise the evidence-based guidelines for clinical practice, as needed, and approve.		Project		Completed	08/04/2015	10/31/2015	08/04/2015	10/31/2015	12/31/2015	DY1 Q3
Task Once approved, the guidelines will be incorporated into protocols		Project		Completed	11/01/2015	12/31/2015	11/01/2015	12/31/2015	12/31/2015	DY1 Q3

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and implemented by medical providers and care teams at sites of participating member organizations.										
Task Develop mechanisms for regular review of project-selected evidence-based guidelines (EBGs) to assure our PPS is utilizing the most up-to-date tools and that those updated guidelines/protocols continue to be clinically integrated across the PPS.		Project		Completed	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	DY2 Q4	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed training and comprehensive asthma self-management education, to include basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task a.i.r. nyc and Asthma work group will review the National Standards for asthma self-management to ensure that training is comprehensive and utilizes national guidelines for asthma self-management : (Gardner A., Kaplan B., Brown W., et al. (2015). National standards for asthma self-management education. Ann Allergy Asthma Immunol. 114 (3). doi: 10.1016/j.anai.2014.12.014.)		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Select/develop new or additional culturally/linguistically and literacy appropriate patient/caregiver educational materials as needed that improve asthma health literacy and improve self-efficacy and self-management.		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Disseminate/embed (in EHR/PHR, where feasible) patient/caregiver educational information and materials across participating PPS providers.		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Conduct ongoing education/training to introduce/update/refresh care teams' knowledge of new patient educational materials and		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
evidence-based guidelines										
Task Establish protocols and methods that promote medication adherence, including local participating pharmacists to support patient education, especially on inhaler/spacer use.		Project		Completed	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone #5 Ensure coordinated care for asthma patients includes social services and support.	DY3 Q2	Project	N/A	In Progress	08/03/2015	09/30/2017	08/03/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has developed and conducted training of all providers, including social services and support.		Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task All practices in PPS have a Clinical Interoperability System in place for all participating providers.		Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has assembled a care coordination team that includes use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.		Project		In Progress	08/03/2015	09/30/2017	08/03/2015	09/30/2017	09/30/2017	DY3 Q2
Task In conjunction with the Workforce Subcommittee, develop training that includes social services reports and develop training calendars.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Conduct educational sessions/webinar and ongoing training as needed for providers on use of Asthma Project COP.		Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Develop and implement provider-specific technical assistance program to facilitate use of various interoperable IT systems.		Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Identify and document required clinical and care management protocols for priority programs, projects and interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data		Project		Completed	08/15/2015	10/15/2015	08/15/2015	10/15/2015	12/31/2015	DY1 Q3
Task Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations for how interventions will be logged, tracked and reported.		Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Task Deploy systems to improve and promote effective care transitions, include protocols for tracking and follow-up		Project		Completed	01/15/2016	02/28/2016	01/15/2016	02/28/2016	03/31/2016	DY1 Q4
Task Operationalize partner and workforce roles by providing gap analysis and appropriate training.		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Establish data collection, survey and reporting mechanisms to enable BPHC monitoring to ensure that patients are receiving appropriate health care and community support in priority projects, based on needs identified in prior planning activities		Project		In Progress	02/01/2016	12/31/2016	02/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Review process for rapid cycle evaluation and continuous improvement of data collection, survey and reporting methods based on priority project experience and modify process as needed to ensure patients receive appropriate health care and community support		Project		Not Started	08/01/2016	12/31/2016	08/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task In conjunction with Workforce Subcommittee, describe roles and responsibilities of care coordination team that includes clinical practice care team (e.g., PCPs, nurses, medical assistants), dietitians, pharmacists and community health workers.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task a.i.r. nyc will present its current intake and assessment process and assessment tools to Asthma Project Work Group for review and inclusion in COP.		Project		Completed	08/03/2015	09/30/2015	08/03/2015	09/30/2015	09/30/2015	DY1 Q2
Task a.i.r. nyc will present its current referral protocols to Asthma work groups for review, modification (if needed) and inclusion in COP.		Project		Completed	08/03/2015	09/30/2015	08/03/2015	09/30/2015	09/30/2015	DY1 Q2
Task a.i.r. nyc will present its current patient flow chart to Asthma work group for review, modification (if needed) and inclusion in COP. The flow chart plots the inter-relationships among a.i.r. nyc staff, referral sources, PCPs and CBOs and the multiple protocols and process workflows.		Project		Completed	08/03/2015	09/30/2015	08/03/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify community organizations for inclusion in the initial iteration of the Community Resource Database, sign agreements with with community based organizations and establish process to facilitate feedback to and from community organizations		Project		In Progress	10/15/2015	03/31/2017	10/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task		Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Perform regular checks of Community Resource Database to ensure data is up to date and accurate and to identify additional resources to consider including										
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	DY2 Q4	Project	N/A	In Progress	08/03/2015	03/31/2017	08/03/2015	03/31/2017	03/31/2017	DY2 Q4
Task Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's family.		Project		In Progress	08/03/2015	03/31/2017	08/03/2015	03/31/2017	03/31/2017	DY2 Q4
Task Establish protocols for frequency of follow-up services		Project		Completed	08/03/2015	12/31/2015	08/03/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish processes and timelines for additional follow-up to ensure root causes have been sustainably eliminated.		Project		Completed	08/03/2015	12/31/2015	08/03/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify patients with ED or hospital visits for an asthma diagnosis, via interoperable systems, e.g., RHIO, CCMS, registry		Project		Completed	03/31/2016	06/30/2016	03/31/2016	06/30/2016	06/30/2016	DY2 Q1
Task Establish processes to identify the root causes of the "outpatient failure," e.g., problems with medication refills, prior authorization of meds, proper inhaler use, education about triggers, pest control issues		Project		In Progress	08/03/2015	12/31/2016	08/03/2015	12/31/2016	12/31/2016	DY2 Q3
Task Establish processes to share root causes with family/care givers and to provide support to eliminate/rectify root causes, as needed		Project		In Progress	08/03/2015	12/31/2016	08/03/2015	12/31/2016	12/31/2016	DY2 Q3
Task Develop mechanisms for ongoing evaluation of the above processes and follow up to assure accountability and continuous quality improvement.		Project		In Progress	01/03/2016	03/31/2017	01/03/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	DY3 Q2	Project	N/A	In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has established agreements with MCOs that address the		Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2

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coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers.										
Task Meet with MCOs to identify triggers and processes for payer care coordination and asthma services to ensure coordination of care and prevent gaps in care and/or redundant services.		Project		Completed	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task PPS has agreement in place with MCOs to address coverage of patients with asthma health issues		Project		Not Started	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Meet with health home managers, PCPs and specialty providers of participating organizations in Asthma project to review project Clinical Operations Plan, inlcuding, but limited to evidence-based guidelines; patient flow charts plotting inter-relationship among a.i.r. nyc staff, referral sources, PCPs home health managers and specialty providers; referral protocols to medical, behavioral health, home care and social support services including PCPs, Health Homes, mental health/behavioral health providers, and CBOs.		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Using Master Services Agreements and schedules, develop partnership agreements with participating health home managers, PCPs and speciality providers that define services they will provide and their responsibilities to adopt and use the Clinical Operations Plan for the project.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop partnership agreements with MCOs affirming coverage and coordination of asthma service benefits.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	DY2 Q4	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	08/03/2015	03/31/2017	08/03/2015	03/31/2017	03/31/2017	DY2 Q4
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Task Perform gap analysis and identify priories to achieving integration of patient record.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project		Project		Completed	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget to build registry and acquire necessary resources		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, with an emphasis on tracking patient engagement with primary care										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	BPHC continued to develop the strategy for this project with the support of its partner (and vendor) a.i.r. nyc, a community-based organization (CBO) with 10 years of experience in providing asthma home-based services. The Clinical Operations Plan (COP) is the foundational document for implementation. It was first distributed in March 2016 and the second edition was released in June 2016. The COP is based on the DSRIP Domain 1 and 3 requirements and measures, using input from the Asthma Transitional Work Group (TWG). It includes chapters on target population, evidence-based guidelines, referral protocols, patient flows, care team roles, patient/caregiver education (self-monitoring, medication use and engagement), and home environmental trigger reduction. This milestone is on track for completion by DY3Q2.
Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	The Clinical Operations Plan (COP) was presented and distributed to all the participating member organizations of our PPS at the Asthma Launch on March 11. The COP includes the evidence-based recommendations of the Task Force on Community Preventive Services for home-based, multi-trigger, multi-component interventions with an environmental focus. The COP also includes procedures for the referral of patients to a.i.r. nyc, as well the training that a.i.r. nyc's community health workers (CHWs) receive to perform such an assessment and the template for the Asthma Action plan which outlines steps to be taken to reduce exposure. This milestone is on track for completion by DY2Q4.
Develop and implement evidence-based asthma management guidelines.	Clinical evidence-based guidelines (EBGs) and home-based services for asthma care and management were developed by our Asthma Transitional Work Group and recommended to the Quality and Care Innovation Subcommittee (QCIS) for adoption last year (DY1Q3). The QCIS approved both sets of guidelines, and were incorporated into the Clinical Operations Plan (COP). The DSRIP Program Directors (DPDs), who are the embedded DSRIP liaison/coordinator for CSO at the largest seven primary care organizations, have begun organization-specific processes to adopt evidence-based guidelines from the COP. The development of mechanisms for regular review of the EBGs was approved by our BPHC QCIS in March. This milestone is on track for completion by DY2Q4.
Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	a.i.r. nyc, our partner and vendor for the Asthma project, has developed a comprehensive "Training & Practicum for Asthma Care Delivery in the Home Setting." This guide contains thorough references to peer-reviewed literature to support its training and education strategy and complies with the National Standards for Asthma self-management. Our Clinical Integration Plan (COP) for asthma includes a chapter on patient education outlining the curriculum and specific resources. We expect excellent results for this milestone as a.i.r. nyc has 10 years of experience in the field and is recognized across the City as a leader in the area of training and comprehensive asthma self-management education. This milestone is on track for completion by DY2Q4.
Ensure coordinated care for asthma patients includes social services and support.	The Asthma Clinical Operation Plan (COP) includes chapters on clinical and care management protocols. The model for care coordination was finalized last quarter (D1Q4) and included in the COP for the Health Home At-Risk program project (it is referenced in the asthma COP). The care team model is adaptable to add other people, including nursing staff, pharmacists, dieticians and community health workers (CHWs). BPHC is continuing to develop processes for close coordination with the a.i.r. nyc team. a.i.r. nyc's CHWs use evidence-based guidelines to directly engage an asthma patient in a series of action steps that lead to better health. CHW training focuses on four subject matters, including self-management education, social support services, care coordination and environmental assessment, education and mitigation. Asthma

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	was identified as one of the priority areas for the Health Home At-Risk work. Since the implementation of team-based care is foundational to BPHC's primary care projects, this project launched last January to allow sites time to begin building their teams and making selected hires to build capacity for PCMH and Domain 3 (Chronic Disease Management) DSRIP requirements. The COP also includes chapters on the roles and responsibilities of a.i.r. nyc and workforce at sites, including tracking and reporting. Hiring for the care coordinator roles began at the partner sites last quarter (DY1Q4) and continued this quarter (DY2Q1). The planning for implementation of the system to support care coordination (Care Coordination Management System, CCMS) has continued this quarter (DY2Q1) as well, and expect to finalize by next quarter. This is on track for completion by DY3Q2.
Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	The Asthma Clinical Operations Plan (COP) dedicates chapters on root cause analyses after ED visits to avoid future events, including protocols on follow-up services. Implementing population health workflows is a key focus area for DY2Q2 through DY2Q4. We have a meeting planned for July to discuss coordination of the asthma project with our 30-Day Care Transitions Intervention Program and Emergency Department Care Triage for At-Risk Populations. The analysis of root causes will be an area of focus for the meeting. This is on track for completion by DY2Q4.
Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	The model for care coordination was finalized last year (DY1Q3) and included in the Clinical Operations Plan (COP) for the Health Home At-Risk project (it is referenced in the asthma COP). The COP was presented and distributed to all the participating member organizations of our PPS at the Asthma Launch on March 11. Additionally, BPHC is continuing to develop an overarching, cross-project strategy for referrals to and communication between Health Home care managers, PCPs, specialty providers, contracted CBOs and potentially clinical pharmacists. Independent of the DSRIP work, HealthFirst has been doing a pilot program with a.i.r. nyc recently to fund home-based asthma care, which may serve an impetus for other managed care organizations (MCOs) to similar fund these services. BPHC has continued discussion around identification of BPHC HealthFirst patients and will continue this work in future quarters. BPHC's Chief Medical Officer has made the topic of partnership/agreements with Medicaid MCOs a priority topic at the regularly scheduled cross-PPS meetings hosted by Greater New York Hospital Association (GNYHA), so some of these agreements may be in collaboration with other PPSs. This is on track for completion by DY3Q2.
Use EHRs or other technical platforms to track all patients engaged in this project.	We are executing a comprehensive plan to support our safety net providers in obtaining Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) certification, which includes the use of targeted patient registries in conjunctions with our clinical projects. We have a strategy in place for care management which includes the uses of registries, EHRs, Care Coordination Management Systems, and referral tracking systems.. Our major partners which account for 87% of BPHC PCPs and 81% of non-PCPs, are already sharing clinical data to varying degrees with the Bronx RHIO and anticipate the quality and quantity of this data to increase. We reviewed DSRIP performance measures and Quality and Care Innovations Subcommittee recommended registry fields, and have been working with BxRHIO to further define which are most feasible to build out and release to our largest partners in DY2. Bronx RHIO has conducted a gap analysis on data currently in the RHIO and identified missing and other data quality issues relevant to those initial proxy measures and registries. Bronx RHIO had already begun development of Spectrum, its population health management (PHM) and analytics tool, which the PPS will utilize as part of our PHM solution. Though still in development this quarter, we obtained accounts and initial training on Spectrum for key staff in the CSO to begin understanding it. We are also simultaneously exploring potentials to utilize the MAPP/Salient resources to use as additional PHM source to understand the population we serve and their utilization patterns. Furthermore, we are actively pursuing to improve consent rates for Bronx RHIO and initiated a data use agreement (DUA) where each partner allows the Bronx RHIO to share their data with BPHC to create an environment where PHM will be more comprehensively implemented. We are confident that we are also close to securing a Care Coordination and Management System (CCMS) for the PPS. BPHC also deployed a rapid cycle evaluation (RCE) process and selected initial set of key process measures to support our implementation progress. Tracking of actively engaged patients will be a coordinated effort between referring sites and a.i.r. nyc. It was presented at the Asthma project launch on March 11 and reviewed in detail in a webinar held on March 28. Actively engaged patients will be tracked by both the referring organization as well as a.i.r. bronx and reported using data from a.i.r. nyc's case management system, which is built using the Salesforce platform. Finalization of initial closed-loop referral processes between a.i.r. nyc and providers is on track for completion in DY2, Q2. The milestone is on track for completion by DY2Q4.

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Mid-Point Assessment	Completed	Mid-Point Assessment			06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Mid-Point Assessment	zstopak	Templates	36_DY2Q1_PROJ3dii_MDL3dii4_PPS1548_TEMPL_2a_Mid-Point_Assessment_Project_Narrative_3dii_FINAL_4910.docx	Mid-Point Assessment Project Narrative - 3.d.ii Asthma Home-Based Self-Management	08/02/2016 07:19 PM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment	

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

Instructions :

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) The primary risk associated with this project is that substance use disorder and mental health services are siloed. To mitigate this risk, BPHC and its MHSA Collaborative Workgroup PPS partners – Community Care of Brooklyn, OneCity Health, and Bronx Health Access – will include content experts from both sectors to de-silo the services and offer a cohesive program to the participating schools. The Jewish Board will also participate in mitigating this risk, as the lead agency, as they are a local expert in this field.
(2) If the lead agency, in collaboration with the PPSs, lacks the ability to evaluate the MHSA interventions by diversifying the program too much without requiring the "core" program being implemented consistently through all participating schools, identifying where MHSA's interventions succeeded or failed will be difficult. To mitigate this risk, the PPSs have begun driving the conversation about the program, insisting that there be at least one "core" element that will be standardized across all the schools for evaluation purposes.
(3) Another possible risk is that school-based staff will be disengaged, based on their own biases or misunderstanding of MHSA-related diseases, or fears of being held responsible for individual student outcomes related to MHSA issues. To mitigate this risk, partnerships with teachers and school staff will be established at the ground level. Staff trainings will address issues like bias and stigma and will educate staff on the nature of MHSA conditions. The PPSs will also train school-based staff on when to refer students with potentially more serious problems to available referral channels and help to ensure warm handoffs to appropriate community-based MHSA services.
(4) Another possible risk is that the other PPSs may not sustain a high level of commitment towards the project over the demonstration period. To mitigate this risk, the PPSs have signed a contract with The Jewish Board that commits every stakeholder to engage in the MHSA Collaborative Workgroup over the entire demonstration period to spearhead programming. To date the Workgroup has had a high level of attendance and participation across all the PPS's, the lead agency, and specifically with participation by BPHC staff.

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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 Participate in citywide MHSA Workgroup meetings	Completed	BPHC will join and contribute to a cross-PPS workgroup to develop, implement, and monitor the collaborative MHSA interventions.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Participate in cross-PPS workgroup	Completed	Contribute to the formation of an MHSA Work Group composed of representatives of the four collaborating PPSs, including community-based representatives	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify subject matter experts for workgroup	Completed	Identify PPS subject matter experts to join cross-PPS Work Group	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Invite city agency representatives for workgroup	Completed	Invite representatives from DOE-affiliated Office of School Health and DOHMH to join Workgroup as advisory members	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Attend regular meetings for cross-PPS workgroup	Completed	Particpate in cross-PPS MHSA Workgroup meetings under the standing structure	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone Establish cross-PPS Collaboration structure	Completed	In collaboration with cross-PPS workgroup and participating subject matter experts and City agencies, establish formalized structure for cross-PPS collaboration on governance and implementation of MHSA project	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Confirm commitment to cross-PPS collaboration	Completed	BPHC will confirm its commitment to partner in City-wide implementation of MHSA Project	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Develop governance structure	Completed	Develop governance structure and process among collaborating PPSs to oversee the implementation and ongoing operation of the MHSA project, and document functions, roles, and responsibilities for parties including Workgroup	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone Review of existing programs	Completed	A critical component of successful implementation will be to identify effective means to adapt the collaborative care model among the adolescent population. The PPSs will work together to conduct research and adapt evidence-based models of collaborative care for adolescents.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Conduct baseline analysis	Completed	A baseline analysis of existing programs and CBOs providing MHSA services to adolescents in schools will be conducted. Special focus will be on screening for depression and drug/alcohol abuse.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Review of evidence based interventions	Completed	Review evidence-based adaptations of Collaborative Care (CC) model that have targeted adolescents	07/01/2015	12/31/2015	07/01/2015	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
Task Draft findings and integrate into plans	Completed	Findings from analysis and review of evidence based interventions on MHSA for adolescent populations will be integrated into MHSA project concept document	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone Develop operations plan	In Progress	An operations plan detailed MHSA project operational plan for Collaborative Care Adaptation in schools will be created	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Develop concept paper	Completed	Engage MHSA Workgroup to develop concept paper describing the approach to strengthening the MHSA infrastructure in schools	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop selection process for lead agency	Completed	Design/implement process to select well qualified Lead agency to manage detailed program planning and implementation of the MHSA cross-PPS initiative	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Contract with selected Lead Agency	Completed	Contract with selected Lead Agency to manage all aspects of the MHSA project including developing operational plan, selection of community mental/behavioral health agencies, selection of target schools, project staffing structure, and training curriculum	07/31/2015	12/31/2015	07/31/2015	12/31/2015	12/31/2015	DY1 Q3
Task Draft operational plan	Completed	Develop draft operational plan for MHSA Workgroup review that incorporates development of culturally and linguistically sensitive MEB health promotion and prevention resources, data-collection and evaluation, staffing, training, and referral planning, as needed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize operational plan	Completed	Finalize draft operational plan and budget; share with MHSA Collaborative cross-PPS Governance body for approval	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone Implement Collaborative Care (CC) Adaptation in schools	In Progress	Implementation will encompass details on contracting, collaboration with NYCDOE, school selection, and launch of intervention in schools.	07/01/2015	09/30/2017	07/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Implement process for community agency selection	Completed	Design and implement process to select and contract with community mental/behavioral agencies to implement programs in the schools	01/31/2016	06/30/2016	01/31/2016	06/30/2016	06/30/2016	DY2 Q1
Task Solicit DOE input on school selection methodology	In Progress	DOE will provide input and feedback on proposed process for community mental/behavioral health agency selection	01/31/2016	09/30/2017	01/31/2016	09/30/2017	09/30/2017	DY3 Q2
Task Identify target schools	In Progress	Identify target schools for implementation of CC adaptation	04/01/2016	06/30/2017	04/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task Develop project activities schedule	In Progress	Develop schedule for MHSA project activities, including activities preparatory to launch of CC adaptation in schools such as contracting,	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
		staff recruitment and deployment, training						
Task Launch MHSA project in schools	Not Started	Launch implementation of MHSA Project CC adaptation in schools	10/01/2016	09/30/2017	10/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone Design programs for young adults	Not Started	Adult-interfacing programs will be implemented to reach young people who are out of grade school. These programs will target young people though relevant community-based locations, including, but not limited to community colleges.	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Identify target young adult groups	Not Started	Identify target young adult groups, including, but not limited to, community college students	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Refine MHSA intervention	Not Started	Refine MHSA intervention to integrate programming to reach these young adult groups, including by developing culturally and linguistically sensitive MEB health promotion and prevention resources, data-collection and evaluation plan, and staffing and training plans	07/01/2017	03/31/2018	07/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task Launch young adult programs	Not Started	Launch young adult programs	04/01/2017	03/31/2018	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone Mid-Point Assessment	Completed	Mid-Point Assessment			06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Participate in citywide MHSA Workgroup meetings	repstein	Meeting Materials	36_DY2Q1_PROJ4aiii_MDL4aiii2_PPS1142_MM_MHSA_Joint_Planning_Meeting_Notes_11.10.2014_5155.pdf	Meeting minutes	08/03/2016 04:37 PM
	repstein	Meeting Materials	36_DY2Q1_PROJ4aiii_MDL4aiii2_PPS1142_MM_MHSA_Joint_Planning_Meeting_Notes_01.12.2015_5151.pdf	Meeting minutes	08/03/2016 04:36 PM
	repstein	Implementation Plan & Periodic Updates	36_DY2Q1_PROJ4aiii_MDL4aiii2_PPS1142_IMP_MHSA_RFI_Release_Letter_FINAL_3683.docx	MHSA RFI Release Letter	07/11/2016 10:31 AM
	repstein	Implementation Plan & Periodic Updates	36_DY2Q1_PROJ4aiii_MDL4aiii2_PPS1142_IMP_MHSA_RFI_Final_Draft_3682.docx	MHSA RFI	07/11/2016 10:30 AM
Establish cross-PPS Collaboration structure	repstein	Implementation Plan & Periodic Updates	36_DY2Q1_PROJ4aiii_MDL4aiii2_PPS1143_IMP_Appendix_B_-_Year_Two_Protected_5161.xlsx	RFI Appendix 2	08/03/2016 04:41 PM
	repstein	Implementation Plan & Periodic Updates	36_DY2Q1_PROJ4aiii_MDL4aiii2_PPS1143_IMP_Appendix_B_-_Year_One_Protected_5160.xlsx	RFI Appendix 1	08/03/2016 04:40 PM

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PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	repstein	Implementation Plan & Periodic Updates	36_DY2Q1_PROJ4aiii_MDL4aiii2_PPS1143_IMP_MHSA_RFI_Final_Draft_5159.docx	RFI	08/03/2016 04:39 PM
	repstein	Implementation Plan & Periodic Updates	36_DY2Q1_PROJ4aiii_MDL4aiii2_PPS1143_IMP_MHSA_RFI_Release_Letter_FINAL_5158.docx	RFI Release Letter	08/03/2016 04:39 PM
Review of existing programs	repstein	Report(s)	36_DY2Q1_PROJ4aiii_MDL4aiii2_PPS1144_RPT_MHSA_Stakeholders_06_02_16_5164.xlsx	MHSA service providers table	08/03/2016 04:42 PM
Mid-Point Assessment	zstopak	Templates	36_DY2Q1_PROJ4aiii_MDL4aiii2_PPS1549_TEMPL_2a_Mid-Point_Assessment_Project_Narrative_4aiii_FINAL_4912.docx	Mid-Point Assessment - 4.a.iii - MHSA	08/02/2016 07:41 PM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Participate in citywide MHSA Workgroup meetings	Update: Bronx Partners for Healthy Communities (BPHC) staff have continued to participate in all meetings of the cross-PPS collaborative. The Jewish Board has continued to manage the implementation of this shared project. The cross-PPS collaborative continues to meet regularly to vet plans and provide input on project implementation, led by the JBFCS. The cross-PPS workgroup has also met with the New York City Department of Health and Mental Hygiene (DOHMH), the New York City Department of Education (DOE), and the Office of School Health (OSH), a joint program of the DOE and the DOHMH that provides health and preventive services to DOE students, to discuss implementation plans, the Request for Information (RFI) draft, and to garner input on which schools the pilot program should be implemented. BPHC shared the RFI with our community-based organizations (CBOs), mental health services organizations (Article 31), and substance abuse services organizations (Article 32), all competent in their respective programs for adolescents and teens; five organizations submitted proposals for review by the JBFCS and then the cross-PPS collaborative. Milestone has been completed and we will continue to update the progress.
Establish cross-PPS Collaboration structure	Update: In addition to the cross-PPS collaborative agreement, Bronx Partners for Health Communities (BPHC) participated in the forming of the Request for Information (RFI) for community-based organizations (CBOs), mental health services organizations (Article 31), and substance abuse services organizations (Article 32). The RFI outlines what the cross-PPS collaborative would like the organization to implement in the schools. The inclusion of city and state agencies in this process ensured subject-matter experts were participating and helping guide this school-based project. Milestone completed early on 12/31/2015 (DY1 Q3) and we will continue to update the progress.
Review of existing programs	Update: Bronx Partners for Healthy Communities (BPHC) continues to review existing programs and community-based organizations (CBOs) that provide MHSA services. This additional program review will be imperative during the proposal review process, when the cross-PPS collaborative will select the project implementer. Milestone is complete and we will continue to update the progress.
Develop operations plan	Update: The lead agency for the cross-PPS MHSA, The Jewish Board, in conjunction with the participating PPSs, developed a Request for Information (RFI) based on the previously drafted concept paper and existing program review. The RFI outlines the many facets of the project including the training of school-based staff to identify behavioral indicators of subclinical MHSA needs and implement universal, selected, and targeted intervention for students to address those issues, integrating an adaptation of the Collaborative Care model into schools by training school support staff to perform assessments and interventions for students with mild to moderate MHSA clinical needs, and for students with higher acuity MHSA needs, training school support staff to form effective linkages to community mental health, substance use, and care coordination services and other community-based services, and strengthen existing linkages. The RFI was sent to over 70 organizations within the PPS, including community-based organizations (CBOs), mental health services organizations (Article 31), and substance abuse services organizations (Article 32), all viable candidates for the work laid out above. Upon review of the proposals, Astor Services for Children and Families, an Article 31, was selected to implement the project in the schools beginning this fall. Astor Services for Children and Families currently provides early childhood development programs, community-based mental health programs, and residential treatment programs throughout the Bronx and Greater New York City. The operational plan will continue to develop as the partnership with Astor Services for Children and Families is solidified. Milestone is on

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
	track for completion by DY2 Q4.
Implement Collaborative Care (CC) Adaptation in schools	Update: The Jewish Board, as lead agency, continues to work with the New York City Department of Health and Mental Hygiene (DOHMH), the New York City Department of Education, and the Office of School Health (OSH), a joint DOHMH and DOE program, in addition to the PPS's. The Request for Information (RFI) laid out the many components that the Jewish Board and cross-PPS collaboration expect the contracted community-based organization (CBO) to implement in the school. The Jewish Board, along with the DOE plans to use a geographic cluster approach to school selection; piloting five schools in the South Bronx beginning in the fall. Five schools will also be clustered in Middle Brooklyn for the pilot. From there the project will expand to additional schools in the South Bronx and Middle Brooklyn, eventually reaching schools in Manhattan and Queens. Milestone is on track for completion by DY3 Q2.
Design programs for young adults	UPDATE: This is on hold until the milestone begins in DY2 Q3.
Mid-Point Assessment	

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

Instructions :

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

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

Instructions :

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

HIV patients have a high prevalence of substance use disorder, homelessness, chronic trauma, behavioral health diagnoses and other chronic co-morbid conditions. Moreover, HIV disproportionately impacts ethnic/racial and gender minorities who often face stigma both in their communities and by providers. As a result, they may have to travel far from their community to receive culturally responsive care, which is not always feasible. To mitigate this risk, we plan to work closely with BPHC partners to identify HIV-positive individuals wherever they currently access services. We will ensure that partners have information about how to link these patients to appropriate care, not only for HIV services but to manage other conditions as well. We will also develop and provide training in cultural competency for providers and support staff, to expand the number of welcoming care delivery sites for HIV-positive individuals. The demographics of the populations most in need of linkages to HIV services may change over time. To mitigate this risk, we intend to continue working with the Domain 4 HIV Collaborative Workgroup, formed by the PPSs during the planning phase. Another risk is PPSs working in silos, which will potentially create a duplication of efforts and confusion for downstream providers. To mitigate this risk, the cross-PPS HIV Workgroup will continue collaborating to ensure that the PPSs effectively share knowledge, experience, and perspectives, avoid service duplication, and improve project design and implementation. This will entail building collaborations between healthcare and supportive service providers as well as providers offering the same services. For example, there are a number of community-based organizations that are instrumental in HIV care, but silos often lead to ineffective working relationships, lack of care coordination, and gaps in care. We will meet with all BPHC partners providing HIV services to get a better sense of current HIV work happening across the PPS. We will also continue to meet with providers, colleagues and stakeholders to ensure that we remain coordinated, sharing challenges and best practices across all providers in order to promote a standard for HIV-providers across the city. Our greatest risk is meeting the needs of this project with limited funding. Many providers have reported that they need additional staff to deliver better care and, although the PPS has funded the largest seven primary care organization partners to build up technical platforms and hire staff, these monies may not directly impact the HIV providers at this time, in particular the original plan indicated embedding Credentialed Alcoholism and Substance Abuse Counselors (CASAC) at care delivery sites, and also providing peer supports. Neither of these roles were explicitly included in the Request for Information (RFI), which was used to determine disbursement of funds to PPS partners Building buy-in among providers of HIV care has been a challenge, as a result of many identifying funding for staff as a significant challenge. To mitigate this risk, we intend to establish peer support programs, particularly in ethnic/racial minority communities, as peers are often more effective in helping patients overcome cultural barriers to care. We will work in collaboration with Health People to ensure any education campaigns directed at community-based HIV awareness, testing, and treatment are evidence-based and relevant to the population. To assess the scope of need for CASACs in care delivery settings, we will work with our clinical and community providers to identify partnership opportunities that can improve access to CASACs in care delivery settings. BPHC will explore how to leverage existing or external resources to improve access to treatment for drug and alcohol abuse among HIV positive individuals.

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Implement evidence based best practices for disease management, specific to HIV and viral load suppression, in community and ambulatory care settings.	In Progress	evidence-based interventions will address the seven sectors selected by the cross-PPS workgroup, addressing: HIV morbidity and disparities and retention to care; peer-led interventions; educational campaigns targeting high-risk populations; Interventions addressing co-factors (e.g., homelessness); training in cultural competency for providers; empowerment of patient population; and interventions for high-risk patients, such as therapy for depression.	08/01/2015	06/30/2017	08/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Create the BPHC HIV Work Group	Completed	BPHC workgroup will be comprised of representatives from partner organizations, including Health Homes (HH), Care Management (CM) agencies, and HIV supportive housing providers to support development of and approve elements of the implementation plan.	08/01/2015	09/30/2015	08/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify evidence-based guidelines	Completed	Identify relevant evidence-based guidelines for HIV and Viral Load Suppression (VLS)	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify DSRIP project requirements related to PCMH elements	Completed	Identify DSRIP project requirements which are related to PCMH elements and incorporate into PCMH strategy and project planning documents	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop budget	Completed	Develop the project implementation budget	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop evidence-based strategies for disease management and control	Completed	Develop evidence-based strategies for the management and control of HIV in the PPS designated area.	10/31/2015	12/31/2015	10/31/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify clinical champions and operational leaders in each participating organization	Completed	Clinical champions and operational leaders from participating organization will develop and lead implementation of the program at each of their providers/sites. These facility-based champions/leaders form the Site-Specific Implementation Team	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Create detailed implementation workplan and timelines	Completed	Develop a workplan and timeline to guide implementation of strategies for the HIV population	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task	Completed	In conjunction with workforce subcommittee, evaluate staffing needs to	12/01/2015	03/31/2016	12/01/2015	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
Design culturally competent training and recruitment strategy		design culturally competent training and recruitment strategy						
Task Obtain approval of implementation workplan and timelines	In Progress	Submit elements of implementation plan to Quality and Care Innovation Sub-Committee (QCIS) for approval	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Disseminate gap analysis tool to providers	Completed	PPrepare and disseminate gap analysis tool based on Clinical Operations Plan to participating providers to determine implementaton support needs	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Hold informational webinar	Completed	Hold webinar for participating partner organizations	01/15/2016	03/31/2016	01/15/2016	03/31/2016	03/31/2016	DY1 Q4
Task Identify partner and target organizations for project implementation	Completed	Identify partner organizations participating in project (sites and CBOs) and target organizations addressing co-existing burdens of high-needs populations, including but not limited to housing, substance abuse, Mental, Emotional and Behavioral health (MEBH), domestic violence, food access, etc.	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Define program elements	Completed	Develop the implementation plan to define the program elements, define the required and suggested components of those elements, and identify relevant resources to achieve them. Elements include health information exchange and technology requirements, and evidence-based guidelines and high-value treatment protocols	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Create a rapid deployment collaborative	In Progress	The rapid deployment collaborative, or implementation workgroup, will be comprised of representatives from partner organizations to support implementation of the implementation plan.	02/01/2016	03/31/2017	02/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop and implement plans for CQI	In Progress	Develop feedback mechansims for accountability and continuous quality improvement and implement in appropriate settings	01/01/2016	06/30/2017	01/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task Regular review of evidence-based guidelines	In Progress	Develop mechanisms for regular review of project-selected evidence-based guidelines to assure our PPS is utilizing the most up-to-date tools and that those updated guidelines/protocols continue to be clinically integrated across the PPS.	04/01/2016	06/30/2017	04/01/2016	06/30/2017	06/30/2017	DY3 Q1
Milestone Participate in a NYC cross-PPS Collaborative	In Progress	Due to the collaborative nature of the HIV interventions, 7 NYC PPSs have convened and aligned sectors of focus for their projects and will continue to collaborate throughout implementation.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify cross-PPS convener	Completed	Participate in contract negotiations with DOHMH to house the cross-PPS collaborative	08/01/2015	09/30/2015	08/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Convener contract Development	Completed	Participate in drafting shared contract with DOHMH	09/01/2015	12/31/2015	09/01/2015	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
Task Convener contract execution	Completed	Participate in getting contract with DOHMH approved and signed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify data sharing needs	Completed	Identify data sharing needs and the resources to support effective data sharing	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Create cross-PPS workplan	Completed	Contribute to development of cross-PPS workplan in alignment with internal BPHC project implementation	10/20/2015	06/30/2016	10/20/2015	06/30/2016	06/30/2016	DY2 Q1
Task Establish cross-PPS milestones	Completed	Establish agreed upon milestones for cross-PPS project implementation	01/15/2016	06/30/2016	01/15/2016	06/30/2016	06/30/2016	DY2 Q1
Task Collaborate with NYCDOHMH to develop and implement broad-based education campaigns	Completed	Collaborate with NYCDOHMH to develop and implement broad-based education campaigns	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Identify population health and data management tools	Completed	Identify existing population health management tools and data interfacing tools within the PPSs	02/01/2016	06/30/2016	02/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Conduct gap analysis	In Progress	Conduct gap analysis on available data and needed data to meet project requirements	03/01/2016	09/30/2016	03/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Conduct gap analysis on available data and needed data to meet project requirements	In Progress	Conduct gap analysis on available data and needed data to meet project requirements	03/01/2016	09/30/2016	03/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Leverage existing capacities	In Progress	As part of overall IT approach, identify strategies, including RHIO use and NYC DOHMH HIV syndromic surveillance data, to leverage existing capacities and resources that will support project requirements and meet population needs	06/01/2016	09/30/2016	06/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Vet cross-PPS projects with rapid deployment collaborative and Executive Committee	In Progress	Vet agreed upon project commonalities and shared resources with relevant BPHC sub-committees and Executive Committee	02/01/2016	03/31/2017	02/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Vet cross-PPS data sharing proposal with BPHC sub-committees and Executive Committee	In Progress	Vet agreed-upon data sharing system to address reporting and implementation needs with relevant BPHC sub-committees and Executive Committee	02/01/2016	03/31/2017	02/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Participate in a cross-PPS HIV Learning	In Progress	Participate in a cross-PPS HIV Learning Collaborative	12/01/2015	03/31/2020	12/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Collaborative								
Milestone Develop adherence protocol and staffing plans	In Progress	Engage with HHs and CM agencies to develop plans for PHM to improve retention in care and medication adherence to support VLS	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Develop workplan for Retention to Care Unit	Completed	Retention to Care Unit will be comprised of Care Managers and peer workers to reach clients who have not achieved VLS, to supplement the care coordination that HHs and their partnering CM agencies are doing.	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Review and develop protocols for evidence-based guidelines	Completed	Engage HHs and CM agencies in HIV workgroup (from milestone 1) to review evidence-based guidelines and develop protocols	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish partnerships	Completed	Establish partnerships with and participation of needed social service agencies and community resources that cover issues such as housing, substance abuse, Mental, Emotional and Behavioral health (MEBH), domestic violence, food access, etc.	02/01/2016	03/31/2016	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Identify sites for VLS intervention implementation	Completed	Identify HHs and CM agencies to implement VLS interventions	04/15/2016	06/30/2016	04/15/2016	06/30/2016	06/30/2016	DY2 Q1
Task Conduct a gap analysis	Completed	Conduct a gap analysis on staffing and resource needs	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Hire and train staff	In Progress	In conjuction with Workforce Subcommittee, recruit, hire and train existing and new staff. Include cultural competence around LGBTQ community and SUD.	05/01/2016	12/31/2016	05/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Recruit peer leaders	Not Started	Identify peer leaders who have achieved VLS to co-facilitate support groups, assist with education and outreach, and act as escorts for apointments	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Establish Retention to Care Unit.	In Progress	Establish Retention to Care Unit with trained staff and peer supports	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Implement interventions	Not Started	Identify and implement interventions targeting high-needs populations	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop and implement plans for CQI	Not Started	Develop feedback mechansims for accountability and continuous quality improvement	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone Utlize EHR and other IT platforms for population health management	In Progress	Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Define population health management requirements	Completed	Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff	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
Task Assess EHR capabilities	Completed	Perform current state assessment of EHR capabilities among participating safety net providers	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform gap analysis	Completed	Perform gap analysis and identify priorities to achieving integration of patient record.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define requirements and elements for patient registry	Completed	Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Vet patient registry proposal with BPHC sub-committees and Executive Committee	Completed	Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify technology and resource requirements for registry	Completed	Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget	Completed	Create budget to build registry and acquire necessary resources	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Secure Care Coordination Management Solution	In Progress	Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries	04/01/2016	06/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Develop project implementation and testing for registry	Completed	Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop training plan and curriculum on registry use	Completed	Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Execute registry testing plan and training program	In Progress	The registry testing plan and training program will target providers and care managers and train them on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.	04/02/2016	06/30/2016	04/02/2016	03/31/2017	03/31/2017	DY2 Q4
Task Issue user credentials and provide trainings on CCMS	Not Started	Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.	07/01/2016	12/31/2016	07/01/2016	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
Task Launch and monitor registry	Not Started	Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone Implement peer-based supports	Not Started	Develop and implement peer-based educational support and self-management programs	07/01/2016	09/30/2017	07/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Hold trainings	Not Started	Hold trainings for providers,care managers and peer support teams on cultural competency, motivational interviewing, and other adherence support strategies.	08/01/2016	12/31/2016	08/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Launch support programs	Not Started	Launch peer educator support programs that focus on adherence to HIV management	02/01/2017	03/31/2017	02/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Provide complementary resources to reinforce trainings	Not Started	Provide follow up support and materials to reinforce training objectives, including connecting clients with case managers/ retention to care unit and screening for barriers to adherence.	03/31/2017	06/30/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1
Task Develop and implement plans for CQI	Not Started	Develop feedback mechanisms for continuous quality improvement	03/03/2017	06/30/2017	03/03/2017	06/30/2017	06/30/2017	DY3 Q1
Task Execute educational campaigns	Not Started	Execute educational campaigns developed in collaboration with cross-PPS collaborative and NYCDOHMH	08/01/2016	06/30/2017	08/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task Identify training curricula	Not Started	In conjunction with BPHC Workforce Subcommittee, identify curricula for training providers, including care managers and peer support teams, on cultural competency, motivational interviewing, and other adherence support strategies. Include cultural competence around LGBTQ community and SUD.	07/01/2016	09/30/2017	07/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone Mid-Point Assessment	Completed	Mid-Point Assessment			06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Mid-Point Assessment	zstopak	Templates	36_DY2Q1_PROJ4cii_MDL4cii2_PPS1550_TEMPL_2a_Mid-Point_Assessment_Project_Narrative_4cii_FINAL_4913.DOCX	Mid-Point Assessment Project Narrative - 4.c.ii HIV	08/02/2016 07:48 PM

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Implement evidence based best practices for disease management, specific to HIV and viral load suppression, in community and ambulatory care settings.	Update: The CSO has been actively engaging partners and the HIV Implementation Work Group (IWG) to develop and implement an evidence- and need-based program around retention to care and viral load suppression. Through this engagement clinical champions have been identified and are participating in the IWG, most notably the IWG Chair, Dr. Ed Telzak, who is Chair of SBH Health Systems' Department of Medicine and former HIV Director at Bronx Lebanon. In the previous quarter the IWG approved a partnership with NY Links of the AIDS Institute to design and implement a Regional Group around performance improvement in HIV care, with a specific emphasis on the State's Prevention Agenda/DSRIP measures. The first regional meeting, which also served as BPHC HIV project official kickoff, took place on June 30, 2016 and over 50 attendees were in attendance representing over 20 organizations. The regional group is inclusive of non-PPS members – all participating regional members can participate in the quality improvement project. In collaboration with NY Links, assessments have been conducted with Bronx Partners for Healthy Communities (BPHC) member organizations that provide HIV care and services. The assessment looked at their current rates for linkage, retention, and viral load suppression and quality improvement work. The assessments will help inform topics and resources developed for future Regional Group meetings and improvement activities. The cross-PPS Coalition is now actively identifying priorities and areas of collaboration which will inform how each PPS will implement their local projects. Additionally, the task, "submit elements of implementation plan and timelines for Quality and Care Innovations Subcommittee approval" was pushed back into DY2Q2 to allow time for more comprehensive assessments to be completed and the project implementation plans developed reflecting participant input. Although tasks must be pushed back to accommodate collaborative planning, this milestone is on track for completion.
Participate in a NYC cross-PPS Collaborative	Update: The New York City Department of Health and Mental Hygiene (DOHMH) will act as convener for the cross-PPS HIV Coalition. Bronx Partners for Healthy Communities (BPHC) is actively participating in meetings with the cross-PPS HIV Coalition. The cross-PPS Coalition is currently working towards establishing standing committees around topics where the PPSs can collaborate. These committees will decide how the PPSs will work together and develop associated workplans. The DSRIP HIV Coalition holds quarterly membership meetings, additionally standing committees have been developed to launch learning labs around project implementation. There will be Standing Committees for each of the following topics: Viral Load Suppression, data usage, HIV testing and linkage, peer workforce development, and PrEP implementation. For the data usage standing committee, the City University of New York School of Public Health will provide a series of presentations around data usage for Viral Load Suppression interventions, which will be available online. This milestone is on track for completion.
Develop adherence protocol and staffing plans	Update: HIV Health Home and Care Management providers have been invited to join the HIV Implementation Work Group (IWG). Representation from Montefiore, Albert Einstein, Morris Heights Health Center, SBH Health System that participate in the Bronx Accountable Health Network (BAHN) Health Home are members of the IWG. The downstream care management agencies (CMAs) are also represented by Morris Heights Health Center, Montefiore Medical Center, Institute for Family Health, and Boom! Health are also members of the IWG to provide oversight and guidance on project development and implementation. Additionally, a Health Home Work Group has been established to address health home needs across DSRIP projects. Issues like establishing a retention to care unit and conducting staffing analyses at respective practices and organizations will be addressed through the quality improvement project with NY Links. NY Links will provide guidance and technical support to participants on implementing improvement projects and strategies. BPHC is working closely with its ACO partners and has undertaken a process to engage Health Homes in the Integrated Delivery System, utilizing existing capabilities to deepen PPS-wide clinical integration. The Vice President of Montefiore's Pioneer ACO is a member of BPHC's Executive Committee and our work is informed by Pioneer's experience building an integrated care management network. This milestone is on track for completion.
Utlize EHR and other IT platforms for population health management	We are executing a comprehensive plan to support our safety net providers in obtaining Meaningful Use (MU) and Patient-Centered Medical Home (PCMH) certification, which includes the use of targeted patient registries in conjunction with our clinical projects. We have a strategy in place for care management which includes the uses of registries, EHRs, Care Coordination Management Systems, and referral tracking systems. Our major partners which account for 87% of BPHC PCPs and 81% of non-PCPs, are already sharing clinical data to varying degrees with the Bronx RHIO and anticipate the quality and quantity of this data to increase. We reviewed DSRIP performance measures and Quality and Care Innovations Subcommittee recommended registry fields, and have been working with BxRHIO to further define which are most feasible to build out and release to our largest partners in DY2. Bronx RHIO has conducted a gap analysis on data currently in the RHIO and identified missing and other data quality issues relevant to those initial proxy measures and registries. Bronx RHIO had already begun development of Spectrum, its population health management (PHM) and analytics tool, which the PPS will utilize as part of our PHM solution. Though still in development this quarter, we obtained accounts and initial training on Spectrum for key staff in the CSO to begin understanding it. We are also simultaneously exploring potentials to utilize the MAPP/Salient resources to use as additional PHM source to understand the population we serve and their utilization patterns. Furthermore, we are actively pursuing to improve consent rates for Bronx RHIO and initiated a data use agreement (DUA) where each

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
	partner allows the Bronx RHIO to share their data with BPHC to create an environment where PHM will be more comprehensively implemented. We are confident that we are also close to securing a Care Coordination and Management System (CCMS) for the PPS. BPHC also deployed a rapid cycle evaluation (RCE) process and selected initial set of key process measures to support our implementation progress. The milestone is on track for completion.
Implement peer-based supports	There is currently no narrative around this milestone and its associated tasks, as the start date is DY2Q2 and is currently on hold.
Mid-Point Assessment	

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IPQR Module 4.c.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 'SBH Health System', 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:	ST BARNABAS HOSPITAL
Secondary Lead PPS Provider:	
Lead Representative:	Leonard T Walsh
Submission Date:	09/19/2016 11:43 AM
Comments:	

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Status Log				
Quarterly Report (DY,Q)	**Status**	**Lead Representative Name**	**User ID**	**Date Timestamp**
DY2, Q1	Adjudicated	Leonard T Walsh	jfraher	09/30/2016 03:36 PM

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Comments Log			
Status	**Comments**	**User ID**	**Date Timestamp**
Adjudicated	The IA has adjudicated the DY2 Q1 quarterly report.	jfraher	09/30/2016 03:36 PM
Adjudicated	The IA has adjudicated the DY2 Q1 quarterly report.	jfraher	09/30/2016 03:36 PM
Returned	The IA had returned the DY2, Q1 Quarterly Report for Remediation.	sacolema	09/02/2016 03:55 PM

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Section	Module Name	Status
Section 01	IPQR Module 1.1 - PPS Budget - Waiver Revenue (Baseline) - READ ONLY	Completed
	IPQR Module 1.2 - PPS Budget - Waiver Revenue (Quarterly)	Completed
	IPQR Module 1.3 - PPS Flow of Funds - Waiver Revenue (Baseline) - READ ONLY	Completed
	IPQR Module 1.4 - PPS Flow of Funds - Waiver Revenue (Quarterly)	Completed
	IPQR Module 1.5 - Prescribed Milestones	Completed
	IPQR Module 1.6 - PPS Defined Milestones	Completed
	IPQR Module 1.7 - PPS Budget - Non-Waiver Revenue (Baseline)	Completed
	IPQR Module 1.8 - PPS Budget - Non-Waiver Revenue (Quarterly)	Completed
	IPQR Module 1.9 - PPS Flow of Funds - Non-Waiver Revenue (Baseline)	Completed
	IPQR Module 1.10 - PPS Flow of Funds - Non-Waiver Revenue (Quarterly)	Completed
	IPQR Module 1.11 - 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

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Section	Module Name	Status
	IPQR Module 3.8 - Progress Reporting	Completed
	IPQR Module 3.9 - IA Monitoring	
Section 04	IPQR Module 4.1 - Prescribed Milestones	Completed
	IPQR Module 4.2 - PPS Defined Milestones	Completed
	IPQR Module 4.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 4.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 4.5 - Roles and Responsibilities	Completed
	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

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Section	Module Name	Status
	IPQR Module 7.2 - PPS Defined Milestones	Completed
	IPQR Module 7.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 7.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 7.5 - Roles and Responsibilities	Completed
	IPQR Module 7.6 - Key Stakeholders	Completed
	IPQR Module 7.7 - IT Expectations	Completed
	IPQR Module 7.8 - Progress Reporting	Completed
	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

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Section	Module Name	Status
	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	
Section 11	IPQR Module 11.1 - Workforce Strategy Spending (Baseline)	Completed
	IPQR Module 11.2 - Prescribed Milestones	Completed
	IPQR Module 11.3 - PPS Defined Milestones	Completed
	IPQR Module 11.4 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 11.5 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 11.6 - Roles and Responsibilities	Completed
	IPQR Module 11.7 - Key Stakeholders	Completed
	IPQR Module 11.8 - IT Expectations	Completed
	IPQR Module 11.9 - Progress Reporting	Completed
	IPQR Module 11.10 - Staff Impact	Completed
	IPQR Module 11.11 - Workforce Strategy Spending (Quarterly)	Completed
	IPQR Module 11.12 - 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.a.iii	IPQR Module 2.a.iii.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 2.a.iii.2 - Patient Engagement Speed	Completed
	IPQR Module 2.a.iii.3 - Prescribed Milestones	Completed
	IPQR Module 2.a.iii.4 - PPS Defined Milestones	Completed
	IPQR Module 2.a.iii.5 - IA Monitoring	
2.b.iii	IPQR Module 2.b.iii.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 2.b.iii.2 - Patient Engagement Speed	Completed
	IPQR Module 2.b.iii.3 - Prescribed Milestones	Completed
	IPQR Module 2.b.iii.4 - PPS Defined Milestones	Completed
	IPQR Module 2.b.iii.5 - IA Monitoring	
2.b.iv	IPQR Module 2.b.iv.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 2.b.iv.2 - Patient Engagement Speed	Completed
	IPQR Module 2.b.iv.3 - Prescribed Milestones	Completed
	IPQR Module 2.b.iv.4 - PPS Defined Milestones	Completed
	IPQR Module 2.b.iv.5 - IA Monitoring	
3.a.i	IPQR Module 3.a.i.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 3.a.i.2 - Patient Engagement Speed	Completed
	IPQR Module 3.a.i.3 - Prescribed Milestones	Completed
	IPQR Module 3.a.i.4 - PPS Defined Milestones	Completed
	IPQR Module 3.a.i.5 - IA Monitoring	
3.b.i	IPQR Module 3.b.i.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 3.b.i.2 - Patient Engagement Speed	Completed
	IPQR Module 3.b.i.3 - Prescribed Milestones	Completed

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

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Section	Module Name / Milestone #	Review Status	
Section 01	Module 1.1 - PPS Budget - Waiver Revenue (Baseline) - READ ONLY	Pass & Ongoing	
	Module 1.2 - PPS Budget - Waiver Revenue (Quarterly)	Pass & Ongoing	
	Module 1.3 - PPS Flow of Funds - Waiver Revenue (Baseline) - READ ONLY	Pass & Ongoing	
	Module 1.4 - PPS Flow of Funds - Waiver Revenue (Quarterly)	Pass & Ongoing	
	Module 1.5 - Prescribed Milestones		
	Milestone #1 Complete funds flow budget and distribution plan and communicate with network	Pass & Complete	
	Module 1.7 - PPS Budget - Non-Waiver Revenue (Baseline)	Pass & Ongoing	
	Module 1.8 - PPS Budget - Non-Waiver Revenue (Quarterly)	Pass & Ongoing	
	Module 1.9 - PPS Flow of Funds - Non-Waiver Revenue (Baseline)	Pass & Ongoing	
	Module 1.10 - PPS Flow of Funds - Non-Waiver Revenue (Quarterly)	Pass & Ongoing	
Section 02	Module 2.1 - Prescribed Milestones		
	Milestone #1 Finalize governance structure and sub-committee structure	Pass & Complete	
	Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Pass & Complete	
	Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	Pass & Complete	
	Milestone #4 Establish governance structure reporting and monitoring processes	Pass & Complete	
	Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	Pass & Complete	
	Milestone #6 Finalize partnership agreements or contracts with CBOs	Pass & Complete	
	Milestone #7 Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	Pass & Ongoing	
	Milestone #8 Finalize workforce communication and engagement plan	Pass & Complete	
	Milestone #9 Inclusion of CBOs in PPS Implementation.	Pass & Complete	
Section 03	Module 3.1 - Prescribed Milestones		
	Milestone #1 Finalize PPS finance structure, including reporting structure	Pass & Complete	

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Section	Module Name / Milestone #	Review Status	
	Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	Pass & Complete	
	Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Pass & Complete	
	Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	Pass & Ongoing	
	Milestone #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	Pass & Ongoing	
	Milestone #6 Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	Pass & Ongoing	
	Milestone #7 Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	Pass & Ongoing	
	Milestone #8 >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	Pass & Ongoing	
Section 04	Module 4.1 - Prescribed Milestones		
	Milestone #1 Finalize cultural competency / health literacy strategy.	Pass & Complete	
	Milestone #2 Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	Pass & Complete	
Section 05	Module 5.1 - Prescribed Milestones		
	Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	Pass & Complete	
	Milestone #2 Develop an IT Change Management Strategy.	Pass & Complete	
	Milestone #3 Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	Pass & Ongoing	
	Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	Pass & Complete	
	Milestone #5 Develop a data security and confidentiality plan.	Pass & Complete	
Section 06	Module 6.1 - Prescribed Milestones		
	Milestone #1 Establish reporting structure for PPS-wide performance reporting and communication.	Pass & Complete	
	Milestone #2 Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	Pass & Complete	
Section 07	Module 7.1 - Prescribed Milestones		
	Milestone #1 Develop Practitioners communication and engagement plan.	Pass & Complete	
	Milestone #2 Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	Pass & Complete	
Section 08	Module 8.1 - Prescribed Milestones		

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Section	Module Name / Milestone #	Review Status	
	Milestone #1 Develop population health management roadmap.	Pass & Ongoing	
	Milestone #2 Finalize PPS-wide bed reduction plan.	Pass & Ongoing	
Section 09	Module 9.1 - Prescribed Milestones		
	Milestone #1 Perform a clinical integration 'needs assessment'.	Pass & Complete	
	Milestone #2 Develop a Clinical Integration strategy.	Pass & Complete	
Section 11	Module 11.1 - Workforce Strategy Spending (Baseline)	Pass & Complete	
	Module 11.2 - Prescribed Milestones		
	Milestone #1 Define target workforce state (in line with DSRIP program's goals).	Pass & Ongoing	
	Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	Pass & Ongoing	
	Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	Pass & Ongoing	
	Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	Pass & Complete	
	Milestone #5 Develop training strategy.	Pass & Ongoing	
	Module 11.10 - Staff Impact	Pass & Ongoing	
	Module 11.11 - Workforce Strategy Spending (Quarterly)	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
2.a.i	Module 2.a.i.2 - Prescribed Milestones		
	Milestone #1 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.	Pass & Ongoing	
	Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	Pass & Complete	
	Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	Pass & Ongoing	
	Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	Pass & Ongoing	
	Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Pass & Ongoing	
	Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Pass & Ongoing	
	Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	Pass & Ongoing	
	Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	Pass & Ongoing	
	Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	Pass & Ongoing	
	Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	Pass & Ongoing	
	Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	Pass & Ongoing	
2.a.iii	Module 2.a.iii.2 - Patient Engagement Speed	Pass (with Exception) & Ongoing	
	Module 2.a.iii.3 - Prescribed Milestones		
	Milestone #1 Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.	Pass & Ongoing	
	Milestone #2 Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #3 Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.	Pass & Ongoing	
	Milestone #4 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.	Pass & Ongoing	
	Milestone #5 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Pass & Ongoing	
	Milestone #6 Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.	Pass & Ongoing	
	Milestone #7 Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.	Pass & Ongoing	
	Milestone #8 Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).	Pass & Ongoing	
	Milestone #9 Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.	Pass & Ongoing	
2.b.iii	Module 2.b.iii.2 - Patient Engagement Speed	Pass (with Exception) & Ongoing	
	Module 2.b.iii.3 - Prescribed Milestones		
	Milestone #1 Establish ED care triage program for at-risk populations	Pass & Ongoing	
	Milestone #2 Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable	Pass & Ongoing	
	Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	Pass & Ongoing	
	Milestone #4 Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)	Pass & Ongoing	
	Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
2.b.iv	Module 2.b.iv.2 - Patient Engagement Speed	Pass (with Exception) & Ongoing	
	Module 2.b.iv.3 - Prescribed Milestones		
	Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	Pass & Ongoing	
	Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	Pass & Ongoing	
	Milestone #3 Ensure required social services participate in the project.	Pass & Ongoing	
	Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	Pass & Ongoing	
	Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Pass & Ongoing	
	Milestone #6 Ensure that a 30-day transition of care period is established.	Pass & Ongoing	
	Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
3.a.i	Module 3.a.i.2 - Patient Engagement Speed	Pass (with Exception) & Ongoing	
	Module 3.a.i.3 - Prescribed Milestones		
	Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Pass & Ongoing	
	Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Pass & Ongoing	
	Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Pass & Ongoing	
	Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #5 Co-locate primary care services at behavioral health sites.	Pass & Ongoing	
	Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Pass & Ongoing	
	Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Pass & Ongoing	
	Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #9 Implement IMPACT Model at Primary Care Sites.	Pass & Ongoing	
	Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Pass & Ongoing	
	Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Pass & Ongoing	

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	Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	Pass & Ongoing	
	Milestone #13 Measure outcomes as required in the IMPACT Model.	Pass & Ongoing	
	Milestone #14 Provide "stepped care" as required by the IMPACT Model.	Pass & Ongoing	
	Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
3.b.i	Module 3.b.i.2 - Patient Engagement Speed	Pass (with Exception) & Ongoing	
	Module 3.b.i.3 - Prescribed Milestones		
	Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Pass & Ongoing	
	Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	Pass & Ongoing	
	Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Pass & Ongoing	
	Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	Pass & Ongoing	
	Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	Pass & Ongoing	
	Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Pass & Ongoing	
	Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	Pass & Ongoing	
	Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	Pass & Ongoing	
	Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	Pass & Ongoing	
	Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	Pass & Ongoing	
	Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	Pass & Ongoing	
	Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	Pass & Ongoing	
	Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	Pass & Ongoing	
	Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status
	Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	Pass & Ongoing
	Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	Pass & Ongoing
	Milestone #18 Adopt strategies from the Million Hearts Campaign.	Pass & Ongoing
	Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	Pass & Ongoing
	Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	Pass & Ongoing
3.c.i	Module 3.c.i.2 - Patient Engagement Speed	Pass (with Exception) & Ongoing
	Module 3.c.i.3 - Prescribed Milestones	
	Milestone #1 Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.	Pass & Ongoing
	Milestone #2 Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.	Pass & Ongoing
	Milestone #3 Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.	Pass & Ongoing
	Milestone #4 Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.	Pass & Ongoing
	Milestone #5 Ensure coordination with the Medicaid Managed Care organizations serving the target population.	Pass & Ongoing
	Milestone #6 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing
	Milestone #7 Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.	Pass & Ongoing
3.d.ii	Module 3.d.ii.2 - Patient Engagement Speed	Pass (with Exception) & Ongoing
	Module 3.d.ii.3 - Prescribed Milestones	
	Milestone #1 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	Pass & Ongoing
	Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	Pass & Ongoing
	Milestone #3 Develop and implement evidence-based asthma management guidelines.	Pass & Ongoing
	Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	Pass & Ongoing

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #5 Ensure coordinated care for asthma patients includes social services and support.	Pass & Ongoing	
	Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	Pass & Ongoing	
	Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	Pass & Ongoing	
	Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
4.a.iii	Module 4.a.iii.2 - PPS Defined Milestones	Pass & Ongoing	
4.c.ii	Module 4.c.ii.2 - PPS Defined Milestones	Pass & Ongoing	

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Providers Participating in Projects

	Selected Projects										
	Project 2.a.i	**Project 2.a.iii**	**Project 2.b.iii**	**Project 2.b.iv**	**Project 3.a.i**	**Project 3.b.i**	**Project 3.c.i**	**Project 3.d.ii**	**Project 4.a.iii**	**Project 4.c.ii**	**Project**
Provider Speed Commitments	DY4 Q4	DY3 Q4	DY3 Q4	DY3 Q2	DY4 Q2	DY3 Q4	DY3 Q4	DY3 Q2			

Provider Category		**Project 2.a.i**		**Project 2.a.iii**		**Project 2.b.iii**		**Project 2.b.iv**		**Project 3.a.i**		**Project 3.b.i**		**Project 3.c.i**		**Project 3.d.ii**		**Project 4.a.iii**		**Project 4.c.ii**		**Project**	
		Selected	**Committed**	**Selected**	**Committed**	**Selected**	**Committed**	**Selected**	**Committed**	**Selected**	**Committed**	**Selected**	**Committed**	**Selected**	**Committed**	**Selected**	**Committed**	**Selected**	**Committed**	**Selected**	**Committed**	**Selected**	**Committed**
Practitioner - Primary Care Provider (PCP)	Total	577	889	528	711	574	0	574	711	523	756	569	469	574	469	574	711	504	0	540	0	0	0
	Safety Net	279	301	260	256	279	301	279	256	259	205	275	180	277	180	277	256	245	0	265	0	0	0
Practitioner - Non-Primary Care Provider (PCP)	Total	2,006	3,130	1,593	1,878	1,946	0	1,946	2,504	1,593	782	1,901	1,721	1,999	1,721	1,999	1,721	1,984	0	1,999	0	0	0
	Safety Net	410	726	336	617	403	0	403	617	335	181	391	399	410	399	410	399	405	0	410	0	0	0
Hospital	Total	2	3	1	0	2	0	2	3	1	0	2	0	2	0	2	0	2	0	2	0	0	0
	Safety Net	2	4	1	0	2	3	2	4	1	0	2	0	2	0	2	0	2	0	2	0	0	0
Clinic	Total	4	24	4	24	4	0	4	0	4	18	4	18	4	18	4	18	2	0	4	0	0	0
	Safety Net	4	25	4	25	4	25	4	0	4	25	4	25	4	25	4	25	2	0	4	0	0	0
Case Management / Health Home	Total	0	16	0	16	0	0	0	16	0	0	0	16	0	16	0	16	0	0	0	0	0	0
	Safety Net	0	7	0	7	0	9	0	7	0	0	0	7	0	9	0	9	0	0	0	0	0	0
Mental Health	Total	0	308	0	231	0	0	0	0	0	185	0	115	0	115	0	0	0	0	0	0	0	0
	Safety Net	0	83	0	83	0	0	0	0	0	58	0	36	0	36	0	0	0	0	0	0	0	0
Substance Abuse	Total	0	30	0	30	0	0	0	0	0	30	0	24	0	15	0	0	0	0	0	0	0	0
	Safety Net	0	30	0	30	0	0	0	0	0	30	0	24	0	24	0	0	0	0	0	0	0	0
Nursing Home	Total	0	35	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Safety Net	0	34	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy	Total	0	7	0	7	0	0	0	0	0	0	0	7	0	7	0	7	0	0	0	0	0	0
	Safety Net	0	5	0	5	0	0	0	0	0	0	0	5	0	5	0	5	0	0	0	0	0	0
Hospice	Total	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

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Provider Category		Project 2.a.i		Project 2.a.iii		Project 2.b.iii		Project 2.b.iv		Project 3.a.i		Project 3.b.i		Project 3.c.i		Project 3.d.ii		Project 4.a.iii		Project 4.c.ii		Project	
		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed	
	Safety Net	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Based Organizations	Total	0	46	0	46	0	0	0	46	0	41	0	49	1	41	1	41	0	0	0	0	0	0
	Safety Net	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
All Other	Total	0	1,773	0	203	0	0	0	532	0	532	0	532	0	532	0	532	0	0	0	0	0	0
	Safety Net	0	677	0	203	0	0	0	203	0	203	0	121	0	121	0	121	0	0	0	0	0	0
Uncategorized	Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Safety Net	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Additional Providers	Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Safety Net	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

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