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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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Quarterly Report - Implementation Plan for Care Compass Network

Year and Quarter: DY2, Q3 **Quarterly Report Status:** Adjudicated

Status By Section

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

Status By Project

Project ID	Project Title	Status
2.a.i	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management	Completed
2.b.iv	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions	Completed
2.b.vii	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)	Completed
2.c.i	Development of community-based health navigation services	Completed
2.d.i	Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care	Completed
3.a.i	Integration of primary care and behavioral health services	Completed
3.a.ii	Behavioral health community crisis stabilization services	Completed
3.b.i	Evidence-based strategies for disease management in high risk/affected populations (adult only)	Completed
3.g.i	Integration of palliative care into the PCMH Model	Completed
4.a.iii	Strengthen Mental Health and Substance Abuse Infrastructure across Systems	Completed
4.b.ii	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer	Completed

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Section 01 – Budget

IPQR Module 1.1 - PPS Budget - 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	33,827,204	36,048,681	58,295,242	51,620,214	33,827,204	213,618,544
Cost of Project Implementation & Administration	**5,241,298**	**18,757,727**	**29,765,197**	**26,024,102**	**17,952,275**	**97,740,599**
Administration	3,062,649	3,972,040	4,079,485	4,174,969	4,256,334	19,545,477
Implementation	2,178,649	14,785,687	25,685,712	21,849,133	13,695,941	78,195,122
Revenue Loss	**0**	**6,143,640**	**12,287,279**	**18,430,919**	**24,574,558**	**61,436,396**
Hospitals	0	5,644,310	11,288,620	16,932,930	22,577,240	56,443,100
Physicians	0	499,330	998,659	1,497,989	1,997,318	4,993,296
Internal PPS Provider Bonus Payments	**469,388**	**3,959,184**	**4,693,878**	**5,000,000**	**5,877,551**	**20,000,001**
Cost of non-covered services	**0**	**0**	**0**	**0**	**0**	**0**
Other	**244,447**	**3,239,498**	**6,777,237**	**13,419,772**	**12,965,546**	**36,646,500**
Expected Loss Due to Unmet Goals	206,947	3,189,498	5,531,404	8,586,439	8,132,213	25,646,501
Contingency/Sustainability	37,500	50,000	1,245,833	4,833,333	4,833,333	10,999,999
Total Expenditures	**5,955,133**	**32,100,049**	**53,523,591**	**62,874,793**	**61,369,930**	**215,823,496**
Undistributed Revenue	**27,872,071**	**3,948,632**	**4,771,651**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Updates have been made to the baseline budget to reflect actual expenses through DY1Q3 and expected DY1Q4 expenses. For DY2 - DY5, the baseline budget now reflects the CCN approved budget from 10/13/2015.

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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
36,048,681	213,618,544	30,524,854	205,058,958

Budget Items	DY2 Q3 Quarterly Amount - Update	Cumulative Spending to Date (DY1 - DY5)	Remaining Balance in Current DY	Percent Remaining in Current DY	Cumulative Remaining Balance	Percent Remaining of Cumulative Balance
Cost of Project Implementation & Administration	**1,520,158**	**6,773,737**	**14,812,802**	**78.97%**	**90,966,862**	**93.07%**
Administration	1,139,616					
Implementation	380,542					
Revenue Loss	**0**	**0**	**6,143,640**	**100.00%**	**61,436,396**	**100.00%**
Hospitals	0					
Physicians	0					
Internal PPS Provider Bonus Payments	**1,003,150**	**1,218,094**	**2,741,090**	**69.23%**	**18,781,907**	**93.91%**
Cost of non-covered services	**0**	**0**	**0**		**0**	
Other	**0**	**567,755**	**2,878,690**	**88.86%**	**36,078,745**	**98.45%**
Expected Loss Due to Unmet Goals	0					
Contingency/Sustainability	0					
Total Expenditures	**2,523,308**	**8,559,586**				

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

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Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

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Care Compass Network (PPS ID:44)

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	33,827,204	36,048,681	58,295,242	51,620,214	33,827,204	213,618,544
Practitioner - Primary Care Provider (PCP)	60,728	305,789	373,921	380,333	217,455	1,338,226
Practitioner - Non-Primary Care Provider (PCP)	12,714	640,387	1,323,184	1,733,037	3,260,761	6,970,083
Hospital	414,685	7,975,729	17,100,315	21,758,322	40,015,516	87,264,567
Clinic	480,534	1,653,319	3,438,003	3,420,988	4,010,420	13,003,264
Case Management / Health Home	163,932	576,725	1,068,056	1,056,864	1,034,724	3,900,301
Mental Health	398,166	1,463,205	2,849,748	2,843,375	3,184,536	10,739,030
Substance Abuse	151,317	520,397	1,015,037	1,011,200	1,081,270	3,779,221
Nursing Home	116,010	251,164	430,329	587,594	869,967	2,255,064
Pharmacy	20,066	145,117	189,376	186,992	176,888	718,439
Hospice	263,735	817,689	1,880,904	1,794,261	2,393,974	7,150,563
Community Based Organizations	566,151	4,395,348	6,854,357	4,363,445	6,333,458	22,512,759
All Other	0	0	0	0	0	0
Uncategorized						0
PPS PMO	3,062,649	3,972,040	4,079,485	4,174,969	4,256,334	19,545,477
Total Funds Distributed	**5,710,687**	**22,716,909**	**40,602,715**	**43,311,380**	**66,835,303**	**179,176,994**
Undistributed Revenue	**28,116,517**	**13,331,772**	**17,692,527**	**8,308,834**	**0**	**34,441,550**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

The modified funds flow tables now represent funds disbursed based on the October 13th, 2015 budget approved by the CCN Board of Directors.

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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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
36,048,681.00	213,618,544.00	31,111,239.75	208,180,739.75

Funds Flow Items	DY2 Q3 Quarterly Amount - Update	Percentage of Safety Net Funds - DY2 Q3 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.b.iv	2.b.vi i	2.c.i	2.d.i	3.a.i	3.a.ii	3.b.i	3.g.i	4.a.iii	4.b.ii		
Practitioner - Primary Care Provider (PCP)	0	0.00%	0	0.00%	0	0	0	0	0	0	0	0	0	0	0	0	305,789	1,338,226
Practitioner - Non-Primary Care Provider (PCP)	0	0.00%	0	0.00%	0	0	0	0	0	0	0	0	0	0	0	0	640,387	6,970,083
Hospital	980,824.25	100.00%	991,654.25	100.00%	991,654.25	93.3	1.59	.21	1.77	.08	3.04	0	0	0	0	0	6,984,074.75	86,272,912.75
Clinic	85,900	100.00%	91,155	100.00%	91,155	98.58	0	0	0	1.42	0	0	0	0	0	0	1,562,164	12,912,109
Case Management / Health Home	37,778	100.00%	37,778	100.00%	37,778	95.66	0	0	1.76	2.58	0	0	0	0	0	0	538,947	3,862,523
Mental Health	82,188	100.00%	86,585.50	100.00%	86,585.50	76	0	0	1.49	2.3	20.21	0	0	0	0	0	1,376,619.50	10,652,444.50
Substance Abuse	45,990	100.00%	52,720	100.00%	52,720	0	0	0	0	0	100	0	0	0	0	0	467,677	3,726,501
Nursing Home	31,230	100.00%	48,495	100.00%	48,495	40.03	0	59.97	0	0	0	0	0	0	0	0	202,669	2,206,569
Pharmacy	30,377.50	100.00%	33,537.50	100.00%	33,537.50	96.3	0	0	2.84	.86	0	0	0	0	0	0	111,579.50	684,901.50
Hospice	22,052	0.00%	0	0.00%	22,052	11.34	2.36	0	0	0	0	0	0	86.31	0	0	795,637	7,128,511
Community Based Organizations	118,646.50	0.00%	0	0.00%	139,904	70.14	0	0	22.13	3.91	2.13	1.69	0	0	0	0	4,255,444	22,372,855
All Other	54,026	25.56%	23,154	36.54%	63,371	22.51	2.04	0	.18	.84	0	0	74.44	0	0	0	0	0
Uncategorized	4,529	0.00%	1,040	0.98%	105,769	57.83	0	0	0	0	0	42.17	0	0	0	0	0	0
Additional Providers	0	0.00%	0	0.00%	0													
PPS PMO	1,139,616	100.00%	3,264,420	100.00%	3,764,783												707,620	15,780,694
Total	**2,633,157.25**	**92.96%**	**4,630,539.25**	**93.78%**	**5,437,804.25**													

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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.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

New York State Department Of Health
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* Safety Net Providers in Green

Waiver Quarterly Update Amount By Provider		
Provider Name	**Provider Category**	**DY2Q3**
Practitioner - Primary Care Provider (PCP)		**0**
	Practitioner - Primary Care Provider (PCP)	0
Practitioner - Non-Primary Care Provider (PCP)		**0**
	Practitioner - Non-Primary Care Provider (PCP)	0
Hospital		**980,824.25**
Our Lady Of Lourdes Mem	Hospital	280,810
Corning Hosp	Hospital	156,429.25
Cortland Reg Med Ctr	Hospital	87,685
Cayuga Medical Ctr/Ithaca	Hospital	184,000
United Health Serv Hosp Inc	Hospital	271,900
Clinic		**85,900**
Planned Parenthood So Finger Lakes	Clinic	17,028
Planned Prthd So Central Ny	Clinic	26,000
Family Hlth Netwrk Central Ny	Clinic	42,872
Case Management / Health Home		**37,778**
Catholic Charities Cortland	Case Management / Health Home	35,278
Liberty Resources Inc	Case Management / Health Home	2,500
Mental Health		**82,188**
Chenango Cty Community Sv Brd	Mental Health	5,292.50
Delaware Cnty Comm Svc Board	Mental Health	7,398
Catholic Charities Chenango	Mental Health	22,457
Family And Childrens Society Inc	Mental Health	24,512.50
Family Counsel Svc Cortland	Mental Health	22,528
Substance Abuse		**45,990**
Alcohol & Sub Abuse Tompkins	Substance Abuse	45,990
Nursing Home		**31,230**
Ideal Senior Living Ctr Snf	Nursing Home	4,555
James G Johnston Mem Snf	Nursing Home	3,330
Chase Memorial Nur Home In Co	Nursing Home	5,680

* Safety Net Providers in Green

Waiver Quarterly Update Amount By Provider		
Provider Name	**Provider Category**	**DY2Q3**
Good Shepherd-Fairview Hm Inc	Nursing Home	4,580
Bridgewater Ctr Rehab & Nrs	Nursing Home	1,200
Absolut Ct Nr & Reh At Endicott	Nursing Home	3,875
Vestal Rehabilitation & Nursing Ctr	Nursing Home	4,580
Elizabeth Church Manor Nh Inc	Nursing Home	3,430
Pharmacy		**30,377.50**
Geroulds Prof Pharm Inc	Pharmacy	30,377.50
Hospice		**22,052**
Southern Tier Hospice/Pall Ca	Hospice	22,052
Community Based Organizations		**118,646.50**
Chenango Health Network, Inc.	Community Based Organizations	10,720
Ywca Binghamton & Broome County	Community Based Organizations	8,225
Mothers And Babies Perinatal Network Of Scny, Inc.	Community Based Organizations	22,875
Family Medicine Associates Of Ithaca	Community Based Organizations	20,424
Alcohol And Drug Abuse Council Of Delaware County	Community Based Organizations	5,225
Rural Health Network Of South Central New York, Inc.	Community Based Organizations	31,500
Suicide Prevention And Crisis Service	Community Based Organizations	4,510
Cayuga Area Preferred	Community Based Organizations	7,017.50
Cayuga Medical Associates, Inc	Community Based Organizations	2,530
S2ay Rural Health Network	Community Based Organizations	2,860
Cornerstone Family Healthcare	Community Based Organizations	2,760
All Other		**54,026**
Elder Choice Inc	All Other	2,630
Guthrie Clinic Ltd	All Other	40,217
Vns Ithaca & Tompkins Co Inc	All Other	8,259
Jm Murray Center Inc Smp	All Other	2,920
Uncategorized		**4,529**
Mental Health Association Of The Southern Tier, Inc.	Uncategorized	4,529

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* Safety Net Providers in Green

Waiver Quarterly Update Amount By Provider			
Provider Name	**Provider Category**	**IA Provider Approval/Rejection Indicator**	**DY2Q3**
Additional Providers			**0**
	Additional Providers		0

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

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
plan to PPS Network partners.									
Task Step 8 - Hold education sessions for PPS partners on the funds flow and distribution plan in order to promote transparency and build trust among the network.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

Milestone Review Status

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

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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	0	0	0	0	0	0
Cost of Project Implementation & Administration	**0**	**0**	**0**	**0**	**0**	**0**
Administration	0	0	0	0	0	0
Implementation	0	0	0	0	0	0
Revenue Loss	**0**	**0**	**0**	**0**	**0**	**0**
Internal PPS Provider Bonus Payments	**0**	**0**	**0**	**0**	**0**	**0**
Cost of non-covered services	**0**	**0**	**0**	**0**	**0**	**0**
Other	**0**	**0**	**0**	**0**	**0**	**0**
Total Expenditures	**0**	**0**	**0**	**0**	**0**	**0**
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 :

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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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
0	0	0	0

Budget Items	DY2 Q3 Quarterly Amount - Update	Cumulative Spending to Date (DY1 - DY5)	Remaining Balance in Current DY	Percent Remaining in Current DY	Cumulative Remaining Balance	Percent Remaining of Cumulative Balance
Cost of Project Implementation & Administration	**0**	**0**	**0**		**0**	
Administration	0					
Implementation	0					
Revenue Loss	**0**	**0**	**0**		**0**	
Internal PPS Provider Bonus Payments	**0**	**0**	**0**		**0**	
Cost of non-covered services	**0**	**0**	**0**		**0**	
Other	**0**	**0**	**0**		**0**	
Total Expenditures	**0**	**0**				

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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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	0	0	0	0	0	0
Practitioner - Primary Care Provider (PCP)	0	0	0	0	0	0
Practitioner - Non-Primary Care Provider (PCP)	0	0	0	0	0	0
Hospital	0	0	0	0	0	0
Clinic	0	0	0	0	0	0
Case Management / Health Home	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0
Substance Abuse	0	0	0	0	0	0
Nursing Home	0	0	0	0	0	0
Pharmacy	0	0	0	0	0	0
Hospice	0	0	0	0	0	0
Community Based Organizations	0	0	0	0	0	0
All Other	0	0	0	0	0	0
Uncategorized	0	0	0	0	0	0
PPS PMO	0	0	0	0	0	0
Total Funds Distributed	**0**	**0**	**0**	**0**	**0**	**0**
Undistributed Non-Waiver 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 :

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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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
0.00	0.00	0.00	0.00

Funds Flow Items	DY2 Q3 Quarterly Amount - Update	Percentage of Safety Net Funds - DY2 Q3 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	0.00%	0	0.00%	0	0	0
Practitioner - Non-Primary Care Provider (PCP)	0	0.00%	0	0.00%	0	0	0
Hospital	0	0.00%	0	0.00%	0	0	0
Clinic	0	0.00%	0	0.00%	0	0	0
Case Management / Health Home	0	0.00%	0	0.00%	0	0	0
Mental Health	0	0.00%	0	0.00%	0	0	0
Substance Abuse	0	0.00%	0	0.00%	0	0	0
Nursing Home	0	0.00%	0	0.00%	0	0	0
Pharmacy	0	0.00%	0	0.00%	0	0	0
Hospice	0	0.00%	0	0.00%	0	0	0
Community Based Organizations	0	0.00%	0	0.00%	0	0	0
All Other	0	0.00%	0	0.00%	0	0	0
Uncategorized	0	0.00%	0	0.00%	0	0	0
Additional Providers	0	0.00%	0	0.00%	0		

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Funds Flow Items	DY2 Q3 Quarterly Amount - Update	Percentage of Safety Net Funds - DY2 Q3 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
PPS PMO	0	0.00%	0	0.00%	0	0	0
Total	**0**		**0**		**0**		

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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* Safety Net Providers in Green

Non-Waiver Quarterly Update Amount By Provider		
Provider Name	**Provider Category**	**DY2Q3**
Practitioner - Primary Care Provider (PCP)		**0**
	Practitioner - Primary Care Provider (PCP)	0
Practitioner - Non-Primary Care Provider (PCP)		**0**
	Practitioner - Non-Primary Care Provider (PCP)	0
Hospital		**0**
	Hospital	0
Clinic		**0**
	Clinic	0
Case Management / Health Home		**0**
	Case Management / Health Home	0
Mental Health		**0**
	Mental Health	0
Substance Abuse		**0**
	Substance Abuse	0
Nursing Home		**0**
	Nursing Home	0
Pharmacy		**0**
	Pharmacy	0
Hospice		**0**
	Hospice	0
Community Based Organizations		**0**
	Community Based Organizations	0
All Other		**0**
	All Other	0
Uncategorized		**0**
	Uncategorized	0

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* Safety Net Providers in Green

Non-Waiver Quarterly Update Amount By Provider			
Provider Name	**Provider Category**	**IA Provider Approval/Rejection Indicator**	**DY2Q3**
Additional Providers			**0**
	Additional Providers		0

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	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task Step 1 - Establish a Board of Directors, governed by bylaws, responsible for the direction and financial stability of the PPS. The Board of Directors shall initially include each of the six CEO's of the partnering health systems and federally qualified health centers. In addition, five board members shall be seated after nomination from the Community Based Organizations Stakeholder group (PAC).	Completed	Complete - The Care Compass Network Board of Directors was seated as a full board on April 8, 2015. The full board includes the CEOs of the PPS six member organizations as well as five board members voted from the PPS Stakeholders, as facilitated through the PAC Executive Council. Additionally, the PPS Executive Director is the 12th member of the board and serves as a non-voting member. During the April 8 and May 12 board meetings all past board actions were ratified by the fully seated board, including adoption of CCN Bylaws.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 2 - Define and establish four primary operating committees which report to the board of directors, including the Finance Governance Committee, IT & Data Governance Committee, Clinical Governance Committee, and Compliance/Audit Committee.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Completed	This milestone must be completed by 12/31/2015. Clinical Quality Committee charter and committee structure chart	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1 - Following requirements prescribed by	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
the STRIPPS Bylaws, establish a Clinical Governance Committee framework, which is responsible for overall PPS Clinical Governance. The Clinical Governance Committee will include a direct reporting relationship to the Board of Directors and include a multi-disciplinary group of clinical professionals, from across the PPS, including 12 members from partner organizations - three per Regional Performing Unit ("RPU").									
Task Step 2 - For each of the four PPS Regional Performing Units (RPUs), establish a RPU Quality Committees, which will report to the overarching PPS Clinical Governance Committee. Each RPU Clinical Quality Committee shall be comprised of 6-10 members.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3 - Ensure the Clinical Governance Framework includes adequate RPU based Quality Committees (subcommittees to the PPS level Clinical Governance Committee), with a suggested minimum framework as follows: a. Behavioral Health Committee (with specific focus on projects 3ai Integration of Primary Care and Behavioral Health, 3aii Crisis Stabilization, and 4aiii Infrastructure). b. Disease Management Committee (with specific focus on projects 2biv Care Transitions, 2bvii INTERACT, 3bi Chronic Disease CVD, 3gi Palliative Care, and 4bii Chronic Disease/COPD). c. Onboarding Committee (with specific focus on projects 2ci Navigation, 2di Project 11, consenting, and outreach).	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4 - Leverage the regional expertise and relationships of the Coordinating Council and	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Regional Performing Unit (RPU) Leads and their associated teams, reporting to the CBO Engagement Council, to identify any recommendations to the RPU Quality Committee framework based on regional need. To supplement pre-existing regional healthcare knowledge, the RPU Leads should also leverage the results of the Pre-Engagement Survey to better identify the capabilities and readiness of providers and CBO members in their respective RPU.									
Task Step 5 - Leverage the regional expertise and relationships of the Coordinating Council and Regional Performing Unit (RPU) Leads and their associated teams, reporting to the CBO Engagement Council, to identify a slate of candidates for each subcommittee to the Clinical Governance Committee. The member slate should be ratified by the Stakeholders / PAC, as well as the PAC Executive Council, who will present the slates to the Board of Directors for final approval.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6 - Establish a Charter for each RPU Clinical Quality Committee, outlining roles, responsibilities (including monitoring, metrics, etc.), reporting requirements, and participation requirements.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7 - Each of the three recommended RPU Quality Committees (e.g., Behavioral Health Committee, Disease Management Committee, and Onboarding Committee) shall nominate a representative to the Clinical Governance Committee, to achieve three RPU representatives on the Clinical Governance	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Committee, representative of a multi-disciplinary group. The member slate should be ratified by the Stakeholders / PAC, as well as the PAC Executive Council, who will present the slates to the Board of Directors for final approval.									
Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	Completed	This milestone must be completed by 9/30/2015. Upload of bylaws and policies document or committee guidelines.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task Step 1 - Establish bylaws to serve as a guide for the authority, operations, and functionality of the Board of Directors, as well as define Committees which shall report to the Board of Directors. In addition, the bylaws will contain language which outlines the structure of the Committees, including the number of seats, purpose/goals, and requirements. Once completed, the bylaws will be reviewed and adopted by the Board of Directors.	Completed	Complete - The Care Compass Network Board of Directors was seated as a full board on April 8, 2015. The full board includes the CEOs of the PPS six member organizations as well as five board members voted from the PPS Stakeholders, as facilitated through the PAC Executive Council. Additionally, the PPS Executive Director is the 12th member of the board and serves as a non-voting member. During the April 8 and May 12 board meetings all past board actions were ratified by the fully seated board, including adoption of CCN Bylaws.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - Before establishing each Committee which reports to the Board of Directors, establish a methodology for seating positions which considers the RPU needs by domain, such as Stakeholder and technical/clinical expertise representation, to be included. The Board of Directors will review and approve the Committee resolutions for prior to seats being filled.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3 - Once completed, the governance documents, including bylaws, meeting minutes, and related attachments or amendments shall be uploaded to the PPS SharePoint for central access by PPS members.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #4 Establish governance structure reporting and monitoring processes	Completed	This milestone must be completed by 12/31/2015. Governance and committee structure document, including description of two-way reporting processes and governance	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		monitoring processes.							
Task Step 1 - Develop a governance and committee governance structure reporting and monitoring process, as defined PPS bylaws and supplemented by PowerPoint presentation ("governance and committee structure document"), which aligns with the bylaws requirements and allows for two-way reporting processes and the governance monitoring process.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2 - Include in each regular board meeting a placeholder for each standing Committee (IT Governance, Clinical Governance, Finance Governance, and Compliance & Audit Committees) to present updates. In addition, standard materials to support the Board of Directors meeting will include agenda, report from each Committee, report from the PAC Executive Council, report from the Coordinating Council, and report from the Executive Director.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3 - Following each meeting, the related materials will be uploaded to the established PPS SharePoint for central access by PPS partner organizations.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4 - Following each meeting, the Committee chairperson, Executive Director, and other responsible persons will provide Committee updates reflective of the Board of Directors meeting.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 5 - The PPS Project Management Office (PMO), or alternate designee, will monitor the PPS governance and committee structures and	Completed	In Process - The Board of Directors was fully seated in Q1 and committees which report to the board are scheduled for completion in Q2. Each committee is permitted by Bylaws to establish the necessary subcommittee structure to achieve	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
reporting developments. A dashboard will be created and managed by the PMO which monitors performance, such as the achievement of two-way reporting during each monthly/quarterly cycle, obtention of minutes, agendas, and other materials. As needed, updates, including identification and communication of missing reports, will be communicated through the associated Committees and/or Committee chairs so changes can obtain the appropriate approval(s) and PPS SharePoint documentation can be updated to align with the current governance model.		their goals. Once seated in Q2, and subcommittee structures have been finalized, the governance and committee governance structure process documents will be finalized and made available to PPS members. Once overall structures are in place the PMO or alternate designess will finalize the dashboard for performance management purposes. On track for completion by DY1, Q3 as scheduled.							
Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	Completed	Community engagement plan, including plans for two-way communication with stakeholders.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task Step 1 - Establish a PPS Communication Workgroup to oversee the development of PPS internal and external communications, such as public facing website, PPS newsletter, PPS SharePoint (including structure, content framework, and delegation of access/rights).	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - The PPS Communications Workgroup consisting of provider and CBO representatives within the PPS will develop a five year Community Engagement Plan, which includes milestones for each DSRIP quarter.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3 - The PPS Communications Workgroup will take the draft five year plan to the key stakeholders for content review. This will allow for adequate representation from across the PPS	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
based on RPU, project, etc. A focus will be to ensure communications with both PPS public and non-public provider organizations, such as schools, churches, homeless services, housing providers, law enforcement, transportation/dietician services, etc. are included. At minimum the review teams should include RPU leadership, CBO Council, PAC Executive Council, and the stakeholders/ PAC meeting.									
Task Step 4 - Leveraging input from the various constituents, the PPS Communications Workgroup will present the revised five year plan to the PPS Stakeholders / PAC group for review and approval.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5 - The PPS Communications Workgroup will present the Stakeholders/PAC approved five year plan to the Board of Directors for final review and approval.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6 - Once finalized, associated documentation and plans will be posted to the appropriate forums (for example, the PPS Public Facing Website for delivery of non-provider and public information and PPS SharePoint for internal stakeholder communications) for archiving and communication purposes.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #6 Finalize partnership agreements or contracts with CBOs	In Progress	Signed CBO partnership agreements or contracts.	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1 - Establish CBO Council which will lead the CBO facilitation process as related to the various DSRIP requirements. The CBO Council should include membership allocated by RPU.	Completed	Complete - Starting 5/12/15 the CBO Engagement Council convened and includes representation from across each RPU. From the CBO Engagement Council leads were nominated for each RPU and efforts have begun to coordinate engagement with Stakeholders from across the	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		PPS. During Q1, the CBO Engagement Council achieved the development and distribution of the Pre Engagement Survey, as coordinated with input from the IT consultants from WeiserMazars, the Coordinating Council (PPS Project Leads), and the Stakeholders PAC meeting.							
Task Step 2 - The CBO Council should coordinate the development of a CBO contact list for each Regional Performing Unit (RPU). The list should consider impacting factors, such as overlapping RPU and/or overlapping PPS involvement.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3 - Leveraging the CBO Contact List, an outreach plan for CBO contracting should be developed at the RPU level.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4 - In conjunction with the development of the outreach plan, the PPS will assist CBOs with a Readiness Assessment to identify CBO current state with regards to DSRIP plans.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5 - Using the output from the outreach plan and readiness assessment, the PPS will develop performance based measures for inclusion with each CBO partnership agreement. The performance based measures will align the CBOs DSRIP participation with the PPS funds flow model and infrastructure or service/performance related terms of the partnership agreement.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6 - Present draft partnership agreements (e.g., performance contracts) to each identified CBO for review and negotiation.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7 - Consider input and negotiations with CBOs to finalize and execute contracts.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 8 - Migrate contracts to the contract management process to allow for ongoing contract monitoring at the RPU level.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #7 Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	In Progress	Agency Coordination Plan.	04/01/2015	12/31/2016	04/01/2015	06/30/2017	06/30/2017	DY3 Q1	NO
Task Step 1 - Establish CBO Council which will lead the CBO facilitation process as related to the various DSRIP requirements. The CBO Council should include membership allocated by RPU.	Completed	Complete - Starting 5/12/15 the CBO Engagement Council convened and includes representation from across each RPU. From the CBO Engagement Council leads were nominated for each RPU and efforts have begun to coordinate engagement with Stakeholders from across the PPS. During Q1, the CBO Engagement Council achieved the development and distribution of the Pre Engagement Survey, as coordinated with input from the IT consultants from WeiserMazars, the Coordinating Council (PPS Project Leads), and the Stakeholders PAC meeting.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - The CBO Council should coordinate the development of a CBO contact list for each Regional Performing Unit (RPU). The list should consider impacting factors, such as overlapping RPU and/or overlapping PPS involvement as well as the inclusion of critical factors within each region including but not limited to local government agencies, state agencies, and both nonprofit and private community-based organizations (CBOs).	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3 - Leveraging the CBO Contact List, an outreach plan for CBO contracting should be developed at the RPU level accounting for the scope and diversity of organizations listed. This task will be executed by the PPS RPU Provider	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Relations professionals. The role of public sector agencies should be identified at this time.									
Task Step 4 - In conjunction with the development of the outreach plan, the PPS will assist CBOs with a Readiness Assessment to identify CBO current state with regards to DSRIP plans.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5 - Using the output from the outreach plan and readiness assessment, the PPS will develop performance based measures for inclusion with each CBO partnership agreement. The performance based measures will align the CBOs DSRIP participation with the PPS funds flow model and infrastructure or service/performance related terms of the partnership agreement.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6 - Draft partner agreements (e.g., performance contracts) which include any legislative steps and/or regulatory compliance (as appropriate).	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7 - Present draft partnership agreements (e.g., performance contracts) to each identified CBO for review and negotiation.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 8 - Consider input and negotiations with CBOs to finalize and execute contracts.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 9 - Migrate contracts to the contract management process to allow for ongoing contract monitoring at the RPU level.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #8 Finalize workforce communication and engagement plan	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).	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 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 Step 1 - Conduct dialogue to create mutually acceptable guidelines among key stakeholders regarding workforce requirements and sensitivities. Upon development the guidelines should be approved by the Board of Directors.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - Commission a workforce communications sub-committee that has inclusive membership including representation from groups such as PPS union(s), PPS board member(s), workforce team member(s), etc. which will be responsible for the development of the workforce communication and engagement plan. This sub-committee will also be commissioned to include communication with external stakeholders such as local government and state agencies (e.g., OASAS) in its communication and engagement plan in addition to the PPS' internal stakeholders represented during the planning process.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3 - Consolidate specific workforce changes within the PPS; incorporating speed and scale projections by position, a recruitment plan for new hires (see Detailed Gap Analysis), retraining/re-deployment strategies (see Compensation and Benefit Analysis), training timelines (see Training Strategy) and the creation of a Communication and Engagement Plan. The plan should include quarterly milestones to be achieved relative to the Communication and Engagement Plan for the duration of the DSRIP program	Completed	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4 - Generate a workforce Transition Roadmap, based on inputs from the Workforce	Completed	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
implementation plan, the Target Workforce State, and the Detailed Workforce Gap Analysis.									
Task Step 5 - Workforce communication and engagement plan (e.g., Transition Roadmap) is approved by the governing body.	Completed	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
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 Step 2 - Distribute the PPS Contract to CBO members. Utilize PPS Provider Relations professionals to coordinate the overall contracting process.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3 - Create a contracting management system to track CBO contracts pursued by the PPS, contract terms (dates), and aligned with which project(s) they have been engaged for.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 1 - Through PPS Provider Relations staff and involvement from the CBO Engagement Council identify gaps in CBO involvement at the RPU level. This may include leveraging results of the CBO Engagement Council Pre Engagement Survey, as well as Partner Organization List.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description
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.

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IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description
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	sculley	Meeting Materials	44_DY2Q3_GOV_MDL21_PRES1_MM_122216_IT_Governance_Committee_Minutes_8792.pdf	Minutes from IT & Data Governance meeting 12-22-16	01/26/2017 10:17 AM
	sculley	Templates	44_DY2Q3_GOV_MDL21_PRES1_TEMPL_CCN_Meeting_Schedule_Templates_DY2Q3_8791.pdf	CCN Meeting Schedule Template.	01/26/2017 10:16 AM
	sculley	Templates	44_DY2Q3_GOV_MDL21_PRES1_TEMPL_Governance_Committee_Template_DY2Q3_8790.xlsx	Governance Committee Template.	01/26/2017 10:16 AM
	sculley	Other	44_DY2Q3_GOV_MDL21_PRES1_OTH_CCN_Updated_Org_Chart_8789.pdf	CCN updated org chart.	01/26/2017 10:15 AM
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	sculley	Templates	44_DY2Q3_GOV_MDL21_PRES2_TEMPL_CCN_DY2Q3_Clinical_Governance_Committee_Meeting_Schedule_8801.pdf	CCN DY2Q3 Clinical Governance Committee Meeting Schedule template.	01/26/2017 10:20 AM
	sculley	Other	44_DY2Q3_GOV_MDL21_PRES2_OTH_CCN_DY2Q3_Committee_Charter_updates_8798.pdf	CCN Committee Charter updates.	01/26/2017 10:19 AM
	sculley	Templates	44_DY2Q3_GOV_MDL21_PRES2_TEMPL_DY2,Q3_Clinical_Governance_Template_8796.xlsx	CCN Clinical Governance Template	01/26/2017 10:19 AM
Finalize bylaws and policies or Committee Guidelines where applicable	sculley	Meeting Materials	44_DY2Q3_GOV_MDL21_PRES3_MM_Minutes_of_the_November_2016_Board_Meeting_8816.docx	Minutes from the November 2016 Board of Directors meeting.	01/26/2017 10:26 AM
	sculley	Other	44_DY2Q3_GOV_MDL21_PRES3_OTH_CCN_DY2Q3_IT_Charter_Updates_8815.pdf	CCN IT Charter updates made in DY2Q3.	01/26/2017 10:25 AM
	sculley	Policies/Procedures	44_DY2Q3_GOV_MDL21_PRES3_P&P_CCN_DY2Q3_Policy_Updates_8812.pdf	CCN policy updates in DY2Q3.	01/26/2017 10:24 AM
	sculley	Policies/Procedures	44_DY2Q3_GOV_MDL21_PRES3_P&P_Summary_of_Compliance_Policy_Changes_8811.pdf	Summary of compliance policy changes in DY2Q3.	01/26/2017 10:23 AM
Establish governance structure reporting and monitoring processes	sculley	Meeting Materials	44_DY2Q3_GOV_MDL21_PRES4_MM_CCN_Proof_of_2way_Reporting_DY2Q3_8818.pdf	Evidence of 2 way reporting in DY2Q3.	01/26/2017 10:27 AM
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	sculley	Communication Documentation	44_DY2Q3_GOV_MDL21_PRES5_COMM_CCN_Social_Media_Content_Strategy_Call12-12_8828.pptx	CCN Social Media Content strategy.	01/26/2017 10:30 AM
	sculley	Templates	44_DY2Q3_GOV_MDL21_PRES5_TEMPL_DY2Q3_Community_Engagement_Template_8826.xlsx	CCN Community Engagement Template for DY2Q3	01/26/2017 10:30 AM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	sculley	Other	44_DY2Q3_GOV_MDL21_PRES5_OTH_Combined_Communications_Plan_and_Timeline_01-18-17_8822.pdf	Communications and Community Engagement Plan with updated deliverables.	01/26/2017 10:29 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize governance structure and sub-committee structure	This milestone was reported as complete in the DY1, Q2 report however, as part of the ongoing quarterly reporting, we have updates to provide. In DY2Q3, there were subcommittee structure changes to report. As shown in the uploaded document CCN Updated Org Chart.ppt, previously the Technology Advisory group was split into two workgroups – Technical and Clinical. This was done primarily due to the RHIOs looking for technical meetings and CCN wanting to be respectful of clinician's time. The meetings have since shifted away from this delineation, so the workgroups have been rolled into one subcommittee. The Change Management committee will be implemented in the future as the Technology Advisory subcommittee is currently fulfilling that role. The membership of the IT Informatics and Data Governance committee has changed. Anne DePugh has been added as she also serves on the Clinical Governance Committee and will aide in the cross- pollination of committees. Sri Poranki and Robin Kinslow-Evans have needed to step down from both the IT Informatics and Data Governance committee as well as the Technology Advisory subcommittee due to limited time availability. The changes mentioned above were discussed at the IT Informatics and Data Governance Committee meeting on December 22, 2016. There have also been other membership changes to the Technology Advisory subcommittee. Mark Pendell, Family Health Network, and Brandi Devine, HealthLinkNY, have been added to the Technology Advisory committee. Additionally, several members were removed by their own request due to scheduling conflicts as a result of being involved in other committees as well as their full-time positions. They are: Robert Duthe, Anne DePugh, Stacie Hansen, Sandra Cherinko, and Robert Carangelo. The membership of the Technology Advisory subcommittee continues to be assessed to ensure that an appropriate mix of skill sets and IT environments are represented. On the Finance Committee, there was one change in membership. Philip J. Ryan was hired as Interim Chief Financial Officer of Guthrie and has replaced Rick Bennett, retired CFO of Guthrie, as a member on the Finance Committee. On the Compliance & Audit Committee, there was one change in membership. Anne Wolinski has retired from Our Lady of Lourdes Memorial Hospital, Inc. As a result, she has been removed from the Compliance & Audit Committee. The Governance Committee Template has been updated to reflect the membership of the Governance committees as of DY2Q3.
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	This milestone was reported as complete in the DY1, Q3 report however we have changes to report. The PPS Governance structure did not change during DY2Q3 however the membership for two South RPU quality committees changed between October 1, 2016 and December 31, 2016. For the South RPU Onboarding quality committee Crystal Sackett was removed from the committee due to conflicts in schedule. Additionally, for the South RPU Behavioral Health quality committee, Cheryl Minnier was added to the committee by committee vote on October 21, 2016. The North RPU PCMH quality committee also had changes to the committee membership. Beginning in October 2016 all practices engaging in the PCMH transformation process and receiving RMS consulting services are now included as members of the North RPU PCMH committee. The PCMH Committee is used as a collaborative learning environment for CCN partners to come together to learn about the PCMH process and share best practices for providing patient-centered care. As a result, several new members were added. The new members added were Anne Landon from Dryden Family Medicine, Amy Ortega and Sofiya Glidden from Trumansburg Family Medicine, Holly Sincebaugh From Dr.'s Costello, Jander and Griffin, Jessica Delia from Dr. Djfari's office, Kate Alm from Family Health Network, Kristin Hall and Matthew Rouff from Schuyler Primary Care, Lisa Ledoux and Tamara Bame-Hawley from Cayuga Medical Associates, Melissa Miller from Northeast Pediatrics, Bob Bloom from Familiy Medicine Associates, Stephanie Giordano-Foster from IthacaMed. Three members, Paula

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Milestone Name	Narrative Text
	Currie, Sue Ryan and Gail Rhodes, came off the committee as a result of scheduling conflicts or retirement. The updated charters for all three committees as well as the Clinical Governance Committees template have been uploaded as part of the supporting documentation for ongoing reporting of this completed milestone.
Finalize bylaws and policies or Committee Guidelines where applicable	: This milestone was reported as complete in the DY1, Q2 report however we have changes to report. Regarding Policies/Guideline updates, four policies were updated as a result of the annual review of the compliance policies. The four policies are: Reporting Instances of Non-Compliance and Non-Retaliation Policy (CCN_CC5), Conducting Compliance Audits Policy (CCN_CC9), Conflict of Interest Policy (CCN_CC10), Breach Notification Policy (CCN_PS1). A summary of the changes along with the updated policies has been uploaded. (reference document Summary of Compliance Policy Changes.pdf). There were four other policy changes during DY2Q3. The Innovation Fund Policy (CCN_FN7) was modified to include the use of the scoring matrix. Policy Administration (CCN_AD1) and Mandatory Annual Training (CCN_AD2) were updated to add the policy review history. This was an administrative change only and did not require approval. Acceptable Use Policy (CCN_IT1) was updated in November 2016 to update the Appendix A: Care Compass Network Confidentiality Pledge. The policies were approved by the Board of Directors at the November 2016 meeting. Additionally, the IT, Informatics, and Data Governance Committee charter and Technology Advisory committee charter have been updated to reflect membership changes from the Governance Milestone 1 narrative. Lastly, the Care Compass Network Bylaws have not changed.
Establish governance structure reporting and monitoring processes	This milestone was reported as complete in the DY1, Q3 report. Each of the governing body committees continues to report out to the Board of Directors and to the PAC Executive Council as per the governance structure reporting and monitoring process. Additionally, a standing Board of Directors update remains on each agenda for the four governing body committee meetings held monthly where possible, a board member is available to provide these updates. CCN has uploaded documentation from various meetings showing evidence of two-way reporting.
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	This milestone was reported as complete in the DY1, Q3 report. We continue to have DSRIP Awareness-healthcare transformation educational sessions across the PPS. In DY2Q3 CCN focused on building content across the social media sites aimed at existing CCN Partners as well as potential Partners. A social media web content strategy was updated and is currently being executed aligning LinkedIn, Twitter and the CCN website. A copy of the strategy has been uploaded with this milestone. The social media strategy has been the primary focus during DY2Q3 and the other tasks identified in the Community Engagement Plan deliverable section have been updated as a result. We have uploaded the latest Community Engagement Plan with updates where specific tasks were completed in the October 1, 2016 – December 31, 2016 timeframe and we have uploaded the list of community engagement activities completed by 12/31/16.
Finalize partnership agreements or contracts with CBOs	Care Compass Network (CCN) continues to work with Community Based Organizations (CBOs) in the 9-county region. CCN would note that 'contracting' with a CBO in our network thus far involves PPS direct contracting with CBOs including Partner Agreement, BAA, and direct contract for work associated with the eleven PPS projects. Supporting this approach is a detailed payment mechanism on how efforts are reimbursed and other incentives provided. As of 12/31/16 the PPS had executed over $3M of contracts directly with CBOs. These CBO contracts are likely to evolve over time as 'sub-contracts' with Safety Net providers are further developed and established. This effort has already commenced through this period. Additionally, we would note that CCN will remain open to contracting with any new organization that provides a service to the Medicaid member beyond the Milestone completion date and leverage appropriate network addition periods created by the DOH to facilitate. CBOs have recognized the PPS for their efforts around community collaboration, transparency, and inclusion in PPS meetings as well as non-DSRIP related forums. The experience and engagement of our CBOs has been noticed as CCN has been recognized as a state leader in CBO engagement which has led to the PPS being contacted for involvement in leadership groups. In one most recent example, Bassett PPS collaborated with CCN to speak at their quarterly Stakeholder meeting on CBO engagement.
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	Milestone 7 is due for completion in DY2Q3 however the PPS is deferring this milestone to DY3Q1 in order to engage all the Public Sector Agencies. During DY2Q3 CCN updated the Agency Coordination Plan created in DY1. In order to make the Agency Coordination Plan more thorough, Care Compass Network followed a five-step process to inform the development of the Plan. First, all of the local government units within the PPS were identified, along with a brief

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Milestone Name	Narrative Text
Services, Corrections, etc.)	description of what types of services they provide for Medicaid members. Next, a survey was distributed to local government unit leaders. The survey asked about their involvement with CCN and if they experienced any barriers when pursuing a contract with CCN. Next, strategies were identified to avoid and/or overcome the described barriers. All of these steps have culminated in producing this report. In order to more thoroughly create a plan for engagement with providers, a survey was created and sent out to agency leaders on the provider profiles list. This list currently includes both agencies that have and have not partnered with CCN. The survey aimed to determine what barriers are preventing agencies from contracting with CCN, or what barriers agencies experienced during the contracting process. From the survey, CCN determined three major barriers that impede the contracting process. These three barriers are: 1. Legal Barriers: multiple agency leaders reported that when contracts are developed and sent to their county attorneys to approve the contract, it often takes weeks if not months for the attorney to actually sign off on the contract. Often times once the contract is eventually signed, the projects have changed or funding is no longer available, preventing partnership between CCN and providers. 2. Reimbursement Barriers: the reimbursement structure of CCN and New York State Medicaid often prevents providers from pursuing a contract with CCN. Either the providers are not reimbursed enough from CCN to make a contract worth pursuing, or they do not want to "double dip," taking reimbursements from both CCN and New York State. 3. Lack of Workforce: one of the most reported barriers for those who have not partnered with CCN is the lack of time and manpower to keep up with required meetings and reporting that comes along with a CCN partnership. Local government agencies' workforces are already stretched thin, and agency leaders believe that contracting with CCN would stretch their workforce even thinner. Because the most widely reported barrier among providers that have not partnered was lack of workforce, CCN will put it efforts into overcoming this. One strategy that CCN will pursue is the creation of an online platform. This online platform will give agencies access to meeting minutes and have an option for providers to leave feedback. This ideally will save time for agencies, as they will not have to send an individual out of the office to attend a meeting. The other two major barriers are largely out of the control of CCN. However, CCN can provide more education to county legal departments on how it is important for their county's agencies to partner with CCN. Additional education could also be given to agencies on CCN's funding and reimbursement structure so that they better understand ways in which a CCN partnership can aid their Medicaid reimbursements. Other strategies include CCN educating themselves on the different needs of different RPUs. The Medicaid needs in the North RPU often are different than that of the Medicaid needs of the South RPU. CCN will also continue to collaborate with other PPSs to determine best practices in overcoming contracting barriers. CCN will use the next six months to implement changes in order to engage the remaining Public Sector Agencies.
Finalize workforce communication and engagement plan	No Changes.
Inclusion of CBOs in PPS Implementation.	No changes to report. CCN continues to include CBOs in implementation of the DSRIP projects. Our approach has been recognized in various forms across New York State as best practice for CBO engagement.

Milestone Review Status

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

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #4	Pass & Complete	
Milestone #5	Pass & Complete	
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Complete	
Milestone #9	Pass & 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	Organizational Narrative for Mid-Point Assessment	06/01/2016	06/30/2016	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

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment	

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

Instructions :

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

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

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

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

IPQR Module 2.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

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

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

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IPQR Module 2.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
South RPU Lead	Keith Leahey, Executive Director / Mental Health Association Wayne Mitteer, Advisory Expert / Lourdes	Responsible for alignment of RPU needs at the Governance Level and Coordination of Common Projects where PPS overlap occurs.
North RPU Lead	Amy Gecan, Director System Integration and Operations / Cayuga Medical Center	Responsible for alignment of RPU needs at the Governance Level and Coordination of Common Projects where PPS overlap occurs.
East RPU Lead	Greg Rittenhouse retired from UHS Home Care	Responsible for alignment of RPU needs at the Governance Level and Coordination of Common Projects where PPS overlap occurs.
West RPU Leads	Josie Anderson / Guthrie Robin Stawasz / CareFirst	Responsible for alignment of RPU needs at the Governance Level and Coordination of Common Projects where PPS overlap occurs.
Project Managers	Emily Pape, Bouakham Rosetti, Stephanie Woolever, Jennifer Parks, Emily Balmer, Rachael Haller, Nancy Frank / Care Compass Network	Alignment of RPU project needs from staffing, resource, timing, and contracting basis - as coordianted with Provider Relations professionals. Responsible for performance and consolidation of results monthly to the Project Management Office (PMO).
Provider Relations Professionals	Kris Bailey, Julie Rumage, Jessica Grenier, & CAP / Care Compass Network	Responsible for maintenance of Partner Organization list for accuracy, completeness, and pertinence to the PPS. Will also coordinate PPS contracting efforts and provide CBO and provider education.
Project Management Coordinator	Nicolette Roselli, Justin Commane	Responsible for alignment of RPU needs at the Governance Level and Coordination of Common Projects where PPS overlap occurs, including sustainment of vision for how all regions come together to achieve milestones.
Director, Project Management	Dawn Sculley	Responsible for overall vision for PPS Project Management Office, with outputs including plan delivery and quarterly consolidation of results to DOH/IA.
Executive Director	Mark Ropiecki, Executive Director / Care Compass Network	Reports to the Board of Directors and promotes alignment of standards across the PPS/RPUs, Overall PPS Guidance.
PPS Compliance Team	Andrea Rotella, PPS Compliance Officer	Responsible for overall development and maintanence of PPS Compliance program, including items such as training, data security, user agreements, privacy, and technology compliance with reports to the Board of Directors.
Board of Directors	Chair - Matthew Salanger, President and CEO / UHS Vice Chair - Kathryn Connerton, President and CEO / Our Lady of	General management of the affairs, property, and business of the Corporation.

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

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Module 2.6 - IPQR Module 2.6 - Key Stakeholders

Instructions :

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

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

IPQR Module 2.7 - IT Expectations

Instructions :

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

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

IPQR Module 2.8 - Progress Reporting

Instructions :

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

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

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

IPQR Module 2.9 - IA Monitoring

Instructions :

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Section 03 – Financial Stability

IPQR Module 3.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize PPS finance structure, including reporting structure	Completed	This milestone must be completed by 12/31/2015. PPS finance structure chart / document, signed off by PPS Board.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task Step 1 - Create organizational chart for functions related to finance including the roles and responsibilities of the Finance Committee. Note: The chart should clearly articulate and define the financial relationship model between the application Lead Entity (UHS) and the STRIPPS NewCo ("Care Compass Network").	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - PAC Executive Council to solicit nine nominations for the Finance Committee.	Completed	Complete - The PAC Executive Council reviewed the requested skillset of potential Finance Committee members during the June 5, 2015 PAC Executive Council meeting. A call for nominations from the Stakeholders group was subsequently presented during the Friday 6/12/15 Stakeholders meeting (attached slide 9 of 33).	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 3 - PAC to discuss and rank order the slate of nine nominations.	Completed	Complete - Once the full slate was prepared, the bios for the Stakeholders slate were distributed to the PAC Executive council on 6/24/15 (attached) for final review by the PAC Executive Council and ranking prior to submission to the Stakeholders group for confirmation at the 6/26/15 meeting. Following approval by the Stakeholders, the Finance Committee slate was presented to the Board of Directors during the July 14, 2015 meeting for action. To note continued progress beyond Q1 and this step to	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		implementation, the Board of Directors voted and approved five members from the Stakeholders list to the Finance Committee during the July 14, 2015 meeting.							
Task Step 4 - Board of Directors to approve five from the slate of nine to officially seat the Finance Committee.	Completed	See Narrative.	04/01/2015	07/14/2015	04/01/2015	07/14/2015	09/30/2015	DY1 Q2	
Task Step 5 - Finance Committee to set a tentative schedule of future meetings.	Completed	See Narrative.	04/01/2015	08/03/2015	04/01/2015	08/03/2015	09/30/2015	DY1 Q2	
Task Step 6 - Present finance organizational chart to PPS Board of Directors for approval.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	Completed	This milestone must be completed by 3/31/2016. Network financial health current state assessment (to be performed at least annually). The PPS must: - identify those providers in their network that are financially fragile, including those that have qualified as IAAF providers; -- define their approach for monitoring those financially fragile providers, which must include an analysis of provider performance on the following financial indicators: days cash on hand, debt ratio, operating margin and current ratio; -- include any additional financial indicators that they deem necessary for monitoring the financial sustainability of their network providers	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task Step 1 - Prepare a list of all providers in the PPS including Provider Type, Safety-Net Status, IAAF, VAP, PCMH, Contact Info, etc.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2 - Prepare an initial Financial Assessment Survey including inquiries regarding the following financial indicators: days cash on hand, debt ration, operating margin, current ratio, etc.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3 - Distribute Financial Assessment Survey to Finance Committee for review and input	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
regarding what other key indicators should be reviewed.									
Task Step 4 - Review feedback from Finance Committee and finalize Financial Assessment Survey accordingly.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5 - Distribute Survey to all members of the PPS using finalized Financial Assessment Survey.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6 - Compile Survey results into complete data set.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7 - Analyze survey results and identify those providers who are financially fragile based on indicators that finance committee agreed to.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 8 - Prepare report of those providers who are financially fragile and present results to Finance Committee.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 9 - For those providers who are identified as "Financially fragile" based on survey analysis, open dialogue between finance manager and provider to review the results of the survey.	Completed	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 10 - Finance manager to determine if provider is truly Financially Fragile or if explanations are acceptable and provider is truly stabile.	Completed	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 11 - If provider is still deemed Financially Fragile, provider to supply Finance Manager with plan on how provider plans on to move towards Financial Stability.	Completed	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task	Completed	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 12 - Financial Assessment Survey will be required quarterly for those who are deemed Financially Fragile until the Finance Manager deems they have reached Financially Stability for a period of time.									
Task Step 13 - Financial Assessment Survey will be disbursed annually.	Completed	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Completed	This milestone must be completed by 12/31/2015. Finalized Compliance Plan (for PPS Lead).	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1 - Compliance Officer to complete a review of NY Social Services Law 363-d, determine scope and requirements of compliance program and plan based upon the DSRIP related requirements that are within the scope of responsibilities of the PPS Lead and the NewCo (STRIPPS, dba: Care Compass Network).	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2 - Develop written policies and procedures that define and implement the code of conduct and other required elements of the PPS Lead compliance plan that are within the scope of responsibilities of the PPS Lead and the NewCo (STRIPPS, dba: Care Compass Network).	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3 - Obtain confirmation from PPS network providers that they have implemented a compliance plan consistent with the NY State Social Services Law 363-d.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4 - Develop requirements to be included in the PPS Provider Operating Agreement that the network providers will maintain a current compliance plan to meet NY State requirements for a provider.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 5 - Obtain Executive Body approval of the Compliance Plan and Implement the plan.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #4 Develop a Value Based Payments Needs Assessment ("VNA")	In Progress	Administer VBP activity survey to network	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Task Step 1 - Establish VBP committee comprised of members from PPS constituency with representation from all provider types. VBP Committee will seek to follow & leverage industry wide VBP Prepatory Strategies via HANYS.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - Cultivate pathways between VBP Committee and the rest of the system in order to survey and educate current landscape of existing VBP arrangements amongst PPS providers in PPS.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3 - Create education and communication plan, including the myriad components intrinsic to VBP, particularly the different strata of risk.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4 - Secure educational resources for outreach endeavors.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 5 - Carry out education and outreach endeavors for PPS providers ensuring a thorough understanding of the various VBP models and methods. Coordinate regional payor forums with providers in the region.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6 - Create a readiness self-assessment survey (High, Moderate, Low) for individual providers within the PPS to assess the varying levels of evolution as movement towards fully implemented VBP occurs. The self-assessment	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
survey will include the following (per the state): Degree of experience operating in VBP models and preferred compensation modalities; Degree of sophistication in ability to negotiate plan contracts, monitor and report on service types; Estimated volume of Medicaid Managed Care spending received by the network. Estimate of total cost of care for specific services (modeled along bundles Status of requisite IT linkages for network funds flow monitoring. Provider ability (financial stability) and willingness to take downside risk in a risk sharing arrangement. Level of assistance needed to negotiate plan options with Medicaid Managed Care (High, Moderate, Low).									
Task Step 7 - Distribute the readiness self-assessment survey to all providers to establish accurate baseline.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 8 - Collect, assemble, and analyze readiness self-assessment survey results.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 9 - Prepare Initial VBP Baseline Assessment based on readiness self-assessment survey results and dialogue from providers.	Completed	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 10 - Disseminate preliminary results of readiness self-assessment survey analysis for review by PPS Providers.	Completed	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 11 - Update, revise and finalize VBP Baseline Assessment based on Providers & Boards review.	Completed	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 12 - PPS Board to sign off on preference for	Completed	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
PPS providers to contract with MCO's at their own discretion.									
Milestone #5 Develop an implementation plan geared towards addressing the needs identified within your VNA	In Progress	Submit VBP support implementation plan	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Task Step 1 - Obtain clarification of VBP requirements from NYS Department of Health and guidance from legal counsel, as well as Department of Justice in regards to the requirements.	On Hold	See Narrative.	04/01/2015	12/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 2 - Analyze the NYSDOH data related to the risk-adjusted cost of care, as well as the potential (shared) savings, at both the total population level as per care bundle and subpopulation per the VBP Roadmap, in order to identify best possible opportunities for PPS providers in their move towards VBP.	On Hold	See Narrative.	04/01/2015	12/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 3 - Expand upon VBP Baseline Assessment creating a matrix of existing mechanisms both helping and hindering the implementation of the VBP model, including NYS VBP Roadmap, existing ACO and MCO models, and other VBP models in the current marketplace.	On Hold	See Narrative.	04/01/2015	12/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 4 - Analyze matrix of existing mechanisms both helping and hindering the implementation of VBP at the provider level of our PPS in order to identify which providers are best equipped to lead the movement towards VBP based on their current level of VBP engagement.	On Hold	See Narrative.	04/01/2015	12/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 5 - Identify within the PPS providers who fall into one of three tiers: 1) Established - Providers currently utilizing	On Hold	See Narrative.	04/01/2015	12/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
VBP models 2) Enthusiastic and/or Equipped - Providers who are eager to pursue the movement towards VBP models and/or equipped to do so based on the helping/hindering matrix 3) Providers who need additional resources in order to start the movement towards utilizing a VBP model.									
Task Step 6 - Coordinate regional payor forums with PPS providers.	On Hold	See Narrative.	04/01/2015	12/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 7 - Re-assess current landscape of VBP adoption throughout PPS by updating VBP Baseline Assessment, reviewing new information if available from the state and feedback from PPS Providers and MCOs regarding the payor forums, as well as lessons learned from early adopters.	On Hold	See Narrative.	04/01/2015	12/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 8 - Perform Gap Analysis based on updated matrix of PPS landscape.	On Hold	See Narrative.	04/01/2015	12/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 9 - Coordinate additional regional payor forums with PPS providers based on Gap Analysis.	On Hold	See Narrative.	04/01/2015	12/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 10 - Collectively review the level of VBP engagement and continue to encourage open dialogue among the PPS providers regarding VBP models and adoption.	On Hold	See Narrative.	04/01/2015	12/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 11 - Update, modify and finalize VBP Adoption Plan.	On Hold	See Narrative.	04/01/2015	12/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Milestone #6	In Progress	Initial Milestone Completion: Submit VBP education/training	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 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
Develop partner engagement schedule for partners for VBP education and training		schedule Ongoing Reporting: Submit documentation to support implementation of scheduled trainings, including training materials and attendance sheets through quarterly reports							
Task TBD	On Hold	Note - On Hold while awaiting milestone DSRIP reporting year and quarter to be set.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Milestone #7 ≥50% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and ≥ 8%* (blended for 15% target for fully capitated plans (MLTC and SNPS) and 5% target for not fully capitated plans) of total MCO payments captured in VBPs has to be in Level 2 VBPs or higher	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Task TBD	On Hold	Note - On Hold while awaiting milestone DSRIP reporting year and quarter to be set.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Milestone #8 ≥80% of total MCO payments (in terms of total dollars) captured in at least Level 1 VBPs, and ≥ 20%* (blended for 35% target for fully capitated plans (MLTC and SNPS) and 15% target for not fully capitated plans) of total MCO payments captured in VBPs has to be in Level 2 VBPs or higher	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Task TBD	On Hold	Note - On Hold while awaiting milestone DSRIP reporting year and quarter to be set.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description
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.

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	mrbobc	Documentation/Certification	44_DY2Q3_FS_MDL31_PRES3_DOC_CCN_DRA_Compliance_Program_Cert_December_2016_8330.pdf	Certification of Compliance Program Document #2	01/23/2017 11:45 AM
	mrbobc	Documentation/Certification	44_DY2Q3_FS_MDL31_PRES3_DOC_CCN_SSL_Compliance_Program_Cert_December_2016_8329.pdf	Certification of Compliance Program Document #1	01/23/2017 11:45 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize PPS finance structure, including reporting structure	This milestone was reported complete for DY1, and has had no changes to the organizational chart for finance previously submitted in DY2, Q2.
Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	There are no updates for the DY2, Q3 submission for this milestone as it was reported complete for DY1, Q4 and has no changes. The PPS sent out the next annual assessment on January 13th, 2017.
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	The PPS successfully completed the recertification process in December 2016 and has attached the annual certification confirmation from OMIG.
Develop a Value Based Payments Needs Assessment ("VNA")	At the All PPS meeting on December 9, 2016, the updated Financial Stability Milestones 4-8 were provided to the PPSs. Milestone 4 remains "On Hold" pending MAPP updates effective in the reporting cycle for DY2, Q4.
Develop an implementation plan geared towards addressing the needs identified within your VNA	At the All PPS meeting on December 9, 2016, the updated Financial Stability Milestones 4-8 were provided to the PPSs. As a result of the DOH modifying this milestone, steps 1-11 will be put on hold and rewritten to align with the updated milestone. Additionally, Milestone 5 remains "On Hold" pending MAPP updates effective in the reporting cycle for DY2, Q4.
Develop partner engagement schedule for partners for VBP education and training	
≥50% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and ≥ 8%* (blended for 15% target for fully capitated plans (MLTC and SNPS) and 5% target for not fully capitated plans) of total MCO payments captured in VBPs has to be in Level 2 VBPs or higher	
≥80% of total MCO payments (in terms of total dollars) captured in at least Level 1 VBPs, and ≥ 20%* (blended for 35% target for fully capitated plans (MLTC and SNPS) and 15% target for not fully capitated plans) of total MCO payments captured in VBPs has to be in Level 2 VBPs or higher	

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Milestone Review Status

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

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IPQR Module 3.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

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

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

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

IPQR Module 3.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

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

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

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

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

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

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IPQR Module 3.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Finance Director	Bob Carangelo / Care Compass Network	Responsible for development and management of the Finance Office and its specific functions. The individual will provide guidance and oversight around the Funds Flow Plan, the Financial Stability Plan, and other relevant processes. The responsibilities include ensuring that funds are managed and distributed according to the approved plan, that reporting requirements are met and that communication regarding the Finance related functions is timely and accurate. Responsible for the daily operation of the Finance Office, including programmatic development of the infrastructure tools critical to the Funds Flow Plan and the related banking, accounts payable and general ledger functions. Primary contact for the PPS Lead finance function for conducting DSRIP related business and responsible for their organization's execution of their DSRIP related finance responsibilities and participation in finance related strategies.
Financial Analyst(s)	Brenda Gianisis / Care Compass Network	Responsible for assisting in the continuity of operations of the data aspects of the Finance Office and providing assistance to the Finance Office as it relates to data analysis, acquisition and reporting, as well as contract management. This position will be responsible for developing and distributing the defined report data set(s) to the designated stakeholders. This position(s) will be responsible for working with the Finance Director and Finance Committee to determine and monitor the reporting protocols/requirements for the PPS providers, the governing body, and DOH. This position(s) also is responsible for generating monthly financial statements for CCN and other appropriate Accounting functions as specified in the CCN Accounting Policies & Procedures Manual.

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Accounting Clerk	Julie Callahan / Care Compass Network	Coordinated by the CCN Finance Director, the Accounting Clerk is responsible for the day-to-day operations of the Accounts Payable function, including drafting policies and procedures when needed, monitoring the accounts payable system, and implementing PPS protocols around reporting and AP check writing related to the DSRIP funds distribution.
Reporting Analyst(s)	Multiple	Responsible for the preparation of reporting requirements for review by the responsible party, including the Finance Director, RPU Project Manager, etc.
Investment Services Staff	Purchased Services - UHSH	Responsible for the day-to-day operations of the Investment function, including the monitoring of DSRIP funds in Investment Accounts, and making recommendations as to new investment opportunities available to CCN.
PPS Compliance Officer	Andrea Rotella, Care Compass Network Compliance Officer	Responsible for overall development and maintanence of PPS Compliance program, including items such as training, data security, user agreements, privacy, and technology compliance with reports to the Board of Directors.
External Auditor	The Bonadio Group	External auditors reporting to the Finance Committee. The firm will perform the audit of the PPS and PPS Lead related to DSRIP services according to the audit plan approved by the PPS governing body. External Auditors to be selected by the Compliance and Audit Committee in DY1.

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IPQR Module 3.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Robin Kinslow-Evans, Director, Strategic Planning	PPS Strategic Planning for Post-DSRIP	The Director, Strategic Planning is responsible for developing a plan for "Year 6."
Mark Ropiecki, Executive Director	PPS DSRIP Executive Director	The DSRIP Executive Director has overarching responsibility for oversight of the DSRIP initiative for the PPS
Dawn Sculley, Director Project Management Emily Pape, Project Manager - West RPU Stephanie Woolever, Project Manager - East RPU Rachael Haller, Project Manager Emily Balmer, Project Manager Bouakham Rosetti, Project Manager	PPS Project Managers	Collaboration with finance re: PPS Project Implementation, status of projects, reporting required to meet DOH requirements.
Amy Gecan, Director System Integration and Operations (Cayuga Medical Center)	North RPU Lead	Alignment of RPU needs at the Governance Level, Coordination of Common Projects where PPS overlap occurs, general oversight of project implementation at the local level.
Greg Rittenhouse	East RPU Lead	Alignment of RPU needs at the Governance Level, Coordination of Common Projects where PPS overlap occurs, general oversight of project implementation efforts at the local level.
Josephine Anderson (Guthrie) Robin Stawasz (CareFirst)	West RPU Co-Leads	Alignment of RPU needs at the Governance Level, Coordination of Common Projects where PPS overlap occurs, general oversight of project implementation efforts at the local level.
Ann Homer, Corporate Compliance and Privacy Officer, Family Health Network	CCN Compliance Officer Advisor	Consulting arrangement to help provide oversight of PPS Compliance Plan and related training, education, and reporting requirements of the plan.
Andrea Rotella, Care Compass Network Compliance Officer	PPS Compliance Officer	PPS Compliance Officer responsible for overall development and implementation of the Compliance function. Also provides Data Security and Privacy Officer roles.
Internal Audit	TBD Manager Internal Audit	Oversight of internal control functions; completion of audit processes related to funds flow, network provider reporting, and other finance related control processes
PPS Finance Committee	Dave MacDougall, Care Compass Network Finance Committee	Board level oversight and responsibility for the PPS Finance

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
	Chair	function; Review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; collaboration with the Compliance Committee for audit and compliance related processes.
PPS Human Resources	Leased Employees are governed by their respective human resources department of their employer of record	The PPS purchases HR services from the UHS, Inc. Human Resources department. Services include training materials, recruitment, support services such as time clock management, and development of PPS related HR programs and policies.
Matthew Salanger, UHS CEO, Care Compass Network Board of Directors Chair	Boards of Directors for PPS Network Partners	The PPS Board of Directors retains general power to manage and control the affairs, property, and business of the corporation and have the full power by majority vote, unless otherwise noted within the Bylaws. The Board of Directors has full authority with respect to the distribution and payment of monies received and owed by the corporation from time to time, subject to the rights of the Members.
Multiple	PPS Partner Organization Leaders (e.g., CEOs, Executive Directors, etc.)	PPS Network Provider partners' CEOs are responsible for their organization's' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies
Keith Leahey, Executive Director, Mental Health Association of the Southern Tier	South RPU Co-Lead	Alignment of RPU needs at the Governance Level, Coordination of Common Projects where PPS overlap occurs, general oversight of project implementation efforts at the local level.
Wayne Mitteer, Executive Advisor, Lourdes Hospital	South RPU Co-Lead	Alignment of RPU needs at the Governance Level, Coordination of Common Projects where PPS overlap occurs, general oversight of project implementation efforts at the local level.
External Stakeholders		
New York State Department of Health	NY DOH defines the DSRIP requirements	The PPS Lead and PPS finance function has responsibility for the overall administration of DSRIP reporting to DOH and the funds flow process.
PPS Stakeholders	Community Representatives	Community needs and interests are significant influencers of DSRIP projects and will contribute to the adoption and buy-in across the network. Communication regarding DSRIP status, results, and future strategies will be important to maintain their contribution and influence.
Government Agencies / Regulators	Government Agencies / Regulators	County and State agencies and regulatory bodies will have oversight and influence in a number of DSRIP related areas - including the importance of waivers or regulatory relief, construction / renovation projects, and other items related to

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
		DSRIP. Communication with them regarding DSRIP status, results, future strategies and their role in DSRIP success will be important.
To Be Determined in DY1	PPS External Audit Function	Provision of annual and quarterly (when needed) review of PPS internal control, operations, and financials.

IPQR Module 3.7 - IT Expectations

Instructions :

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

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

IPQR Module 3.8 - Progress Reporting

Instructions :

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

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

IPQR Module 3.9 - IA Monitoring

Instructions :

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Section 04 – Cultural Competency & Health Literacy

IPQR Module 4.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize cultural competency / health literacy strategy.	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 Step 1 - Establish Cultural Competency Committee (CCC) to meet regularly and be responsible for overseeing cultural competency and health literacy throughout the DSRIP project timeline.	Completed	Complete - The Cultural Competency workgroup was active for most of 2015 and the Chair (Annie Bishop) announced a call for members to the Stakeholders group on 6/12/15 (see attached, slide 7). The first meeting of the CCN Cultural Competency Committee occured on 6/26/15. Also attached is a copy of the distribution which was sent following the meeting, including a copy of the CCN implementation plan to the Cultural Competency Committee members.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - CCC to review CNA to identify	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
priority/focus groups with outstanding health disparities and needs.									
Task Step 3 - CCC to identify recurring themes and key factors from the CNA which are suggested to improve access to primary/behavioral/preventive health care.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4 - Obtain sign off on strategy to ensure standardized PPS Partner Evaluation, Implementation and Training of Cultural Competency and Health Literacy by PPS Board.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 5 - CCC to establish forum for bidirectional communication with community members and community groups.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 6 - PPS to require participation in organizations Cultural Competency/Health Literacy Evaluation, Implementation and Training with Partners through contracting process.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7 - CCC to team up with Workforce Development Team and PPS Partner Human Resources/Employee Development departments to administer PPS contractually required Nathan Kline Assessment Survey (NKAS) survey.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 8 - CCC to train on and implement member-specific relevant evidence-based cultural competency/health literacy tools and assessments which are expected to promote positive health outcomes and promote self-management (example: Cultural and Linguistic Appropriate Services ("CLAS"), and others).	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 9 - CCC to monitor ongoing incoming NKAS	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
results from PPS partners and reflect on newly identified cultural competency/health literacy issues. CCC will use this information and discuss relevance for ongoing training content and training strategy.									
Task Step 10 - CCC and Project Management Office to incorporate Nathan Kline Cultural Competency Assessment results into ongoing regular (at least annually) PPS Cultural Competency and Health Literacy Training and Evaluation Requirements.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 11 - CCC to work with Communications Team to disseminate ongoing messages regarding Cultural and Linguistic Appropriate Services (CLAS) Standards and other Cultural Competency/Health Literacy topics to all PPS Partners to address importance of accessibility of services.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 12 - Establish process with DSRIP Projects/Project Management Office for the CCC to review any project-specific materials prior to community distribution for health literacy (language) appropriateness to maximize potential resonance with target demographic to improve health outcomes. CCC to encourage the use of community navigators (Community Health Advocates from Project 2.c.i.) and the teach-back approach with front line staff when working with community members.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 13 - Submit progress via quarterly reports to NYS.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Develop a training strategy focused on	Completed	This milestone must be completed by 6/30/2016. Cultural competency training strategy, signed off by PPS Board. The	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
addressing the drivers of health disparities (beyond the availability of language-appropriate material).		strategy should include: -- Training plans for clinicians, focused on available evidence-based research addressing health disparities for particular groups identified in your cultural competency strategy -- Training plans for other segments of your workforce (and others as appropriate) regarding specific population needs and effective patient engagement approaches							
Task Step 1 - Obtain sign off on cultural competency and health literacy training strategy by PPS Board.	Completed	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 2 - Collect and aggregate incoming region-specific cultural competency/health literacy needs identified from contracted PPS Partners in their Nathan Kline Cultural Competency Assessments and the PPS CNA.	Completed	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3 - Identify region-neutral, overarching concepts of Cultural Competency and patient engagement strategies.	Completed	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4 - Combine both region-neutral and region-specific concepts of Cultural Competency and patient engagement strategies. These concepts to include, but are not limited to: bias, stereotyping, language barriers, geographical implications, race, educational level as it pertains to literacy/health literacy, etc.	Completed	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5 - CCC to work with PPS Workforce Development Team, PPS Partner Human Resources/Employee Development departments, and Communication Team to create a standardized checklist of required training to be completed by all front line and management staff of all PPS Partners on a regular basis.	Completed	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 6 - Ensure ongoing training is addressed in each CCC meeting agenda.	Completed	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	rachaelm	Templates	44_DY2Q3_CCHL_MDL41_PRES2_TEMPL_CCHL_M2_Training_Schedule_Template_9187.xlsx	Training Schedule (template)	01/30/2017 08:39 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize cultural competency / health literacy strategy.	Complete (Pass & Ongoing) – This Milestone was reported as Complete in DY1Q3 and there are no changes to report to the cultural competency/health literacy strategy.
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	Complete (Pass & Ongoing) – No changes have been made to the Cultural Competency & Health Literacy Training Strategy submitted in DY2, Q1. The Cultural Competency & Health Literacy Committee had the PAC Executive Council review its Cultural Competency & Health Literacy proposals in response to the Requests for Information (RFIs) release received last quarter. The intent is to make these trainings available to all partner organizations through the HWapps platform for which Care Compass Network has acquired a license for all of its partner organizations. As of January, the PAC Executive Council is reviewing proposals for targeted Cultural Competency & Health Literacy trainings in the listed categories/priority populations as identified in our strategy: Cultural Competency & Health Literacy (overall) Low Socio-Economic Status Rural Population Aging Population

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	Other training continues to be rolled out inclusive of cultural competency & health literacy topics including Care Compass Network's Health Coach training, developed by the Visiting Nurse Association (VNS) of Ithaca, a Care Compass Network partner organization in the North Regional Performing Unit (RPU) with experience in home nursing and health coaching. This is a perfect example of our PPS' intention to weave cultural competency & health literacy throughout its efforts and interventions. The Health Coach training covered this matter in relation to the individual's role as a health coach. In DY2, Q3, the Committee also selected a new chair, Samantha Ley, Director of Cultural Diversity at the Mental Health Association of the Southern Tier, a Community Based Organization located within the PPS. This comes at a critical time where major tasks will be undertaken in relation to Cultural Competency & Health Literacy in the upcoming quarter including baselining using the Nathan Kline Assessment Survey, rolling out developed training, and surveying Medicaid Members and the uninsured again about their treatment at provider locations in relation to their cultural identification. The survey will be completed by RMS, the vendor managing an online panel of providers, community-based organizations, and community members. This was last conducted in January of 2016. Care Compass Network hopes to use the survey results to gain insight into the cultural needs of the community and changes over time. The use of the RMS Panel to perform surveys every six weeks has been an effective method to engage and acquire input directly from the Medicaid and uninsured populations.

Milestone Review Status

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

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IPQR Module 4.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

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

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

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

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IPQR Module 4.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

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

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IPQR Module 4.5 - Roles and Responsibilities

Instructions :

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

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

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IPQR Module 4.6 - Key Stakeholders

Instructions :

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

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

IPQR Module 4.7 - IT Expectations

Instructions :

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

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

IPQR Module 4.8 - Progress Reporting

Instructions :

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

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

IPQR Module 4.9 - IA Monitoring

Instructions :

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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	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1 - Establish an IT Governance structure in accordance with CCN bylaws and with appropriate representation across PPS entities & areas of expertise. The IT Governance Structure will be approved by the CCN Board.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - Perform data gathering of the IT environment and specifically in terms of the capabilities of all the participating PPS members, and conduct needs assessment.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3 - Develop high level IT vision which appropriately incorporates and addresses data analytics, population health, EMR technology, telehealth, & home monitoring.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4 - Perform gap analysis that identifies the ability of the current IT environment to support and achieve the organization's desired outcomes.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 5 - Identify and define relevant alternative IT strategies in order for the organization to attain the identified IT Vision, support the organization's strategic DSRIP goals, and successfully address the findings/recommendations of the needs/gap analysis.	Completed	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6 - Develop IT strategic plan and associated Action Plan that includes the timeframe in which the component projects should be initiated, the anticipated elapsed time, the required resources, and the dependencies with other initiatives as well as the associated costs.	Completed	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #2 Develop an IT Change Management Strategy.	Completed	IT change management strategy, signed off by PPS Board. The strategy should include: -- Your approach to governance of the change process; -- A communication plan to manage communication and involvement of all stakeholders, including users; -- An education and training plan; -- An impact / risk assessment for the entire IT change process; and -- Defined workflows for authorizing and implementing IT changes	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task Step 1 - Develop plan to imbed change management strategy into provider relations function.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 -Develop charter for change management advisory group, including periodic monitoring of the effectiveness of the change management process.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3 - Review gap analysis and understand types of changes potentially needed.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4 - Develop a communication plan to	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
communicate the approved required changes through a variety of mechanisms to ensure all PPS members have been notified.									
Task Step 5 - Develop training and education strategy on the change management process and required approvals.	Completed	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6 - Establish process for authorizing and implementing IT changes in accordance with CCN bylaws and subsequent guidance from the IT & Data Governance Committee.	Completed	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #3 Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	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 for interoperability and clinical data sharing; -- A training plan to support the successful implementation of new platforms and processes; and -- Technical standards and implementation guidance for sharing and using a common clinical data set -- Detailed plans for establishing data exchange agreements between all providers within the PPS, including care management records (completed subcontractor DEAAs with all Medicaid providers within the PPS; contracts with all relevant CBOs including a BAA documenting the level of PHI to be shared and the purpose of this sharing).	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task Step 1 - Leverage the needs assessment of the IT strategy and define specific data exchange and system interoperability requirements.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2 - Develop plan to incorporate data sharing agreements and consent agreements with all participating organizations.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3 - Define data governance structure.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 4 - Develop training strategy.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5 - Develop a communication plan.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6 - Develop technical architecture to ensure interoperability among all PPS systems.	Completed	See Narrative	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7 - Evaluate business continuity and data security, confidentiality and integrity controls.	Completed	See Narrative	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 8 - Develop transition plan to migrate paper-based providers to electronic data exchange.	Completed	See Narrative	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	In Progress	PPS plan for engaging attributed members in Qualifying Entities, signed off by PPS Board. The plan should include your approach to outreach into culturally and linguistically isolated communities.	04/01/2015	12/31/2016	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1 - Perform an IT needs assessment for existing /new attributed members.	Completed	See Narrative	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - Perform a gap analysis of existing patient engagement outreach programs, strategies and mechanisms.	Completed	See Narrative	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3 - Develop an action plan for new engagement channels.	Completed	See Narrative	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4 - Develop metrics to ensure successful beneficiary engagement.	Completed	See Narrative	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5 - Establish progress reports on beneficiary engagement.	Completed	See Narrative	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6 - Identify project data points and build baselines so that the plan to engage attributed members can be measured.	Completed	See Narrative	03/01/2016	09/30/2016	03/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Milestone #5 Develop a data security and confidentiality plan.	Completed	Data security and confidentiality plan, signed off by PPS	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
		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.							
Task Step 1 - Evaluate the existing data security and confidentiality plans and identify gaps to meet the needs of the PPS.	On Hold	See Narrative	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 2 - Leverage data governance and data exchange policies to ensure data security and confidentiality.	On Hold	See Narrative	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 3 - Develop plan for mitigating identified data security and confidentiality risks/vulnerabilities.	On Hold	See Narrative	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 4 - Develop plan to monitor security and confidentiality on an ongoing basis, including progress reports.	On Hold	See Narrative	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 5 - Develop a communication strategy and training plan for security and confidentiality.	On Hold	See Narrative	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 1 – Complete SSP Workbooks for Identification & Authentication (IA), Access Control (AC), Configuration Management (CM), Systems & Communication (SC)	Completed	This new step added 2/3/16 replaces the original step 1 to align with the DOH guidance released in regards to the SSP documents.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 2 - Complete SSP Workbooks for Awareness and Training (AT), Audit and Accountability (AU), Incident Response (IR), Physical and Environmental Protection (PE), Personnel Security (PS)	Completed	This new step added 2/3/16 replaces the original step 2 to align with the DOH guidance released in regards to the SSP documents.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3 - Complete SSP Workbooks for Security Assessment & Authorization (CA), Risk	Completed	This new step added 2/3/16 replaces the original step 3 to align with the DOH guidance released in regards to the SSP documents.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Assessment (RA), System & Information Integrity (SI),Media Protection (MP)									
Task Step 4 -Complete SSP Workbooks for Planning (PL), Program Management (PM), System & Services Acquisition (SA), Contingency Planning (CP), Maintenance (MA)	Completed	This new step added 2/3/16 replaces the original step 4 to align with the DOH guidance released in regards to the SSP documents.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
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).	sculley	Meeting Materials	44_DY2Q3_IT_MDL51_PRES1_MM_IT_M1_DY2_Q3_Required_Attachments_9171.pdf	Meeting schedule of the IT Governance in DY2Q3	01/29/2017 09:16 AM
Develop an IT Change Management Strategy.	sculley	Documentation/Certification	44_DY2Q3_IT_MDL51_PRES2_DOC_Change_Management_Strategy_9582.pdf	IT Change Management Strategy uploaded as part of remediation.	03/17/2017 11:07 AM
	sculley	Other	44_DY2Q3_IT_MDL51_PRES2_OTH_IT_Systems_and_Processes_M2_Remediation_9580.docx	Remediation response for IT Milestone 2	03/17/2017 11:05 AM
	sculley	Meeting Materials	44_DY2Q3_IT_MDL51_PRES2_MM_Minutes_of_the_January_2017_Board_Meeting_9213.docx	Board of Directors minutes from January 10, 2017 meeting where the IT Change Management Strategy was approved.	01/30/2017 11:12 AM
	sculley	Policies/Procedures	44_DY2Q3_IT_MDL51_PRES2_P&P_IT_Change_Management_Procedure_9173.docx	IT Change Management Procedure	01/29/2017 09:19 AM
	sculley	Other	44_DY2Q3_IT_MDL51_PRES2_OTH_IT_M2_DY2_Q3_Required_Attachments_9172.pdf	Training Schedule Template and c. Meeting schedule of the IT Governance body pertaining to the discussion of IT Change Management Strategy.	01/29/2017 09:18 AM
Develop roadmap to achieving clinical data	sculley	Meeting Materials	44_DY2Q3_IT_MDL51_PRES3_MM_IT_M3_DY2_	Training Schedule, meeting schedule and updated	01/29/2017 09:21 AM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
sharing and interoperable systems across PPS network			Q3_Required_Attachments_9175.pdf	contract listing for DY2Q3.	
Develop a data security and confidentiality plan.	sculley	Policies/Procedures	44_DY2Q3_IT_MDL51_PRES5_P&P_IT_M5_DY2Q3_Required_Attachments_9176.pdf	Policy regarding HIPAA training.	01/29/2017 09:25 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).	The IT Systems & Processes Milestone 1 was reported as complete in DY1Q4. There have not been any changes to the clinical data sharing and interoperable systems roadmap. Proposals and demonstrations for Primary Care and Long-Term Care EHR systems and electronic screening tools have been completed and a short list of preferred vendors have been created for each technology. The IT Project Manager continues to assess each partner's IT capabilities and readiness for change as they are contracted. Care Compass Network's analytics group prioritized the skilled nursing facilities in our region based on Medicaid volume, hospital readmissions, outpatient ED visits, EHR integration and attributed population served. This data will be used to prioritize outreach to partners that need an EHR. The meeting schedules of the IT governance body for DY2Q3 have been uploaded. In the Milestone Review Status section in MAPP Milestone 1 should indicate Pass & Complete since this milestone was passed and completed in DY1Q4.
Develop an IT Change Management Strategy.	Milestone 2 is due for completion in DY2Q3 and is being reported as complete. The Care Compass Network Change Management Strategy, as approved by the IT, Informatics & Data Governance Committee and the CCN Board of Directors, applies to PPS-wide IT changes and does not impact other efforts within the PPS. The strategy is used to focus the IT committees and CCN resources only on changes that will benefit practice transformations and DSRIP goals. The IT, Informatics & Data Governance Committee maintains oversight of the IT technology selection process so that any development is consistent with CCN's IT Strategy and other CCN IT infrastructure changes. The Technology Advisory Subcommittee is responsible to review, approve and/or deny any substantial change requests. Changes reviewed can be those initiated by Care Compass Network or by a partner organization. Communication of changes is bi-lateral and facilitated via Provider Relations and the RPU Operations committees. The Change Management Strategy includes a recovery strategy that is to be applied on a case-by-case basis individualized for the partner organization and their implemented change. All training will be coordinated with the Workforce Committee and all communications will be coordinated through CCN Marketing to ensure consistent messaging. The Care Compass Network Change Management Strategy was approved by the Board of Directors on January 10, 2017. At this time the IT, Informatics & Data Governance committee has decided to have the change management function fulfilled by the Technology Advisory Subcommittee. This committee already represents a cross-section of the PPS both geographically and by partner organization type. As the functional needs increases, the Change Management Subcommittee included in the IT Governance Structure may be slated. CCN uploaded 2 documents for remediation of this milestone.
Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	The IT Systems & Processes Milestone 3 was completed in DY1Q4. There were no changes to the clinical data sharing and interoperable systems roadmap in DY2, Q3. Much of the PPS effort has been in creating a tactical plan to operationalize the strategic plan. Work continues with the RHIOs to further define how data sharing will operate in a landscape where multiple RHIOs are actively engaged with the partners. This will be a continued focus for the remainder of DY2. Partner engagement with the RHIOs will continue to be strongly encouraged and incentivized by the PPS to support data sharing efforts. An updated contract listing has been uploaded to show additional partners who have signed the Reciprocal BAA with Care Compass Network.
Develop a specific plan for engaging attributed members in	The IT Systems & Processes Milestone 4 is due in DY2Q3, however CCN is deferring the completion of this milestone to DY2Q4 to finalize the steps to engage

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Qualifying Entities	culturally and linguistically isolated patient communities and to review the final plan for engaging attributed members in Qualifying Entities with the CCN Board of Directors. All the other steps have been completed at this time. A needs assessment was conducted by WeiserMazars in 2015 to assess the RHIO capabilities and connectivity of attested partners. This information was presented to the CCN Board of Directors in October 2015 (Step 1 – Complete DY1Q2). WeiserMazars then conducted an IT focused survey for major CCN partners covering current and planned RHIO connectivity, an overall gauge for the degree that partners have requested their patients/clients consent to having their information accessible (Step 2 – Complete DY1Q3). In order to be connected, an organization must be engaged in collecting patient consents for RHIO access. RHIO access and consent collection is an integral part of participating in CCN projects and is part of the CCN partner agreement. CCN's action plan for engaging attributed members with the RHIOs is a culmination of the IT Strategic Plan, approved by the Board of Directors in March 2016, and the Cultural Competency and Health Literacy strategy, approved by the Board in August 2015. As new partners are contracted with CCN, data on their IT systems and connectivity is collected during organizational profiling. Partners are provided relevant information regarding connection capabilities with the three RHIOs in our region. Information is also provided on engaging patients/clients based on the projects they have elected to participate (Step 3 – Complete DY1Q4). As part of the partner agreement, CCN will provide/arrange for training to facilitate connection to a RHIO in the region, provide information for consent policies and practices, and provide direction related to interoperability, connectivity and functionality requirements. The partner agrees to take the necessary steps to participate with the RHIO for secure messaging and data exchange, including implementing consent practices, use of secure messaging and sharing data with CCN and partner organizations. A dashboard has been developed to report partner organization progress collecting consents (Step 4 - Complete DY1Q4). This data will be used to report progress of each partner in obtaining member engagement (Step 5 – Complete DY1Q4). CCN has worked with the three RHIOs in our service area to identify the best way to measure engagement with attributed members. The RHIOs will be sending reports to CCN showing the level of member consents quarterly. These figures will be added to the dashboard so that the trends can be tracked by partner organization (Step 6 – Complete DY2Q2). At present CCN has 68% of its contracted partners engaged with one of the three RHIOs in our region. Over the course of 2016, beneficiary engagement increased 16% across all three RHIOs. CCN will continue to work with the partners to get all contracted partners aligned with RHIO and the best methods to obtain beneficiary engagement for the business conducted by the partner. CCN arranged for a RHIO representative to present information on why and how to engage with their local RHIO at our PAC Stakeholders meeting in December 2016.
Develop a data security and confidentiality plan.	Care Compass Network (CCN) completed all 18 SSP Workbooks in DY2Q1 as required by the Department of Health. All required documentation is contained within the appropriate SSP Workbook. During DY2Q3 there were no changes to the data security and confidentiality plan. All HIPAA compliance training for CCN employees is handled by the host employer according to their training schedules, as required by CCN policy.

Milestone Review Status

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

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IPQR Module 5.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

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

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

IPQR Module 5.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

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

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

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

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

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

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

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

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

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IPQR Module 5.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Governance Development / Chief Information Officer	Weiser Mazars (3rd party consultant)	Responsible for IT Governance, IT Landscaping - (Needs/Gap Assessment), Change Management, and IT Architecture.
Data Security & Information Technology Officer	Rebecca Kennis/ Care Compass Network	Responsible for data security and confidentiality plan, Data Exchange Plan, and DEAA oversight.
Project Management Director	Dawn Sculley / Care Compass Network	Responsible for development and monitoring of Project Portfolio, Risk Register, Vendor Contracts, and Progress Reports.
IT Project Manager	Jennifer Parks / Care Compass Network	Responsible for Execution and Management of Project Portfolio, Risk Register, Vendor Contracts, Progress Reports, and Collaboration with IT Workgroup(s) & Provider Relations.
IT Governance Committee Co-Chairs	Rob Lawlis / CAP Bob Duthe / Cortland Regional	Responsible for Application Strategy & Data Architecture.
IT Workgroup	Multiple	Responsible for development of detailed IT workplans and current state assessments.
PPS Provider Relations and Outreach Coordinator	Julie Rumage / Care Compass Network Jessica Grenier / Care Compass Network Kristine Bailey / Care Compass Network	Responsible for PPS provider relations, including contracting and education. In this role the Provider Relations team will also work as a primary point of contact for contracted entities and distribute PPS materials such as IT related plans or education resources. Further, this role will facilitate questions appropriately within the PPS IT governance structure.

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IPQR Module 5.6 - Key Stakeholders

Instructions :

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

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

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IPQR Module 5.7 - Progress Reporting

Instructions :

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

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

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

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

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

IPQR Module 5.8 - IA Monitoring

Instructions :

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Section 06 – Performance Reporting

IPQR Module 6.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Establish reporting structure for PPS-wide performance reporting and communication.	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	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task Step 1 - Identify and establish Regional Performing Units (RPU's) throughout STRIPPS.	Completed	Complete - Through collaboration with the CCN leadership team (Executive Director, Project Leads, Governance teams) the Care Compass Network created a model in Q1 which identifies Regional Performing Units (RPUs) through which PPS related efforts can be achieved at a local level. The RPU structure was presented to the PPS Stakeholders during the 4/17/15 meeting (see attached). Also, the Clinical Governance Chair Dr. David Evelyn incorporated the RPU model into the proposed Clinical Governance Committee framework by created Clinical Governance Quality Committees which operate by specialty at the RPU level. This model was presented to the Board of Directors during the 6/9/15 meeting (see attached agenda and Clinical Governance materials). Additionally, the functionality of the RPUs has since been incorporated to the CBO Engagement Council which during the meetings in May and June began to identify PPS members by RPU, create RPU teams/leaders, and develop the PPS PreEngagement Survey which was including shaping PPS constituents at the RPU level to better	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		facilitate operations, such as training and outreach efforts.							
Task Step 2 - Establish a PPS level Clinical Governance Committee with membership of 3 members from each of the Four RPU's to discuss Clinical Quality and performance measure.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3 - The PPS will perform a current state assessment of existing reporting processes at the RPU level .	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4 - Develop RPU level Performance Measurement system based on medical record/Salient Reporting, as well as for those process measures that our project development groups are identifying as drivers of the outcomes we aim to realize.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 5- Within each RPU, there will be project based multidisciplinary representation of 6-10 members . These RPU level individuals will serve as the key leads who will hold the RPU partners accountable for the realization and continuous improvement of the multi-disciplinary care pathways underlying their respective projects.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 6- PPS-wide standardized care practices to be established by the Clinical Governance Committee and monitored at the RPU level.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 7 - Establish process for PPS to share/communicating state provided data (accessed through the MAPP Tool, Salient Tool and process measures) to providers through existing templates and Excel files as a short-term solution.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 8 - Finalize arrangements with RPU providers to exchange key information (including additional quality and process metrics) with centralized PPS level analytics dept.									
Task Step 9 - Establish regular two-way reporting structure to govern the monitoring of performance based on both claims-based, non-hospital CAHPS DSRIP metrics and population health metrics (including MAPP PPS-specific Performance Measurement Portal and other process metrics). Results will be gathered by PPS Analytics and reported to the RPU's for performance management, and ultimately reported to the PPS Clinical Governance Committee.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 10 - Finalize layered PPS-wide reporting structure: from the individual providers, through RPU, up to the PPS PMO and up to Clinical, IT and Financial Governance Council at the PPS Board. Performance and improvement information available (including, MAPP, Salient SIM tool and Excel spreadsheet for other process metrics) will be maximally integrated into this reporting structure. This reporting structure will define how providers are to be held accountable for their performance against PPS-wide, statewide and national benchmarks.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 11 - Develop performance reporting dashboards, with different levels of detail for reports to the RPU's, PMO, the Clinical Quality, Finance, IT Committees and the PPS Board. The monthly Executive Board dashboard reports will be shown on overall performance of the PPS. The various dashboards will be linked and will have drill-down capabilities.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #2 Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	Completed	Finalized performance reporting training program.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1 - After performing current state analyses and designing workflows, the PPS Workforce Strategy Team will create a dedicated training team to integrate new reporting processes and clinical metric monitoring workflows into retraining curriculum at the RPU level.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - This training team will integrate Lean, Six Sigma and other performance improvement programs into performance reporting/ Rapid Cycle Evaluation (RCE) training regime at the RPU level.	Completed	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3 - Develop training module to provider champions, critical stakeholders and partners at the RPU level; use their feedback to refine training program throughout the network, including specific program for new hires.	Completed	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4 - Develop schedule to roll out training to all RPU sites across the PPS network, using training at central hubs for smaller providers; specific thresholds will also be defined for minimum numbers to undertake training.	Completed	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5 - In collaboration with the PPS PMO, the training team will identify decision-making providers, partners and staff at each RPU to train in advance of PPS-wide training; these individuals will become performance management champions in their individual providers / sites and will work alongside the practitioner champions for those sites.	Completed	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 6 - Roll out training to RPUs/provider sites.	Completed	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	rachaelm	Templates	44_DY2Q3_PR_MDL61_PRES2_TEMPL_Performance_Reporting_M2_Training_Schedule_Template_9189.xlsx	Copies of Training Schedule (using training schedule template)	01/30/2017 08:46 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish reporting structure for PPS-wide performance reporting and communication.	This Milestone was reported as Complete in DY1Q3. There are no updates to the performance reporting structure or data use agreements at this time.
Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	There have been no changes to the training program. Efforts to train and educate partner organizations continue as outlined in the training schedule attached. In the Milestone Review Status section in MAPP Milestone 2 should indicate Pass & Complete since this milestone was passed and completed in DY2Q1.

Milestone Review Status

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

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IPQR Module 6.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

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

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

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IPQR Module 6.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

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

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

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

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

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

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IPQR Module 6.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
RPU Project Managers	Nancy Frank (South), TBD (North), Stephanie Woolever (East) & Rachael Haller (West), Care Compass Network	Responsible for identification and tracking of metrics related to projects, including their role in the performance reporting structures and processes in place for PPS level Clinical Governannce Committee.
RPU Team members	Coordinating Council	Responsible for quality of clinical protocols, outcomes, and financial results per project as well as the realization and continuous improvement of the multi-disciplinary care pathways underlying their respective projects.
Provider Relations Staff	Julie Rumage & Jessica Grenier, Care Compass Network (South) CAP (North) Kristine Bailey (East) TBD (West)	Responsible for spreading and embedding common culture of continuous performance monitoring and improvement throughout Practitioner Professional Peer Groups. Responsible to PPS Clinical Governance Quality Committee for provider involvement in performance monitoring processes.
PPS IT and Data Analytics Group	Multiple	Responsible for ensuring the implementation, support, and updating of all IT and reporting systems to support performance monitoring framework. Also responsible for ensuring that the systems used provide valuable, accurate, and actionable measurement for providers and staff.
South RPU Lead	Keith Leahey, Executive Director (Mental Health Association) & Wayne Mitteer, Strategy Adviser (Lourdes)	Responsible for identification and tracking of metrics related to projects, including their role in the performance reporting structures and processes in place for PPS level Clinical Governannce Committee.
North RPU Lead	Amy Gecan, Director System Integration and Operations (Cayuga Medical Center)	Responsible for identification and tracking of metrics related to projects, including their role in the performance reporting structures and processes in place for PPS level Clinical Governannce Committee.
East RPU Lead	Greg Rittenhouse, Retired from UHS Home Care	Responsible for identification and tracking of metrics related to projects, including their role in the performance reporting structures and processes in place for PPS level Clinical Governannce Committee.
West RPU Leads	Josie Anderson (Guthrie) & Robin Stawasz (CareFirst)	Responsible for identification and tracking of metrics related to

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

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IPQR Module 6.6 - Key Stakeholders

Instructions :

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

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

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

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IPQR Module 6.7 - IT Expectations

Instructions :

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

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

IPQR Module 6.8 - Progress Reporting

Instructions :

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

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

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

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

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

IPQR Module 6.9 - IA Monitoring

Instructions :

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Section 07 – Practitioner Engagement

IPQR Module 7.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop Practitioners communication and engagement plan.	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	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task Step 1 - At the PPS level, or within each Regional Performance Unit (RPU), appoint the following positions and responsibilities: (a) RPU Provider Relations professional who will coordinate provider relations, training, and touch point contact for key professional groups/ Participating Organizations. (b) RPU Quality Committees, comprised of RPU based physicians and professionals, each of which will report to the PPS Clinical Governance Committee. This group will be responsible for representing the interests and views of practitioners to the PPS Executive Body through the Clinical Governance Committee and representing the Executive Body's views to the various communities of practitioners. (c) RPU Leads / Project Manager(s) who, among	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
other things, is responsible for communication of cross-functional needs with the RPU Provider Relations professional. The RPU Lead will collaborate the RPU project, reporting, and governance needs with other RPU Leads/ Project Managers to allow strategies and methodologies to react uniformly and timely (when needed). (d) PPS Communications Coordinator, to promote development and distribution of internal and external PPS communications, and serve as a central connection for PPS related communications.									
Task Step 2 - Each RPU Quality Committee to develop draft communication and engagement plans, to be aligned where possible and approved by the Clinical Governance Committee. Key plans for development will include: i. Structures and processes for two-way communication between front-line practitioners and the Governance of the PPS; ii. Process for managing grievances rapidly and effectively; iii. High-level approach for the use of learning collaboratives; iv. Identification, creation, and communication of other forums for practitioners to discuss, collaborate, and shape how DSRIP will affect their practices.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3 - Perform an inquiry with professional networks, committees, groups, or stakeholders to develop a process on communication and engagement strategy. This will involve seeking input with the practitioners themselves on their role in the DSRIP transformative process	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4 - Build out practitioner support services designed to support the practitioner engagement plan. At each RPU this will include a	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
collaborative to build out leading practices and promote practitioners and providers improve the efficiency of their operations.									
Task Step 5 - Develop a communication plan to support the RPU structure and allow for connection between the RPU and Clinical Governance Committee by use of the Quality Committee.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6 - Finalize practitioner communication and engagement plans. Report as needed (e.g., quarterly).	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	Completed	Practitioner training / education plan.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1 - Establish Regional Performing Unit (RPU) teams and RPU governance which allows for integration of training/education planning efforts with the Clinical Governance Committee.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2 - Create standardized DSRIP training programs for Provider Relations professionals which detail the following, as appropriate by participant (determined by results of 2.a.i Milestone 1, Step 1c. readiness assessment):	Completed	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2a. Core goals of DSRIP program, PPS projects, & the financial and operational impacts on providers	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2b. Cross-PPS work streams underpinning the delivery of the DSRIP projects, including value-based payment, case management, clinical	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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integration, and clinical improvement									
Task 2c. Financial risk seminars for concerned practitioners (involving MCOs), and PPS-wide plans for mitigating the impacts of revenue loss	Completed	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2d. The services and support available to providers / practices to help them improve the efficiency of their operations and thereby free up the time to allow for a shift to more collaborative models of care	Completed	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2e. Seminars on population health management	Completed	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2f. The role of different groups of practitioners in the delivery of the DSRIP projects	Completed	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2g. New lines of clinical accountability and the expectations around clinical integration	Completed	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2h. The various aspects of IT / data sharing infrastructure development and how this will impact on practitioners day-to-day	Completed	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3 - Leverage RPU Leads and Provider Relations professionals to develop and implement a training & education program delivery model which includes delivery at RPU level through in-person and electronic formats, tracking of participant level data, and training outcomes. The training targets will aim for reaching 65% of practitioners through live training.	On Hold	See Narrative.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 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
Develop Practitioners communication and engagement plan.	sculley	Templates	44_DY2Q3_PRCENG_MDL71_PRES1_TEMPL_DY2,_Q3_Practitioner_Engagement_Meeting_Schedule_Template_9180.xlsx	DY2Q3 Practitioner Engagement meeting schedule template.	01/30/2017 08:33 AM
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.	sculley	Meeting Materials	44_DY2Q3_PRCENG_MDL71_PRES2_MM_2016_Participant_Outreach_Tracker_NRPU_7_5_16_9185.xlsx	North Regional Performing Unit Contracting meeting tracker.	01/30/2017 08:36 AM
	sculley	Meeting Materials	44_DY2Q3_PRCENG_MDL71_PRES2_MM_2016_Contracting_Dashboard_WRPU_6_2_16_9184.xlsx	West Regional Performing Unit Contracting meeting tracker.	01/30/2017 08:36 AM
	sculley	Meeting Materials	44_DY2Q3_PRCENG_MDL71_PRES2_MM_2016_Contracting_Dashboard_SRPU_6_9_16_9183.xlsx	South Regional Performing Unit Contracting meeting tracker.	01/30/2017 08:36 AM
	sculley	Meeting Materials	44_DY2Q3_PRCENG_MDL71_PRES2_MM_2016_Contracting_Dashboard_ERPU_6_3_16_9182.xlsx	East Regional Performing Unit Contracting meeting tracker.	01/30/2017 08:35 AM
	sculley	Templates	44_DY2Q3_PRCENG_MDL71_PRES2_TEMPL_Practitioner_Engagement_DY2Q3_Training_Schedule_Template_9181.xlsx	Practitioner Engagement DY2Q3 Training schedule template.	01/30/2017 08:34 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop Practitioners communication and engagement plan.	Efforts to communicate and engage practitioners continues as it has in previous quarters. There have been no updates to the Practitioner Communication and Engagement Plan. The Practitioner Engagement activities list is also uploaded.
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.	Efforts to train and educate practitioners continues as it has in previous quarters. There have been no changes to the training and education plan.

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Milestone Review Status

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

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IPQR Module 7.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

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

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

IPQR Module 7.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

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

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

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

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IPQR Module 7.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
RPU Project Managers	Nancy Frank / Care Compass Network Stephanie Woolever / Care Compass Network Rachael Haller / Care Compass Network	Responsible for functioning as the liaison between the Project Management Office (PMO) and the Regional Perfomance Unit (RPU).
CBO Engagement Council	Multiple	Responsible for the identification of PPS CBOs/providers and allocation by responsible RPU as well as the ongoing identification of practitioners. Responsible for development of education and awareness campaigns for each RPU.
RPU Clinical Quality Committees	Multiple	Responsible for clinical quality communicated and delivered at the RPU level and RPU results; reports to the PPS Clinical Governance Committee.
RPU Provider Relations	Julie Rumage, South RPU Provider Relations / Care Compass Network Jessica Grenier, South RPU Provider Relations / Care Compass Network Kristine Bailey, East/West RPU Provider Relations / Care Compass Network CAP, North RPU Provider Relations / Care Compass Network	Responsible for managing physician relations, performing education, training, and coordinating agreements at each RPU as well as pursuing contracts with CBOs/providers.
Clinical Governance Leads	Multiple	Responsible for the accuracy, completeness, and timeliness of clinical reporting.

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IPQR Module 7.6 - Key Stakeholders

Instructions :

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

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

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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.

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

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

IPQR Module 7.8 - Progress Reporting

Instructions :

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

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

IPQR Module 7.9 - IA Monitoring

Instructions :

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Section 08 – Population Health Management

IPQR Module 8.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop population health management roadmap.	Completed	Population health roadmap, signed off by PPS Board, including: -- The IT infrastructure required to support a population health management approach -- Your overarching plans for achieving PCMH 2014 Level 3 certification in relevant provider organizations --Defined priority target populations and define plans for addressing their health disparities.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Step 1 - Perform a review of existing PPS supporting infrastructure/capabilities, including at minimum Population Health Management System capabilities (e.g., Salient, RHIO, CBO Systems, etc.) as well as the associated Lead System Experts (e.g., knowledge experts) for each system who can be available to support the needs of the PPS, which can be leveraged in addition to the MAPP tool.	Completed	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 2 - Identify frequent visitors to healthcare organizations using existing systems and algorithms to determine target populations and health disparities within PPS, borrowing Health Homes population health management strategies.	Completed	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3 - Identify and/or develop standard reports	Completed	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
and one-off reports which will be utilized based on the needs of each RPU, project, or overall PPS needs. These reports will be leveraged to analyze the PPS data population to stratify risk and guide PPS implementation and performance achievement efforts. For example, this effort will include benchmarking reports to provide baseline data to the responsible PPS members or performing data analysis to identify where the governing body (e.g., RPU, PPS) is making progress against DSRIP goals.									
Task Step 4 - Create a dashboard to periodically update the program planning and individual care management database and registries, available for easy access by all participating providers in the PPS. Build out a public facing dashboard derived from the internal database to monitor outcomes and successes of the program.	Completed	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 5 - Complete workforce assessment for priority practice groups' care management capabilities, including staff skills and resources required to manage the diabetic and cardiovascular disease populations in each geographic area. Identify population health management strategies for overlapping PPS's.	Completed	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6 - Develop the Population Health Management Road Map and PCMH level 3 overarching plans to be approved by the Board of Directors.	Completed	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 7 - Leverage the IT Committee and RPU Clinical Quality Committees as the working groups responsible for assessing current state and identifying appropriate providers with regard to PCMH 2014 Level 3 certification, identifying	Completed	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
key gaps, and developing overarching plan to achieve Level 3 certification in all relevant providers.									
Task Step 8- Refine priority clinical issues from the Community Needs Assessment (at a whole-PPS level and also specific priorities for specific geographic areas) to ensure alignment between undertaken projects and clinical priorities, with particular focus on diabetes and cardiovascular health. Leverage communication channels established as part of the Practitioner Engagement plan to solicit participating provider feedback before finalization	Completed	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 9 - The Clinical Governance Committee will oversee the development of care guidelines for providers on priority clinical issues; establish metrics for each clinical area to monitor progress in managing population health. As these guidelines are established and modified throughout the DSRIP period the Population Health Management team can align and refine the Population Health Roadmap.	Completed	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 10 - As needed, deploy staff support at provider level (as part of practitioner engagement training plan) to train providers to use and apply information learned from the registries, how to implement established care guidelines, develop disease pathways, determine effectiveness of interventions through team meetings, etc.	Completed	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Milestone #2 Finalize PPS-wide bed reduction plan.	Completed	PPS Bed Reduction plan, signed off by PPS Board. This should set out your plan for bed reductions across your network, including behavioral health units/facilities, in line with planned reductions in avoidable admissions and the shift of activity from inpatient to outpatient settings.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task	Completed	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 1 - Appoint a PPS representative group, including representatives from each acute care provider, chartered off the Board of Directors to perform a PPS-wide bed reduction planning analysis. Given results from the analysis, a detailed review will be performed on the data and assumptions with advisory 3rd party consultant, resulting in a draft Bed Reduction Plan.									
Task Step 2 - The PPS representative group will submit the draft Bed Reduction Plan to the Board of Directors for review. Upon review and consensus, the Board will finalize and sign the Bed Reduction Plan.	Completed	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 3 - Using the Board approved Bed Reduction Plan, an ongoing monitoring process will be developed which will allow for monitoring and reporting activities (e.g., Quarterly Reports) related to the Bed Reduction Plan.	Completed	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4 - Periodic content monitoring will be performed (e.g., quarterly) to summarize current state bed reduction impacts and be reported to the Project Management Office. Significant deviations from the Board approved Bed Reduction Plan will be submitted by the Director of Project Management to the Executive Director for formal review. If significant deviations are confirmed, the Bed Reduction Plan will be re-evaluated to confirm pertinence to the current operating environment, repeating Steps 1-3 above.	Completed	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	

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IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop population health management roadmap.	Care Compass Network (CCN) completed the requisite Population Health Management Roadmap, including all implementation steps in DY2Q2. The roadmap specifies the IT infrastructure required to support the population health management approach, including the Data Warehouse and data aggregation, analytics functions, data movement, statistical tools, data sources, and a care management platform. Over the last quarter there have been two key developments related to the population health strategy; first, initiating work on the Integrated Delivery System, and second, continuing development on the CCN Data Warehouse. CCN is now actively working on building the PCMH credentials of our partner across the PPS. Roughly 85 practices are expected to achieve their 2014 Level 3 certification, either by upgrading an existing certification or by starting with no certification. This work begins to strengthen the care coordination function in these practices; care coordination across the PPS, not just in PCMH settings, is a key component of CCN's vision for the Integrated Delivery System. CCN's Data Warehouse continues to develop. CCN completed the Phase I build, which includes the basic table structure for data on DSRIP services provided by CCN partners, and a basic reporting capability. The next phase, which includes the table structure for the Medicaid claims data and a data mart, will include project and performance metric dashboards. In the Milestone Review Status section in MAPP Milestone 1 should indicate Pass & Complete since this milestone was passed and completed in DY2Q2.
Finalize PPS-wide bed reduction plan.	Care Compass Network completed the Bed Reduction Plan Milestone in DY2Q2. There are no updates to work on this milestone.

Milestone Review Status

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

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Care Compass Network (PPS ID:44)

IPQR Module 8.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

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

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

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

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

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IPQR Module 8.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

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

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

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IPQR Module 8.5 - Roles and Responsibilities

Instructions :

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

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

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IPQR Module 8.6 - Key Stakeholders

Instructions :

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

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

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IPQR Module 8.7 - IT Expectations

Instructions :

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

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

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

IPQR Module 8.8 - Progress Reporting

Instructions :

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

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

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

IPQR Module 8.9 - IA Monitoring

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Instructions :

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Section 09 – Clinical Integration

IPQR Module 9.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform a clinical integration 'needs assessment'.	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 Step 1 - Develop the design of a clinical integration needs assessment framework to identify the needs of the PPS, at the RPU level. These frameworks will outline a comprehensive vision inclusive of skillset, process, technology, and data requirements necessary for clinical integration as it pertains to each of the DSRIP target populations (including the technical requirements for data sharing and interoperability) and make considerations from the previously performed Community Needs Assessment (CNA).	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2 - Assess existing care transition programs.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 3 - Create a provider level map, incorporating the clinical integration framework with the community needs assessment and the DSRIP target populations using the Community Based Organization (CBO) Council and Provider Relations workers. This landscape per RPU will cover the entire continuum of the providers involved.									
Task Step 4 - Analyze results of CNA in order to inform Clinical Integration Strategy.	Completed	See Narrative.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Develop a Clinical Integration strategy.	In Progress	Clinical Integration Strategy, signed off by Clinical Quality Committee, including: -- Clinical and other info for sharing -- Data sharing systems and interoperability -- A specific Care Transitions Strategy, including: hospital admission and discharge coordination; and care transitions and coordination and communication among primary care, mental health and substance use providers -- Training for providers across settings (inc. ED, inpatient, outpatient) regarding clinical integration, tools and communication for coordination -- Training for operations staff on care coordination and communication tools	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1 - For each RPU in the PPS, define what the target clinical integrated state should look like from a skillset, process, technology and data perspective (including assessment and care protocols and specific attention to care transitions). At a core, the Outreach and Engagement needs for each RPU should be identified, as well as any functional barriers to achieving this from the perspective of both provider organizations and individual clinicians.	In Progress	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	
Task Step 2 - Based on this target state and the gaps identified in the integrated care needs	In Progress	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
assessment, define and prioritize the steps required to close the gaps between current state and desired end state at both the care management and clinical quality level (to include any needs for people, process, technology, or data).									
Task Step 3 - Identify synergies between the RPU needs across the PPS. For example: the need for supportive IT infrastructure to enable data sharing. Leverage the results from this review to standardize work flows where possible.	In Progress	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	
Task Step 4 - Conduct engagement exercise with practitioners and other stakeholders, focused on identifying the key clinical (and other) data that will be required to support effective information exchange at transitions of care with provider relations workers and RPU leads/managers operating as champions of this effort.	In Progress	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	
Task Step 5 - Define incentives to encourage the behaviors and practices that underpin the target state (e.g., multi-disciplinary care planning). These incentives might include financial / personnel support to providers looking to improve the efficiency of their operations in order to create more time for coordinated care practices; or the creation of shared back office service functions to improve the efficiency of provider organizations.	In Progress	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	
Task Step 6 - Carry out consultation process on draft strategy with internal and external stakeholders to the transformation (including patients when appropriate).	In Progress	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	
Task Step 7 - Finalize PPS strategy and roadmap	In Progress	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
document on clinical integration.									
Task Step 8 - Develop and implement a process to formally track and monitor progress of the clinical integration strategy/ roadmap. Leverage PPS' regional structure to integrate (Individual providers inform RPU strategy, RPU strategy feeds upward to inform overall PPS approach).	In Progress	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop a Clinical Integration strategy.	swooleve	Other	44_DY2Q3_CI_MDL91_PRES2_OTH_Clinical_Integration_Narrative_DY2Q3_Milestone_8537.docx	Clinical Integration Narrative DY2Q3 Milestone	01/24/2017 03:20 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform a clinical integration 'needs assessment'.	Milestone 1 for Clinical Integration was reported as Complete in DY1, Q4. In the DY2, Q3 timeframe the clinical integration needs assessment did not change.
Develop a Clinical Integration strategy.	Please see the document section for Clinical Integration Narrative DY2Q3 Milestone #2

Milestone Review Status

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

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IPQR Module 9.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

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

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

IPQR Module 9.4 - Major Dependencies on Organizational Workstreams

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Instructions :

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

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

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IPQR Module 9.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Clinical Governance Committee	Dr. David Evelyn, CMO, Cayuga Medical Center, Care Compass Network Clinical Governance Committee Chair	Responsible for the development of PPS Clinical Quality Standards, RPU oversight, and reporting to the Board of Directors.
RPU Quality Committees	11 Total SubCommittees, Inclusive of more than 70 members.	Responsible for individual RPU clinical governance oversight, application of standards at the RPU level, reporting to the Clinical Governance Committee, and remediation strategies for Non-Performance.
Provider Relations	Julie Rumage, Provider Relations / Care Compass Network Jessica Grenier, Provider Relations / Care Compass Network Kristine Bailey, Provider Relations / Care Compass Network Penny Thoman, Provider Relations / Care Compass Network	Responsible for managing physician relations, performing education, training, and coordinating agreements.
South RPU Lead	Keith Leahey, Executive Director (Mental Health Association) Wayne Mitteer, Strategy Adviser (Lourdes)	Alignment of RPU needs at the Governance Level, including clinical integration.
North RPU Lead	Amy Gecan, Director System Integration and Operations (Cayuga Medical Center)	Alignment of RPU needs at the Governance Level, including clinical integration.
East RPU Lead	Greg Rittenhouse, VP, COO, Home Care (UHS)	Alignment of RPU needs at the Governance Level, including clinical integration.
West RPU Leads	Josie Anderson (Guthrie) & Robin Stawasz (CareFirst)	Alignment of RPU needs at the Governance Level, including clinical integration.

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IPQR Module 9.6 - Key Stakeholders

Instructions :

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

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

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IPQR Module 9.7 - IT Expectations

Instructions :

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

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

IPQR Module 9.8 - Progress Reporting

Instructions :

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

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

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

IPQR Module 9.9 - IA Monitoring:

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Instructions :

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Section 10 – General Project Reporting

IPQR Module 10.1 - Overall approach to implementation

Instructions :

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

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

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

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

Instructions :

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

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

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IPQR Module 10.3 - Project Roles and Responsibilities

Instructions :

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

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

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

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

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

Instructions :

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

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

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

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

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IPQR Module 10.5 - IT Requirements

Instructions :

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

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

IPQR Module 10.6 - Performance Monitoring

Instructions :

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

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

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

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

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

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IPQR Module 10.7 - Community Engagement

Instructions :

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

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

IPQR Module 10.8 - IA Monitoring

Instructions :

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Section 11 – Workforce

IPQR Module 11.1 - Workforce Strategy Spending (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	5,645.00	4,516.00	95,964.00	169,349.00	122,307.00	122,307.00	60,213.00	60,213.00	22,580.00	22,580.00	685,674.00
Redeployment	0.00	0.00	6,398.00	11,290.00	14,677.00	19,569.00	15,053.00	18,064.00	10,537.00	9,032.00	104,620.00
New Hires	20,698.00	16,559.00	6,398.00	16,935.00	12,231.00	12,231.00	7,527.00	7,527.00	0.00	0.00	100,106.00
Other	161,822.00	129,458.00	211,121.00	84,674.00	95,400.00	90,508.00	67,740.00	64,729.00	42,149.00	43,654.00	991,255.00
Total Expenditures	**188,165.00**	**150,533.00**	**319,881.00**	**282,248.00**	**244,615.00**	**244,615.00**	**150,533.00**	**150,533.00**	**75,266.00**	**75,266.00**	**1,881,655.00**

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.

Module Review Status

Review Status	IA Formal Comments
Pass & Complete	

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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).	Completed	Finalized PPS target workforce state, 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 Step 1: The Project lead and Workforce Development and Transition Team (WDTT) will continue to convene and recruit new members to the Workforce Development and Transition Team (WDTT) which currently includes: HR representatives, union representatives, subject matter experts and key stakeholders.	Completed	In Process	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: The workforce consultant, under the guidance of the WDTT, will identify methods and tools for tracking and reporting Domain 1 Process Measures.	Completed	In Process	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3: The workforce consultant will work with project leads and the WDTT to identify specific number and type of occupations required to carry out our workforce needs, by DSRIP project.	Completed	In Process	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4: The workforce consultant will work with project leads and the WDTT to identify competencies (skills, training needs) for DSRIP-created positions, by DSRIP project.	Completed	In Process	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5: The workforce consultant will compile a Project-by-Project Analysis (from information garnered during steps 3 & 4) to be reviewed by	Completed	In Process	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
WDTT, project leads, project managers, and other key stakeholders.									
Task Step 6: Based on the reviewer input of the Project-by-Project Analysis, a Future State Staffing Assessment will be conducted by the workforce consultant, under the guidance of the WDTT and including inputs from the compensation and benefits analysis, to develop a comprehensive view of the areas within the PPS that will require more, less, or different staffing resources to support DSRIP projects and ultimately assist in identifying DSRIP-staffing location.	Completed	In Process	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 7: The workforce consultant and WDTT will conduct an Organizational Impact Assessment, informed by a face-to-face session with key stakeholders, that will determine the degree and magnitude of impacts by role/provider organization, key roles and responsibility changes, impact to staffing patterns, etc.	On Hold	In Process	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 8: The WDTT and workforce consultant will create a detailed target state workforce model to include: number of staff by skill, location, shift, pay category, etc.	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 9: This step replaces step number 7 which has been placed on hold. The CCN Workforce Manager will conduct an impact assessment that determines the ability of CCN to fully implement their projects. The CCN Workforce Manager will advise CCN and their partners regarding adequacy of workforce resources.	Completed	Step 9 replaces step 7.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	Completed	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

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 1: Solidify governance model and decision-making structure with the ability to approve workforce decisions.	Completed	In Process	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: The WDTT will define the workforce transition roadmap utilizing inputs from the Target State Workforce Assessment to determine workforce needed, the Gap Analysis to illustrate affects on current positions, the Compensation and Benefits Analysis to show impacts on current positions and salaries and a Communication plan to map out staff involvement.	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 3: Consolidate all specific workforce changes within the PPS; incorporating speed and scale projections by position, a recruitment plan for new hires (see Detailed Gap Analysis), retraining/re-deployment strategies (see Compensation and Benefit Analysis), training timelines (see Training Strategy) and the creation of a Communication and Engagement Plan.	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4: Generate a workforce transition roadmap, based on inputs from Milestone 2, Step 2 and Step 3, the Target Workforce State and the Detailed Gap Analysis.	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 5: Workforce transition roadmap is approved by governing body.	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	Completed	Current state assessment report & gap analysis, 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 Step 1: Identify which positions may involve direct re-deployment vs. retraining with input	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	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
from HR representatives and consideration for HR policies and Labor agreements.									
Task Step 2: Compare job skill requirements of Target Workforce State versus skills of jobs to be reduced/eliminated.	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 3: Utilizing the results from Milestone 3, Step 1 and Step 2, identify eligible staff for re-deployment/retraining through an HR-implemented skill assessment.	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4: Confirm impact analysis of existing workers (current state assessment) by identifying staff availability and competency levels, project-specific implementation needs, by member organization, in order to assess: 1) Staff able to fill target state positions through retraining and 2) Staff who could be redeployed directly into target state roles.	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 5: Make appropriate considerations for the PPS-wide healthcare environment by identifying barriers and affected subgroups.	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 6: Create a recruitment plan for new hire positions that cannot be filled through re-deployment/retraining, to include a recruitment timeline, strategies by position and solutions for positions difficult to fill (i.e. long-term pipeline approach).	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 7: Refine original budget projections based on analysis results.	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 8: Create a Gap Analysis Matrix, to include: 1) Workers impacted by job category; 2) Percent of overall workforce impacted that can be	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	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
retrained or redeployed; 3) Of impacted workers, project number of workers that are expected to achieve full or partial placement.									
Task Step 9: Reflect gap analysis results as they inform the workforce transition roadmap.	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 10: Gap analysis will be reported PPS-wide (RPU's, project leads, clinical performance units) and approved by governing body.	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	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.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES
Task Step 1: Contract Iroquois Healthcare Alliance (IHA) to produce a compensation and benefits analysis to include the healthcare systems and community-based healthcare organizations.	Completed	In Process	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2: Conduct a comprehensive PPS-wide analysis, in collaboration with IHA. Examine findings by: 1) job category; 2) variations on a regional level; and 3) variations on a facility-type level.	Completed	In Process	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3: Based on current state analysis results, solidify origin and destination of staff vulnerable to re-deployment.	Completed	In Process	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4: Work with HR to gather compensation and benefits, to be confidentially provided to a third party vendor, information for vulnerable staff and assess potential changes to compensation.	Completed	In Process	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5: With HR, third party vendor, and Union	On Hold	In Process	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
input, determine specific impacts to partial placement staff and potential contingencies.									
Task Step 6: With HR, third party vendor, and Union input, develop and incorporate policies for staff impacted by partial placement or who refuse retraining or re-deployment.	On Hold	In Process	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 7: Workforce governing body approves compensation and benefits analysis.	Completed	In Process	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 8: This step replaces step 6 which has been placed on Hold. On an as needed basis, CCN will work with HR representatives from partner organizations whose staff is impacted by DSRIP initiatives. CCN will also share and collaborate on available resources for training and job opportunities across the PPS.	Completed	This step replaces step 6 above which was placed on hold.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Milestone #5 Develop training strategy.	Completed	Finalized training strategy, 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 Step 1: The sub-committee will examine target state training/retraining needs to support DSRIP goals by project and position, training need types (skill building, performance metrics, vbp, etc.) and identification of all positions who will require training through surveys, project summaries and project lead interviews.	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 2: Include stakeholders, from positions in the workforce who will require training, in planning efforts.	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 3: Examine PPS-training/retraining capacity to support DSRIP goals by conducting a survey of existing training programs available and identify gaps in current training capacity versus target state training needs (skill building, training	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	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
for performance metrics, VBP, etc.).									
Task Step 4: Explore opportunities to coordinate efforts with existing state-wide education programs.	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 5: Solicit input from the Regional Performance Units (RPUs), finance committee and all other aspects of the organization (governance, IT physician engagement, clinical integration, cultural competency and health literacy, performance reporting) to inform the development of the training strategy. All workforce strategies will be available to other projects and workstreams via the PPS sharepoint site.	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 6: Develop a training strategy to guide the training plan, to include: goals, objectives and guiding principles for the detailed training plan; employee skill assessment; confirm process and approach to training (e.g. voluntary vs. mandatory, etc.).	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 7: Review accuracy of initial assessments, potential shortage of qualified workers, clearly defined position titles, predictions of benefits and compensation, refusal of employees to be retrained or redeployed and incorporate findings into training strategy.	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 8: Provide training strategy to the clinical domain of the governing body for review, feedback and approval.	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 9: Identify methods and tools (IT system) for measuring training effectiveness and tracking and reporting DSRIP-related training.	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	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 Step 10: Generate training plan for approval by governing body.	Completed	In Process	07/01/2015	09/30/2016	07/01/2015	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
Define target workforce state (in line with DSRIP program's goals).	sculley	Meeting Materials	44_DY2Q3_WF_MDL112_PRES1_MM_DY2Q3_Workforce_Transition_Roadmap_Meeting_Schedule_9167.xlsx	Workforce Transition Roadmap Meeting schedule	01/29/2017 06:57 AM
Create a workforce transition roadmap for achieving defined target workforce state.	sculley	Meeting Materials	44_DY2Q3_WF_MDL112_PRES2_MM_DY2Q3_Workforce_Transition_Roadmap_Meeting_Schedule_9168.xlsx	Workforce Transition Roadmap meeting schedule.	01/29/2017 06:58 AM
Develop training strategy.	sculley	Meeting Materials	44_DY2Q3_WF_MDL112_PRES5_MM_DY2Q3_Training_Schedule_9169.xlsx	DY2Q3 Training Schedule	01/29/2017 07:01 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Define target workforce state (in line with DSRIP program's goals).	This milestone was reported as complete in DY2Q2 however, over the course of DY2Q3, Care Compass Network has implemented areas of the transition roadmap. This has been primarily in the area of Project Specific/Organizational Work-stream training. CCN Workforce staff had several meetings in DY2Q3 with the focus of these meetings being creation of the content and structure of two half day summits, both to occur in early DY2Q4. The first workshop will be centered on the current and future training needs across all the projects and all positions. The participants' input will help inform and create and overall training strategy and plan for the Workforce component. The second workshop will be focused on the implementation and reporting features of HW Apps and training CCN's partners on how to use this tool. The intent of both summits is to meet the timeline events of further clarifying and prioritizing specific training needs and existing resources and to ensure training data is captured in CCN's one source, HWapps. All training programs, at both the individual and team level, will be addressed, assessed, and have a coordinated effort put behind them.
Create a workforce transition roadmap for achieving defined target workforce state.	This milestone was reported as complete in DY2Q2 however, over the course of DY2Q3, Care Compass Network has implemented areas of the transition roadmap. This has been primarily in the area of Project Specific/Organizational Work-stream training. CCN Workforce staff had several meetings in DY2Q3 with the focus of these meetings being creation of the content and structure of two half day summits, both to occur in early DY2Q4. The first workshop will be

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	centered on the current and future training needs across all the projects and all positions. The participants' input will help inform and create and overall training strategy and plan for the Workforce component. The second workshop will be focused on the implementation and reporting features of HW Apps and training CCN's partners on how to use this tool. The intent of both summits is to meet the timeline events of further clarifying and prioritizing specific training needs and existing resources and to ensure training data is captured in CCN's one source, HWapps. All training programs, at both the individual and team level, will be addressed, assessed, and have a coordinated effort put behind them.
Perform detailed gap analysis between current state assessment of workforce and projected future state.	This milestone was reported as complete in DY2Q2 however, over the course of DY2Q3, Care Compass Network has implemented areas of the transition roadmap. This has been primarily in the area of Project Specific/Organizational Work-stream training. CCN Workforce staff had several meetings in DY2Q3 with the focus of these meetings being creation of the content and structure of two half day summits, both to occur in early DY2Q4. The first workshop will be centered on the current and future training needs across all the projects and all positions. The participants' input will help inform and create and overall training strategy and plan for the Workforce component. The second workshop will be focused on the implementation and reporting features of HW Apps and training CCN's partners on how to use this tool. The intent of both summits is to meet the timeline events of further clarifying and prioritizing specific training needs and existing resources and to ensure training data is captured in CCN's one source, HWapps. All training programs, at both the individual and team level, will be addressed, assessed, and have a coordinated effort put behind them.
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.	This milestone was reported as complete in DY2Q2 however, over the course of DY2Q3, Care Compass Network has implemented areas of the transition roadmap. This has been primarily in the area of Project Specific/Organizational Work-stream training. CCN Workforce staff had several meetings in DY2Q3 with the focus of these meetings being creation of the content and structure of two half day summits, both to occur in early DY2Q4. The first workshop will be centered on the current and future training needs across all the projects and all positions. The participants' input will help inform and create and overall training strategy and plan for the Workforce component. The second workshop will be focused on the implementation and reporting features of HW Apps and training CCN's partners on how to use this tool. The intent of both summits is to meet the timeline events of further clarifying and prioritizing specific training needs and existing resources and to ensure training data is captured in CCN's one source, HWapps. All training programs, at both the individual and team level, will be addressed, assessed, and have a coordinated effort put behind them.
Develop training strategy.	This milestone was reported as complete in DY2Q2 however, over the course of DY2Q3, Care Compass Network has implemented areas of the transition roadmap. This has been primarily in the area of Project Specific/Organizational Work-stream training. CCN Workforce staff had several meetings in DY2Q3 with the focus of these meetings being creation of the content and structure of two half day summits, both to occur in early DY2Q4. The first workshop will be centered on the current and future training needs across all the projects and all positions. The participants' input will help inform and create and overall training strategy and plan for the Workforce component. The second workshop will be focused on the implementation and reporting features of HW Apps and training CCN's partners on how to use this tool. The intent of both summits is to meet the timeline events of further clarifying and prioritizing specific training needs and existing resources and to ensure training data is captured in CCN's one source, HWapps. All training programs, at both the individual and team level, will be addressed, assessed, and have a coordinated effort put behind them.

Milestone Review Status

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

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #4	Pass & Complete	
Milestone #5	Pass & Complete	

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IPQR Module 11.3 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

IPQR Module 11.5 - Major Dependencies on Organizational Workstreams

Instructions :

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

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

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IPQR Module 11.6 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Workforce Project Lead	Lenore Boris / SUNY Upstate Binghamton Clinical Campus	Responsible for development of IP and execution of all workforce-related activities.
Workforce Development Manager (PPS Staff person)	Maribeth Absi/Care Compass Network	Responsible for executing or supporting the execution of the Implementation Plan activities. Staff liason with workforce committee.
PPS Staff	Robin Kinslow-Evans, Executive Advisor, Mark Ropiecki, Executive Director, Dawn Sculley, Director Project Management, Rebecca Kennis, IT Director	Responsible for reviewing and providing timely feedback/input on various aspects of the PPS Workforce Strategy including the hiring and sub-contracting of vendors. Also, interface with leads for funds, communications, governance, coordinating workforcoce issues into MAPP portal.
IT Project Lead & Consultants	Srikanth Poranki, IT Project Lead Bill Ahrens, Senior Manager Jenna Barsky, Senior Consultant Kathleen Grueter, Consultant	Responsible for understanding workforce data, tracking & reporting needs and providing recommendations for solutions.
Workforce Development and Transition Team (Workforce Committee)	Melissa Alt, Chad Underwood, Mary Rosenthal, Sabrina Johnston, Tara Prochaszka, Jeff Chesebro, Marie Walsh, Lisa Melveney, Melanie Solomon, Brian Forest, Deb Lynch, Jeanette Avolio, Chris McAvoy-Paul, Dorothy Richter, Kaysie Memmer, Lorrie Byerly, Cheryl Gregory, Adrienne Greenwood, Cynthia Heaney, Lisa Lippoldt, Laurie Sperger, Shirley Hadley, Cheryl Henninger, Lynn Murray, Donna Chapman, Barbara Ackley, Tisha Hollenbeck, Dee Kline, Mary Hughs, Kim Riggi, Dee Lambert, Derrick Chrisler, Kim Nagle, Jackie Leaf, Maud Rith, Judy Olson, Wendy Hitchcock, Anne English, Ron Patti, Judy Eckard.	Responsible for overall direction, guidance and decisions related to the workforce strategy plan.
Workforce Strategy Vendor	Central & Northern AHEC	Responsible for the coordination and execution of workforce activities and analyses, reporting directly to the WF Project Lead
Labor Representation	SEIU 1099, CSEA, NYSNA	Provide insights and expertise into likely workforce impacts, staffing models and key job categories that will require retraining, re-deployment or hiring.

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IPQR Module 11.7 - Key Stakeholders

Instructions :

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

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

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

IPQR Module 11.8 - IT Expectations

Instructions :

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

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

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

IPQR Module 11.9 - Progress Reporting

Instructions :

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

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

The Workforce workstream will work with IT and Clinical Governance committees to identify an online tool for workforce data collection and assessment of worker performance. It will also be important for the identified tool to measure the success of the components of the workforce strategy (for example: the training strategy). Establishing mechanisms to capture employee feedback through training completion reports and subsequently sharing with appropriate PPS-partners and HR reps will be incorporated. Once a tool is identified, a reporting structure will be

developed that will funnel the information to the workforce team, who will report progress on a quarterly basis to the New York State Department of Health with respect to domain 1 process measures. The Workforce workstream will ensure training is provided for staff (within PPS and partner HR representatives) on use of the reporting platform in addition to emphasizing the importance of workforce data collection/reporting.
As part of an internal process, the Workforce workstream will measure success based on a detailed workforce action plan that provides specific dates for anticipated implementation, regular meetings and work plan review.

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IPQR Module 11.10 - Staff Impact

Instructions :

Please upload the Workforce Staffing Impact (Projections) and the Workforce Staffing Impact (Actuals) tables provided for quarterly reporting.

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
sculley	Other	44_DY2Q3_WF_MDL1110_OTH_Blank_Document_9192.docx	Module 11.10 required a file to be uploaded so we created this document to meet that requirement.	01/30/2017 09:25 AM

Narrative Text :

There are no updates to report in DY2Q3. Per the DSRIP Workforce Reporting Questions & Answers (QA) Document from January 29, 2016 the Workforce Impact Analysis is semi-annual reporting to align with reporting cycle tied Achievement Values (Q2 & Q4 for each year).

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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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)	940,827.00

Funding Type	Workforce Spending Actuals		Cumulative Spending to Date (DY1-DY5)($)	Cumulative Percent of Commitments Expended through Current DSRIP Year (DY2)
	DY2(Q1/Q2)($)	DY2(Q3/Q4)($)		
Retraining	36,630.00	23,107.50	71,737.50	26.04%
Redeployment	0.00	0.00	0.00	0.00%
New Hires	9,544.00	2,386.00	50,106.00	82.70%
Other	216,162.00	45,667.57	579,829.57	98.77%
Total Expenditures	**262,336.00**	**71,161.07**	**701,673.07**	**74.58%**

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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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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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.

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

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

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

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

Instructions :

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

Project Requirements (Milestone/Task Name)	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.	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 includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1a. - Develop a Participating Organization (e.g., provider) Network List for the PPS to outline the Partner Organization (e.g., providers, Community Based Organization (CBO), social service organizations, etc.) demographics for the PPS Integrated Delivery System.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 1b. - Establish operating units for the PPS called Regional Performing Units (RPUs) within which the PPS Participating Organizations from across the nine county region can be identified and engaged at a localized level.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 1c. Conduct a provider readiness survey and awareness campaign to position the PPS to contract with participating organizations and engage with safety net providers		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 1d. Initiate contracts with safety net providers.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 1e. Establish Participation Agreements for Participating Organizations within each RPU which contract PPS services required to achieve DSRIP goals, such as patient outreach and patient engagement. Manage ongoing process as needed.		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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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
Step 1f. - When appropriate, engage payers at a PPS leadership level roundtable, to be completed at minimum annually and supported by meeting minutes.										
Task Step 1g. - The Provider Relations professionals will perform periodic (e.g., quarterly) assessments of PPS Partner Organizations to confirm relationships exist, are active, and overall participation and results are aligned with the contractual terms or overall needs of the PPS (e.g., updated CNA assessment, etc.) As a result of the quarterly reviews, any changes to the Provider Network List will be made and communicated, and the need for priority status may assigned to further engage PPS Participating Organizations where needed.		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	DY2 Q4	Project	N/A	Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task PPS produces a list of participating HHs and ACOs.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2d. - Identify PPS HH and ACOs and create a Network Provider List. Integrate the Health Home representatives to recurring Stakeholder/ PAC meetings to ensure appropriate Health Home representation exists.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2e. - Review existing Health Home systems and capabilities, particularly the Health Home system architecture and how information is disseminated, and integrate leading practices/service models to the PPS Operating Model at the RPU level. On an ongoing basis, the RPU Project Managers will monitor results and progress to centrally communicate how to further refine the PPS approach or customize the service model at the RPU level.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2

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Step 2f. To the extent possible, identify and leverage Health Home-specific IT elements including case management information sharing, care coordination templates, connectivity/relation to the RHIO, etc.										
Task Step 2g. - To integrate the PPS and further promote the development of the integrated delivery system, assign an RPU Lead who will communicate and reinforce updates to and from the Clinical Governance Committee.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2h. - Note: There are currently no ACO's in place, nor in development, within the STRIPPS Partnering Organizations. This project requirement will be periodically reviewed for ongoing ACO pertinence.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	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		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS trains staff on IDS protocols and processes.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 3f. - Development of a Standard PPS Care Coordination Plan which will be informed by the Care Coordination needs assessment and developed based on guidance provided by the RPU Quality Committee as well as the Clinical Governance Committee. Upon finalization, the Standard PPS Care Coordination Plan will be shared appropriately with the Partnering Organizations and made available on the Care Compass Network SharePoint site. To promote consistency of IDS protocols, education or tutorials may also be provided.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	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 Step 3g. - Implement a process to track performance within the Care Coordination Plan through periodic reporting, including services provided outside of hospitals in order to assist with service integration. RPU adherence to standards established by the Clinical Governance Committee, including Care Coordination Plans, will be monitored by the RPU Quality Committee.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	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 connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Hospital	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Nursing Home	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 4g. - Perform a current state assessment of safety net connectivity to region-specific RHIOs. Expand on the efforts in project 2.a.i. Project Requirement 1a. development of a Participating Organization (e.g., provider) Network List for the PPS which outlines the Partner Organization (e.g., providers, Community Based Organization (CBO), payers, social service organizations, etc.) demographics for the PPS Integrated Delivery System by including EHR system and connectivity demographic overviews for the safety net providers in the PPS.		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task		Project		Completed	04/01/2015	12/31/2017	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Step 4h. - Maintain ongoing communication with RHIO to identify potential capabilities relevant to PPS activities.										
Task Step 4i. - Upon provider completion of project 2.a.i. Project Requirement 5, which includes leveraging a consulting service to assist with a PCMH & Meaningful Use readiness assessment, creation & implementation of the associated implementation plan(s), provide assistance with the application process, and formally document/retain certification related documentation; the PPS IT Coordinator will review and monitor the IT environment to confirm EHR system capabilities are in place are used and functioning as designed ensuring access to real-time data to improve interoperability. Periodic reviews will be performed and include evidence of alerts/secure messaging, availability of training materials, training(s) completed, and percentage of staff trained. The status of these reviews will be reported at minimally quarterly to the IT & Data Governance Committee and/or Clinical Governance Committee as appropriate.		Project		Completed	04/01/2015	12/31/2017	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4j. - The PPS will support partners (e.g., CBOs, providers, etc.) in actively sharing by promoting infrastructure build and/or other requirements as identified by the current state assessment above. As appropriate, partners will be contracted with the PPS for achievement of specific tasks, which will be monitored for completion as reported to the RPU Clinical Quality Committees for review.		Project		Completed	04/01/2015	12/31/2017	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	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 Step 5c. - In conjunction with project 2.a.i. Project Requirement 4, utilize the PPS IT and Data Governance team to identify Safety Net Providers preparation requirements for activation with the		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1

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RHIO. When needed, utilize the PPS IT Coordinator to coordinate resources needed for Safety Net Provider(s) activation with the appropriate RHIO.										
Task Step 5d. - Using the readiness assessment (See 2.a.i Milestone 1, Step 1c), determine PPS providers' status on achievement of PCMH and Meaningful Use requirements.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 5e. - Identify and contract with a Consulting service to assist with a PCMH readiness assessment and implementation and collaborate with adjacent PPS' (as appropriate).		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 5f. - Leverage the PCMH Readiness Assessment as a baseline to create a Meaningful Use and PCMH implementation plan for PPS providers. The plan will include a current state assessment for each safety net provider and detail key milestones which will allow for a phased implementation approach towards PCMH and Meaningful Use DY3, Q4 requirements.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 5g. - The RPU Provider Relations professionals will assist safety net providers with the associated application(s) throughout each phase of the PCMH Level 3 implementation plan.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 5h. - Obtain and retain certification documentation substantiating safety net providers within the PPS have achieved Meaningful Use and PCMH Level 3 standards.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 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	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 6b. - Identify those person(s) responsible for review of population health data and provide requisite HIPAA, PHI, and regulatory training to ensure overall PPS compliance. As applicable, obtain DEAA, BAA, or other required arrangement.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	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
Step 6c. - Identify data elements specified in DSRIP requirements.										
Task Step 6d. - Initiate population health management with available patient data, such as Salient and participating provider clinical systems.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6e. - Identify available patient health registries and population health software.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6f. - Develop a population health stratification approach to confirm EHR completeness and validity.		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 6g. - Develop a population health stratification approach to identify patient groups for targeting.		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 6h. - Develop a defined population health registry for individual patients for enhanced care management and each RPU.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6i. - Develop a dictionary of registry elements to ensure ease of implementation and standardization of use PPS-wide.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6j. - Develop a monitoring process which allows for the RPU Leads to actively track patients for metrics such as status (engaged/not engaged) and performance against project milestones, to be included in reporting at the PPS level.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 6k. - Perform periodic reviews of user access and system requirements to perform population health management.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all eligible 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		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All eligible practices meet 2014 NCQA Level 3 PCMH and/or		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

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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
APCM standards.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 7d. - In conjunction with project 2.a.i. Project Requirement 4, utilize the PPS IT and Data Governance team to identify all participating PCPs for activation with the RHIO. When needed, utilize the PPS IT Coordinator to coordinate resources needed for Primary Care Providers (PCPs) activation with the appropriate RHIO.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 7e. - Identify and contract with a Consulting service to assist with a PCMH readiness assessment and implementation and collaborate with adjacent PPS' (as appropriate).		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 7f. - Leverage the PCMH Readiness Assessment as a baseline to create a Meaningful Use and PCMH implementation plan for PPS providers. The plan will include a current state assessment for each PCP and detail key milestones which will allow for a phased implementation approach towards PCMH and Meaningful Use DY3, Q4 requirements.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 7g. - Monitor primary care access/capacity by performing a PPS survey through existing RMS panel resources and using available provider surveys, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Action plans will be developed, as needed, to address primary care access needs of the PPS.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 7h. - The RPU Provider Relations professional will assist the PCPs with the associated application(s) throughout each phase of the PCMH Level 3 implementation plan.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 7i. - Obtain and retain certification documentation substantiating safety net providers within the PPS have achieved Meaningful Use and PCMH Level 3 standards.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 7j. - Provider Relations professionals will record, monitor, and communicate identified primary care physician needs by their		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Care Compass Network (PPS ID:44)

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
assigned RPU.										
Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	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 holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 9b. - Establish VBP committee comprised of members from PPS constituency with representation from all provider types. VBP Committee will seek to follow & leverage industry wide VBP Prepatory Strategies via HANYS. (Step corresponds with Financial Sustainability Implementation Plan)		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 9c. - Cultivate pathways between VBP Committee and the rest of the system in order to survey and educate current landscape of existing VBP arrangements amongst PPS providers in PPS. (Step corresponds with Financial Sustainability Implementation Plan)		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 9d. - Create education and communication plan, including the myriad components intrinsic to VBP, particularly the different strata of risk. (Step corresponds with Financial Sustainability Implementation Plan)		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 9e. - Secure educational resources for outreach endeavors. (Step corresponds with Financial Sustainability Implementation Plan)		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 9f. - Carry out education and outreach endeavors for PPS providers ensuring a thorough understanding of the various VBP models and methods. Coordinate regional payor forums with providers in the region. (Step corresponds with Financial Sustainability Implementation Plan)		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 9g. - Create a readiness self-assessment survey (High, Moderate, Low) for individual providers within the PPS to assess the varying levels of evolution as movement towards fully implemented VBP occurs. The self-assessment survey will include the following (per the state): Degree of experience		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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operating in VBP models and preferred compensation modalities; Degree of sophistication in ability to negotiate plan contracts, monitor and report on service types; Estimated volume of Medicaid Managed Care spending received by the network. Estimate of total cost of care for specific services (modeled along bundles Status of requisite IT linkages for network funds flow monitoring. Provider ability (financial stability) and willingness to take downside risk in a risk sharing arrangement. Level of assistance needed to negotiate plan options with Medicaid Managed Care (High, Moderate, Low). (Step corresponds with Financial Sustainability Implementation Plan)										
Task Step 9h. - Distribute the readiness self-assessment survey to all providers to establish accurate baseline. (Step corresponds with Financial Sustainability Implementation Plan)		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 9i. - Collect, assemble, and analyze readiness self-assessment survey results. (Step corresponds with Financial Sustainability Implementation Plan)		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 9j - Prepare Initial VBP Baseline Assessment based on readiness self-assessment survey results and dialogue from providers. (Step corresponds with Financial Sustainability Implementation Plan)		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 9k. - Disseminate preliminary results of readiness self-assessment survey analysis for review by PPS Providers. (Step corresponds with Financial Sustainability Implementation Plan)		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 9l. - Update, revise and finalize VBP Baseline Assessment based on Providers & Boards review. (Step corresponds with Financial Sustainability Implementation Plan)		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 9m. - PPS Board to sign off on preference for PPS providers to contract with MCO's at their own discretion. (Step corresponds with Financial Sustainability Implementation Plan)		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 9n. - Established VBP Committee will coordinate with Medicaid MCOs to schedule monthly meetings to discuss utilization trends, performance issues and payment reform based on VBP Adoption Plan.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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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
Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	DY3 Q4	Project	N/A	In Progress	04/01/2015	06/30/2019	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation		Project		In Progress	04/01/2015	06/30/2019	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.		Project		In Progress	04/01/2015	06/30/2019	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 10c. - Identify patient subgroups and populations and stratify by assigning risk values.		Project		In Progress	04/01/2015	06/30/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 10d. - Conduct a provider analysis exercise to determine if the provider is better categorized as a "Large Organized Group Practice Provider" or an "Independent Provider."		Project		In Progress	04/01/2015	06/30/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 10e. - Develop a contracting strategy which correlates DSRIP goals, timelines, patient risk stratification, and physician metrics and results with monetary incentive payments. As part of this process, a compensation model and implementation plan will be developed based on provider categorization. For "Large Organized Group Practice Providers" the PPS will integrate a value based system which focus' on an RVU and quality base. As noted in Step 1 above, Partnering Organizations will be contracted at the RPU level through Provider Relations professionals.		Project		In Progress	04/01/2015	12/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 10f. - For physicians identified as "Independent Providers" the PPS will pursue value based contracts with their associated Medicaid MCO which includes the elements noted in Step 10b. section of the 2.a.i Implementation Plan.		Project		In Progress	04/01/2015	06/30/2019	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 10g. - The Provider Relations professionals, assigned at each RPU, will monitor contract compliance and pertinence of contractual terms to meet DSRIP goals as DSRIP implementation matures and develops. This may be achieved through leveraging the integrated delivery system model, including Population Health professionals as well as the PPS PMO. Results will be reviewed through the PPS PMO performance management process.		Project		In Progress	04/01/2015	06/30/2019	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #11	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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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
Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.										
Task Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 11b. - As noted above in Project 2.a.i Step 1f. and in line with the plan for project 2.d.i., the targeted patient population will be identified and consents subsequently obtained through the use of a robust contracted patient activation outreach worker team, as well as close collaboration with the community-based health navigation team (refer to Project 2.c.i.). These combined efforts, along with the training efforts that will occur through the patient activation training team for safety-net providers in the network, will ensure that the maximum number of individuals complete the PAM. Additionally, the PPS plans to embed the PAM survey in all safety-net practices at a minimum and will implement a process whereby all patients without insurance and all patients with Medicaid coverage will be given the PAM if it is determined they have not yet completed the survey. The PPS plans to leverage the RPU structure to achieve this efficiently and effectively (see attached for RPU structure).		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 11c. - A comprehensive incentive plan will be developed, which will compensate providers for their participation and will assign a value to each PAM survey that is collected. Additionally, the patient activation training team will work with the provider relations component of the PPS to inform providers about the overall DSRIP initiative and PPS objectives, in addition to patient activation and the PAM.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 11d. - A broad range of responsible individuals will receive training in the PAM, and the efforts will initially start out in the 9 hospitals within the PPS network, so that lessons learned can be applied as the project is expanded to other providers. To this effect, Project 2.a.i will work closely with Project 2.d.i. as well as with the Workforce Department group to ensure that the right skillset is matched up with each of the two position types.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	Milestone 1 and the remaining steps are on track for completion to their timelines. From a contracting perspective, CCN has contracts executed with 79 different organizations with 25 of them being Community-Based Organizations, 14 Long-Term Care organizations, 8 Hospitals, a Pharmacy, 5 Clinics (including two FQHCs), 2 Case Management/Health Home Organizations, 3 Hospices, 13 Mental Health/Substance Abuse Clinics, and 8 Independent Primary Care Practices. Many of the 79 organizations have executed contracts for multiple DSRIP projects for a total of over 165 project contracts executed to date with several more in final review with our Partners. Contracts executed with CCN include a Partner Agreement, Reciprocal BAA and at least 1 appendix C for a project. Of the 79 organizations who have executed contracts, 40% are located in the North RPU, 35.8% in the South RPU, 10.3% in the East RPU and 13.9% in the West RPU. The CCN Provider Relations Coordinators continue to meet on a weekly basis to evaluate relationships with organizations in each of the 9 counties and to identify gaps whether they be project related or gaps in the types of organizations represented. CCN Leadership has developed a strategic plan for creating the Integrated Delivery System (IDS) which was presented to an initial group of stakeholders on December 15th, 2016. The Director of Strategic Planning for CCN will bring this plan to each RPU stakeholders group, several CCN governance bodies; Coordinating Council, Clinical Governance Committee, PAC Executive Council as well as to the PPS wide Stakeholders meeting. Once the strategic plan is finalized with input incorporated from Stakeholders, the plan will be reviewed with CCN's Board of Directors for final approval in DY2Q4. With a wide variety of organizations contracted with Care Compass Network, we have built a solid foundation for which to build from with work remaining to integrate the Partners as well as to continue to engage Partners that have not yet contracted with CCN. Through the previous reporting cycle CCN has been able to develop active relationships with MCOs in the region including Fidelis, Excellus, UHC and TotalCare. Regular meetings are established with Excellus, which operates in Broome County, and United Healthcare which operates across the PPS. Discussions with Total Care, which operates in 3 of the 9 PPS counties, are ongoing. CCN is hosting payer forums so that partners across the network can further learn how they can play a role in the Value-Based Payment contracting arrangements. Involvement of the payers continues to be a work in progress with no agreements in place.
Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	No changes to report for DY2Q3 however, the PPS still has full inclusion of Health Home representatives and members from the local Accountable Care Organization. The strategic planning event held on December 15th, 2016 included representatives from CAP (the ACO). Each Regional Performance Unit (RPU) and stakeholders meeting has representation from either a Health Home, Health Home downstream provider or the ACO for review and input of the IDS strategic plan.
Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	The milestone and the subsequent steps are due for completion in DY2Q4. With a variety of organizations (79 total) contracted with Care Compass Network, we have built a solid foundation from which to build. CCN's Director of Strategic Planning has drafted a strategic plan for the Integrated Delivery System and has actively been soliciting input from stakeholders in the PPS. The Stakeholder's input will help to determine the type of communication and integration required for care coordination across the region, the role CCN would play in the population health care platform build and the required elements for building the Integrated Delivery System. CCN continues to work on a plan for care coordination. Within DY2Q4 CCN will be facilitating several pilot projects, including the MAX Series for reduction of super utilizers within the inpatient hospital setting at Cortland Regional Medical Center, that will have care coordination efforts at the center to aid in building the region-specific model of care coordination. These pilots will better identify the current process of communication and data sharing, on a regional level, between health care systems and community based organizations. This will also allow an opportunity to expand upon best practices in place while staying regional and small enough to effectively work through identified gaps. In development towards the ideal clinically interoperable system, CCN has analyzed the availability and use of IT solutions currently in use by health systems and organizations offering community based services. The original pre-engagement assessment completed in June of 2015 was a beginning at assessing the IT needs across the PPS. In follow up CCN's Director of IT has held meetings with the region's leading hospitals and health systems to understand their EHR needs and abilities, connectivity to a RHIO and existing usage. The IT project manager is following up with site visits to all partnering organizations to gather more data on the needs, as a whole, for IT across the PPS. As a result of an analysis of CCN attested partners, there are 100 safety-net providers, 25 non-safety-net providers and 53 providers whose

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	status is not currently disclosed to the PPS. Out of these organizations 59 safety-net providers have executed contracts with the PPS of which 37 have no EHR needs and 45 are connected to the RHIO. Of the non-safety-net providers, 13 have executed contracts with only 3 showing no EHR needs and only 7 with some level of connection to the RHIO. For those organizations, whose safety-net designation is in question, 16 have executed contracts with the PPS yet only 1 having no need for an EHR build and 8 have some level of connection to the RHIO. This has helped CCN identify the need to execute the choice of an EHR immediately and begin implementation first for safety-net providers and then by need across the PPS.
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.	Milestone 4 has 4 steps which are being marked as completed for DY2Q3, with milestone 4, as well as, milestone 5 and other steps on track to completion for DY3Q3. After a partner executes a contract with Care Compass Network to participate in the DSRIP projects, they complete and submit an organizational profile to CCN listing contact information for resources such as workforce, IT and compliance as well as a facility champion. CCN contacts the organization's IT point person and obtains current IT information from the partner in regards to if they have an EHR, which one, if they are connected to a RHIO and which one, as well as, if the information exchanged with the RHIO is bi-directional. Most recently CCN's Director of IT has held meetings with the region's leading hospitals and health systems to understand their EHR needs and abilities, as well as connectivity to a RHIO (Step 4g - Complete). The IT Project Manager has also been meeting with partnering organizations to gather more data on the needs, as a whole, for IT across the PPS. As a result of an analysis of CCN attested partners, there are 100 safety-net providers, 25 non-safety-net providers and 53 providers whose status is not currently disclosed to the PPS. Out of these organizations 59 safety-net providers have executed contracts with the PPS of which 37 have no EHR needs and 45 are connected to the RHIO. Of the non-safety-net providers, 13 have executed contracts with only 3 showing no EHR needs and only 7 with some level of connection to the RHIO. For those organizations, whose safety-net designation is in question, 16 have executed contracts with the PPS yet only 1 having no need for an EHR build and 8 have some level of connection to the RHIO. This has helped CCN identify the need to execute the choice of an EHR immediately and begin implementation first for safety-net providers and then by need across the PPS. The 3 RHIOs supporting the nine-county region, HealthLinkNY, HealtheConnects and the Rochester RHIO, have worked with CCN to connect with stakeholders and demonstrate HIE functionality. Twenty-four of the 38 partners within the HealthLinkNY service area have active agreements, 24 of the 31 partners within the HealtheConnects region have active agreements, and 9 of the 9 partners in the Rochester RHIO have active agreements with the RHIO. The PPS expects to see an increase in that number as the deadline for Article 28 sites approaches in March of 2017. CCN will focus efforts on connecting the remaining partners with the relevant RHIO before the March 2018 deadline. In addition, CCN can focus on developing additional capability, including secure messaging etc (Step 4h - Complete). With this ongoing monitoring of the EHR and IT needs across the PPS and the inclusion of hiring Research and Marketing Strategies, Inc. (RMS) for PCMH consulting services, the focus has been to ensure all Primary Care Practice EHRs meet Meaningful Use (MU) Stage 2 requirements as per the requirements for completing the NCQA certification process. At this time, there have not been any EHRs identified as not meeting the Meaningful Use Stage 2 requirements across 85 practice sites in process of obtaining PCMH 2014 Level 3 certification. CCN will continue to monitor these practices, along with RMS in their consulting role, to quickly identify any IT needs through the certification process (Step 4i - Complete). Each Regional Performing Units (RPU) monitors partners who have executed contracts with the PPS for achievement of specific tasks. Monthly meetings are held to go over identified gaps as well as best practices across the RPU. CCN continues to work with these partners in refining their methods for task completion and identifying best practices across the PPS (Step 4j - Complete).
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.	Milestone 4 has 4 steps which are being marked as completed for DY2Q3, with milestone 4, as well as, milestone 5 and other steps on track to completion for DY3Q3. After a partner executes a contract with Care Compass Network to participate in the DSRIP projects, they complete and submit an organizational profile to CCN listing contact information for resources such as workforce, IT and compliance as well as a facility champion. CCN contacts the organization's IT point person and obtains current IT information from the partner in regards to if they have an EHR, which one, if they are connected to a RHIO and which one, as well as, if the information exchanged with the RHIO is bi-directional. Most recently CCN's Director of IT has held meetings with the region's leading hospitals and health systems to understand their EHR needs and abilities, as well as connectivity to a RHIO (Step 4g - Complete). The IT Project Manager has also been meeting with partnering organizations to gather more data on the needs, as a whole, for IT across the PPS. As a result of an analysis of CCN attested partners, there are 100 safety-net providers, 25 non-safety-net providers and 53 providers whose status is not currently disclosed to the PPS. Out of these organizations 59 safety-net providers have executed contracts with the PPS of which 37 have no EHR needs and 45 are connected to the RHIO.

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Milestone Name	Narrative Text
	Of the non-safety-net providers, 13 have executed contracts with only 3 showing no EHR needs and only 7 with some level of connection to the RHIO. For those organizations, whose safety-net designation is in question, 16 have executed contracts with the PPS yet only 1 having no need for an EHR build and 8 have some level of connection to the RHIO. This has helped CCN identify the need to execute the choice of an EHR immediately and begin implementation first for safety-net providers and then by need across the PPS. The 3 RHIOs supporting the nine-county region, HealthLinkNY, HealtheConnects and the Rochester RHIO, have worked with CCN to connect with stakeholders and demonstrate HIE functionality. Twenty-four of the 38 partners within the HealthLinkNY service area have active agreements, 24 of the 31 partners within the HealtheConnects region have active agreements, and 9 of the 9 partners in the Rochester RHIO have active agreements with the RHIO. The PPS expects to see an increase in that number as the deadline for Article 28 sites approaches in March of 2017. CCN will focus efforts on connecting the remaining partners with the relevant RHIO before the March 2018 deadline. In addition, CCN can focus on developing additional capability, including secure messaging etc (Step 4h - Complete). With this ongoing monitoring of the EHR and IT needs across the PPS and the inclusion of hiring Research and Marketing Strategies, Inc. (RMS) for PCMH consulting services, the focus has been to ensure all Primary Care Practice EHRs meet Meaningful Use (MU) Stage 2 requirements as per the requirements for completing the NCQA certification process. At this time, there have not been any EHRs identified as not meeting the Meaningful Use Stage 2 requirements across 85 practice sites in process of obtaining PCMH 2014 Level 3 certification. CCN will continue to monitor these practices, along with RMS in their consulting role, to quickly identify any IT needs through the certification process (Step 4i - Complete). Each Regional Performing Units (RPU) monitors partners who have executed contracts with the PPS for achievement of specific tasks. Monthly meetings are held to go over identified gaps as well as best practices across the RPU. CCN continues to work with these partners in refining their methods for task completion and identifying best practices across the PPS (Step 4j - Complete).
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Milestone 6 has no steps due for completion in DY2Q3. In DY2Q2 CCN finalized the Population Health Roadmap which was presented and approved by the Board of Directors at the September 13, 2016 meeting. Since Population Health ties in with PCMH certification, our population health stratification approach utilizes EHR completeness as we are building off of the chronic disease focus selections our Partners chose as part of their PCMH 2014 Level 3 application. As part of the Population Health Roadmap CCN will conduct operational risk analysis and stratification beginning with the dimensions such as diagnostic groups, current risk assessments, current utilization patterns, NYS Prevention Agenda measures, current compliance measures, current social determinant factors, HEDIS measures and PCMH indicators. The IT Roadmap is being implemented by our IT Team, including overseeing the Population Health Management Platform (PHM) selection process. The selection process included a scan of all products in the field and a solicitation for proposals to all relevant products. The selection committee completed review and rated each of the 17 submitted proposals. As a result of the review and rating, the committee has narrowed down to five vendors. The on-site presentations for the five remaining vendors were completed in September 2016. The selection committee will choose one leading vendor to present to Clinical Governance Committee, IT and Data Governance Committee and the Board of Directors. The Population Health Platform will enable Care Compass Network to initiate its Population Health initiative.
Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all eligible participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	This milestone does not have any steps due for completion in DY2Q3 however CCN continues to make progress towards completing the milestone. With respect to PCMH 2014 Level 3 certification, a current state analysis indicates five partners have achieved PCMH 2014 Level 3. There are two partners, with large medical groups encompassing the bulk of the PPS providers, who are also in the final stages of application for PCMH 2014 Level 3. There is a large concentration of independent primary care practices in the North Regional Performing Unit (NRPU) so the PPS is funding the consulting fees of Research & Marketing Systems (RMS) to support PCMH achievement. These smaller practice sites are eager to obtain PCMH recognition but the overall build in infrastructure, coupled with the work load associated with application process was proving to be too heavy of a lift. Working in conjunction with the NRPU PCMH quality subcommittee, RMS has completed its assessments of 33 practice site locations. Additionally, CCN's funds flow model has allowed for funding up to $40,000 to incent achievement of PCMH 2014 Level 3 certification based upon predefined timeframes. In the rest of the PPS, this includes both the large medical groups as well as small independent practices. The amount of incentive will vary based on each partner's current certification and ability to meet predefined milestones. With respect to VBP and MCO partnerships, the VBP subcommittee has been meeting at least monthly and is scheduled to continue doing so throughout DY2. The PPS sent out a new VBP assessment January 13, 2017 to gather further understanding of the VBP adoption needs across the PPS. Additionally, the PPS has reviewed the update to the VBP roadmap and is incorporating the changes into the plan. The contracts for project implementation have intentionally been written in one year timeframes to allow PPS contracting efforts to migrate to VBP relationships over time. Our contracts for project work have been made short-term (to the end of the DSRIP year)

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Milestone Name	Narrative Text
	intentionally to allow for changes in commitments and also the ability to migrate the payment mechanisms as we move forward in DSRIP. Year 1 & 2 contracts included development of fee for service standards PPS-wide. Year 3 contracts will include the upside risk contracting with withhold and Year 4 contracts will have the migration to VBP relationship with quality and potential for downside risk. CCN has been able to develop active relationships with MCOs in the region including Fidelis, Excellus, UHC and TotalCare. Regular meetings are established with Excellus which operates in Broome County, and United HealthCare which operates across the PPS. Discussions with Total Care, which operates in three of the nine PPS counties, are ongoing. CCN is hosting payer forums so that partners across the network can further learn how they can play a role in the Value-Based Payment contracting arrangements. The United Healthcare forum was held in Binghamton. It was attended by 39 individuals representing approximately 30 organizations. There is no plan for a forum with Excellus as they only operate in Broome County and will be contracting with Lourdes and UHS. Care Compass Network is working to schedule the remaining forums with TotalCare (recently purchased by Melena) and Fidelis. Involvement of the payers continues to be a work in progress with no agreements in place.
Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	This milestone does not have any steps due for completion in DY2Q3 however CCN continues to make progress towards completing the milestone. With respect to PCMH 2014 Level 3 certification, a current state analysis indicates five partners have achieved PCMH 2014 Level 3. There are two partners, with large medical groups encompassing the bulk of the PPS providers, who are also in the final stages of application for PCMH 2014 Level 3. There is a large concentration of independent primary care practices in the North Regional Performing Unit (NRPU) so the PPS is funding the consulting fees of Research & Marketing Systems (RMS) to support PCMH achievement. These smaller practice sites are eager to obtain PCMH recognition but the overall build in infrastructure, coupled with the work load associated with application process was proving to be too heavy of a lift. Working in conjunction with the NRPU PCMH quality subcommittee, RMS has completed its assessments of 33 practice site locations. Additionally, CCN's funds flow model has allowed for funding up to $40,000 to incent achievement of PCMH 2014 Level 3 certification based upon predefined timeframes. In the rest of the PPS, this includes both the large medical groups as well as small independent practices. The amount of incentive will vary based on each partner's current certification and ability to meet predefined milestones. With respect to VBP and MCO partnerships, the VBP subcommittee has been meeting at least monthly and is scheduled to continue doing so throughout DY2. The PPS sent out a new VBP assessment January 13, 2017 to gather further understanding of the VBP adoption needs across the PPS. Additionally, the PPS has reviewed the update to the VBP roadmap and is incorporating the changes into the plan. The contracts for project implementation have intentionally been written in one year timeframes to allow PPS contracting efforts to migrate to VBP relationships over time. Our contracts for project work have been made short-term (to the end of the DSRIP year) intentionally to allow for changes in commitments and also the ability to migrate the payment mechanisms as we move forward in DSRIP. Year 1 & 2 contracts included development of fee for service standards PPS-wide. Year 3 contracts will include the upside risk contracting with withhold and Year 4 contracts will have the migration to VBP relationship with quality and potential for downside risk. CCN has been able to develop active relationships with MCOs in the region including Fidelis, Excellus, UHC and TotalCare. Regular meetings are established with Excellus which operates in Broome County, and United Healthcare which operates across the PPS. Discussions with Total Care, which operates in three of the nine PPS counties, are ongoing. CCN is hosting payer forums so that partners across the network can further learn how they can play a role in the Value-Based Payment contracting arrangements. The United Healthcare forum was held in Binghamton. It was attended by 39 individuals representing approximately 30 organizations. There is no plan for a forum with Excellus as they only operate in Broome County and will be contracting with Lourdes and UHS. Care Compass Network is working to schedule the remaining forums with TotalCare (recently purchased by Melena) and Fidelis. Involvement of the payers continues to be a work in progress with no agreements in place.
Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	This milestone does not have any steps due for completion in DY2Q3 however CCN continues to make progress towards completing the milestone. With respect to PCMH 2014 Level 3 certification, a current state analysis indicates five partners have achieved PCMH 2014 Level 3. There are two partners, with large medical groups encompassing the bulk of the PPS providers, who are also in the final stages of application for PCMH 2014 Level 3. There is a large concentration of independent primary care practices in the North Regional Performing Unit (NRPU) so the PPS is funding the consulting fees of Research & Marketing Systems (RMS) to support PCMH achievement. These smaller practice sites are eager to obtain PCMH recognition but the overall build in infrastructure, coupled with the work load associated with application process was proving to be too heavy of a lift. Working in conjunction with the NRPU PCMH quality subcommittee, RMS has completed its assessments of 33 practice site locations. Additionally, CCN's funds flow model has allowed for funding up to $40,000 to incent achievement of PCMH 2014 Level 3 certification based upon predefined timeframes. In the rest of the PPS, this includes both the large medical groups as well as small independent practices. The amount of incentive will vary based on each partner's current certification and ability to meet predefined milestones.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	With respect to VBP and MCO partnerships, the VBP subcommittee has been meeting at least monthly and is scheduled to continue doing so throughout DY2. The PPS sent out a new VBP assessment January 13, 2017 to gather further understanding of the VBP adoption needs across the PPS. Additionally, the PPS has reviewed the update to the VBP roadmap and is incorporating the changes into the plan. The contracts for project implementation have intentionally been written in one year timeframes to allow PPS contracting efforts to migrate to VBP relationships over time. Our contracts for project work have been made short-term (to the end of the DSRIP year) intentionally to allow for changes in commitments and also the ability to migrate the payment mechanisms as we move forward in DSRIP. Year 1 & 2 contracts included development of fee for service standards PPS-wide. Year 3 contracts will include the upside risk contracting with withhold and Year 4 contracts will have the migration to VBP relationship with quality and potential for downside risk. CCN has been able to develop active relationships with MCOs in the region including Fidelis, Excellus, UHC and TotalCare. Regular meetings are established with Excellus which operates in Broome County, and United Healthcare which operates across the PPS. Discussions with Total Care, which operates in three of the nine PPS counties, are ongoing. CCN is hosting payer forums so that partners across the network can further learn how they can play a role in the Value-Based Payment contracting arrangements. The United Healthcare forum was held in Binghamton. It was attended by 39 individuals representing approximately 30 organizations. There is no plan for a forum with Excellus as they only operate in Broome County and will be contracting with Lourdes and UHS. Care Compass Network is working to schedule the remaining forums with TotalCare (recently purchased by Melena) and Fidelis. Involvement of the payers continues to be a work in progress with no agreements in place.
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.	This milestone does not have any steps due for completion in DY2Q3 however CCN continues to make progress towards completing the milestone. With respect to PCMH 2014 Level 3 certification, a current state analysis indicates five partners have achieved PCMH 2014 Level 3. There are two partners, with large medical groups encompassing the bulk of the PPS providers, who are also in the final stages of application for PCMH 2014 Level 3. There is a large concentration of independent primary care practices in the North Regional Performing Unit (NRPU) so the PPS is funding the consulting fees of Research & Marketing Systems (RMS) to support PCMH achievement. These smaller practice sites are eager to obtain PCMH recognition but the overall build in infrastructure, coupled with the work load associated with application process was proving to be too heavy of a lift. Working in conjunction with the NRPU PCMH quality subcommittee, RMS has completed its assessments of 33 practice site locations. Additionally, CCN's funds flow model has allowed for funding up to $40,000 to incent achievement of PCMH 2014 Level 3 certification based upon predefined timeframes. In the rest of the PPS, this includes both the large medical groups as well as small independent practices. The amount of incentive will vary based on each partner's current certification and ability to meet predefined milestones. With respect to VBP and MCO partnerships, the VBP subcommittee has been meeting at least monthly and is scheduled to continue doing so throughout DY2. The PPS sent out a new VBP assessment January 13, 2017 to gather further understanding of the VBP adoption needs across the PPS. Additionally, the PPS has reviewed the update to the VBP roadmap and is incorporating the changes into the plan. The contracts for project implementation have intentionally been written in one year timeframes to allow PPS contracting efforts to migrate to VBP relationships over time. Our contracts for project work have been made short-term (to the end of the DSRIP year) intentionally to allow for changes in commitments and also the ability to migrate the payment mechanisms as we move forward in DSRIP. Year 1 & 2 contracts included development of fee for service standards PPS-wide. Year 3 contracts will include the upside risk contracting with withhold and Year 4 contracts will have the migration to VBP relationship with quality and potential for downside risk. CCN has been able to develop active relationships with MCOs in the region including Fidelis, Excellus, UHC and TotalCare. Regular meetings are established with Excellus which operates in Broome County, and United Healthcare which operates across the PPS. Discussions with Total Care, which operates in three of the nine PPS counties, are ongoing. CCN is hosting payer forums so that partners across the network can further learn how they can play a role in the Value-Based Payment contracting arrangements. The United Healthcare forum was held in Binghamton. It was attended by 39 individuals representing approximately 30 organizations. There is no plan for a forum with Excellus as they only operate in Broome County and will be contracting with Lourdes and UHS. Care Compass Network is working to schedule the remaining forums with TotalCare (recently purchased by Melena) and Fidelis. Involvement of the payers continues to be a work in progress with no agreements in place.

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Complete	
Milestone #3	Pass & Ongoing	
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #9	Pass & Ongoing	
Milestone #10	Pass & Ongoing	
Milestone #11	Pass & Ongoing	

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

Instructions :

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

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

No Records Found

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

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

Instructions :

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

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

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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	10,198

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	1,200	2,550	2,804	5,609
	Quarterly Update	70	263	1,470	0
	Percent(%) of Commitment	5.83%	10.31%	52.43%	0.00%
IA Approved	Quarterly Update	0	263	0	0
	Percent(%) of Commitment	0.00%	10.31%	0.00%	0.00%

Warning: PPS Reported - Please note that your patients engaged to date (1,470) does not meet your committed amount (2,804) for 'DY2,Q3'

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
espape	Rosters	44_DY2Q3_PROJ2biv_MDL2biv2_PES_ROST_CCN_2biv_DYQ3-Patient_Registry_Hospital_9085.xlsx	CCN Actively Engaged report for Care Transitions	01/27/2017 12:49 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 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	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1b. The 2biv Project Team, through the Clinical Governance Committee and Board of Directors will identify and adopt evidence-based Care Transition Intervention Models appropriate for implementation and adoption by the Performing Provider System (PPS).		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 1c. Using the approved Care Transition Protocols, the 2biv Project Team and Project Champion from each of the nine PPS hospitals will perform a facility gap analysis to identify differences between the hospital care transition operating model versus the PPS Care Transition Plan. Following the assessment, the PPS will engage with hospitals who meet the criteria of the PPS Care Transition Protocol for Care Transitions Work. Organizations who do not meet the criteria, if any, would have training provided on use of the standardized protocol.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1d. The PPS will leverage the Regional Performing Unit (RPU) model to ensure consistency as well as customizability throughout PPS. RPU-specific Clinical Governance subcommittees (e.g., quality committees) will be used to determine strategies at the RPU level as well as perform oversight of adherence to established Care Transition Protocols.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
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.	DY2 Q4	Project	N/A	In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1

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Project Requirements (Milestone/Task Name)	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 A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 2d. The 2biv Project Team and PMO will collaborate with the Medicaid Managed Care organizations and Health Homes, with focus on strategy development with MCOs and Health Homes to: i) improve care coordination, access, and delivery, ii) strengthen the community and safety-net infrastructure, and iii) prevent illness and reduce disparities. Risk assessment will begin at admission. Within 24 hours of admission, the Care Transition RN will identify what each beneficiary requires for a smooth and safe transition from the acute care hospital. As part of this assessment, the team will leverage tools (e.g., screening tool) to identify whether the patient is i) Not Eligible for Health Home (HH) Services, ii) Eligible for HH and connected to a HH, or iii) Eligible for HH and not connected to a HH. The use of a standardized Care Transition Protocol (CTP) will identify the root cause for admission, assess/address clinical, functional, behavioral, available/lack of available resources and social determinants for each beneficiary. Data analytic and population health technologies will provide a foundation for quality improvement and enable beneficiaries to be effectively risk stratified. A longitudinal plan of care will be developed in concert with appropriate service and community based organizations including Health Homes. In an attempt to break down the barriers between systems (e.g., with MCOs) of mental health and long term care, and in recognition of the complex psycho-social needs of Medicaid beneficiaries as identified in the Care Compass Network		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1

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community needs assessment, the CTP program will work to facilitate linkages with programs across systems. With the beneficiary's consent, the CTP program will refer to Health Homes within the PPS for ongoing care management services. A Health Home care manager will assist in coordinating the ongoing medical, mental health, substance abuse and social service needs of qualifying beneficiaries. Wherever appropriate, beneficiaries will be referred for additional long term care services such as home delivered meals and personal emergency response services. Beneficiaries will also be referred to outpatient services offered through CBOs where appropriate.										
Task 2e. Collaboratively use claims data to identify gaps in care.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2f. Seek community input in designing interventions through quarterly meetings either in-person or telephonically.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2g. Commit resources to transitional care development including, but not limited to fiscal, human, and training resources.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2h. Create a Cross Continuum Team (CCT) made up of representatives from hospitals, discharge planning staff, Emergency Department (ED) staff, behavioral health staff, home care services, and medical directors and administrators from skilled nursing facilities. Members of the Cross Continuum Team can be selected to engage 2-3 beneficiaries in meetings to solicit feedback.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2i. Payer agreements will be reviewed for Managed Care Organizations (MCOs) with patients in the PPS region.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 2j. Leverage telehealth strategies. (Beneficiaries suffering from chronic disease and are at an increased risk of re-hospitalization are candidates for the use of telehealth. Telemonitoring services have proven to be effective among Medicaid beneficiaries for managing such conditions as hypertension, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and diabetes, with improved health outcomes and reductions in hospital admissions and emergency department usage. Telemonitoring promotes self-care behaviors and a sense of control for beneficiaries.)		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1

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Project Requirements (Milestone/Task Name)	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 #3 Ensure required social services participate in the project.	DY2 Q4	Project	N/A	Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Required network social services, including medically tailored home food services, are provided in care transitions.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3b. Identify required social service agencies using feedback from the CBO Engagement Council.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3c. Identify required social service agencies using responses to the PPS' readiness assessment.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3d. Collaborate with the local social services department as well as other CBOs to identify beneficiaries. Community based organizations have been actively engaged since PPS inception. To further identify and cultivate the breadth of services required to deliver project interventions, a CBO Council has been established and meets weekly. The nine county PPS has been divided into four Regional Performance Units (RPUs) to better understand the resources at the community level, foster the relationships among CBOs, and target providers to support outreach, patient activation and care coordination. An Academic Detailing approach will be used to educate and engage providers on Care Transitions as well as other PPS DSRIP projects. Goals of academic modeling include, but are not limited to: improving clinician knowledge of new clinical guidelines or health threats, selecting treatments to increase effectiveness and safety or to decrease overuse, improving patient education by helping clinicians communicate vital information to patients, increasing diagnosis or screening for overlooked conditions, and increasing utilization of complimentary resources such as community-based public health programs.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
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	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task		Provider	Practitioner - Non-Primary	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	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
Policies and procedures are in place for early notification of planned discharges.			Care Provider (PCP)							
Task Policies and procedures are in place for early notification of planned discharges.		Provider	Hospital	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4e. Through the Clinical Governance Committee and the IT Committee as needed, identify methods of early notification of planned discharges and case manager patient visits.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4f. Establish protocols regarding early notification of planned discharges and case manager patient visits through the Clinical Governance Committee.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4g. Leverage RPU model to ensure consistency as well as customizability throughout PPS. RPU-specific Clinical Governance subcommittees will be used to determine strategies and effectiveness of implementation at the RPU level.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	DY2 Q4	Project	N/A	Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
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		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5b. Create a Cross Continuum Team made up of representatives from hospitals, discharge planning staff, ED staff, behavioral health staff, home care services, and medical directors and administrators from skilled nursing facilities. Members of the Cross Continuum Team can be selected to engage 2-3 beneficiaries in meetings to solicit feedback. Physician recommendation is key to patients' acceptance as well as the initial presentation of the programs to beneficiaries and		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	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
caregivers.										
Task 5c. Establish protocols for care record transition with Cross Continuum Team (CCT). Using the Eric Coleman model as a platform (an evidence based nationally recognized) protocol will be implemented inclusive of but not limited to the following four core pillars: 1. Medication reconciliation and teaching - using Medication tools from VNAA, 2. Ensuring follow up appointment with PCP after hospital discharge, 3. Disease/condition-specific teaching as well as recognition of signs and symptoms of worsening disease and how to appropriately respond, and 4. Personal Health Record is created with the patient to improve communication with providers-using document from VNAA.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #6 Ensure that a 30-day transition of care period is established.	DY2 Q4	Project	N/A	Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6c. Through the Clinical Governance Committee, identify appropriate policies and procedures to ensure a 30-day transition of care period with consideration of the following nine elements: 1. Outreach and Engagement - Prior to discharge the Care Transition nurse will identify what each beneficiary requires for a smooth and safe transition from the acute care hospital. This includes but is not limited to: gain knowledge of social and physical factors that affect functional status at discharge (transportation, medication, specialized medical equipment, financial ability to sustain independent living and their feasibility to acquire what is needed). 2. Health Literacy - Assessment of the beneficiary's and caregiver's level of engagement and empowerment is key to developing a safe discharge to home. Assessment of the beneficiary and caregiver's knowledge of the disease process must take place during the hospital stay as limited health literacy has been shown to undermine beneficiary follow up with primary care provider, decreased adherence to treatment protocols, and their own engagement in their care. 3. Meet Patients Physically Where They Are - The Care Transition nurse or appropriate healthcare representative (e.g. Community Health Advocate, Home Care agencies, etc.) will visit beneficiary		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	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
while in inpatient setting and then visit the patient at home. Home visit(s) will emphasize best practices in care transitions including: medication reconciliation, follow-up with primary care physician and/or mental health clinician, awareness of worsening symptoms of a person's health condition, home safety, and connections to home and community-based supports. 4. Family/Caregiver Involvement - Family caregivers play a significant role in keeping loved ones living at home and in the community. The Care Transition nurse will engage with caregivers wherever possible and appropriate. Following the wishes of the beneficiary, family caregivers will be included in education about symptom management and medication management. Caregivers will be informed about support services and respite care to enable them to care for themselves while providing care. 5. Create Warm Hand Offs/ Minimize Hand Offs - Wherever possible, beneficiaries will be connected with CBOs where they have a preexisting relationship. 6. Community Navigation - Identified as a vital component of an effective 30 day transition of care plan, all beneficiaries will be introduced to the array of Community Navigation services within the PPS tailored to each beneficiary's unique profile. 7. Provide Incentives - Care Compass Network will develop guidelines and policy to incentivize beneficiaries for engagement and achievement of personal milestones. The Care Transition nurse will work within this framework. 8. Create Virtual Support Groups/ RMS Panel - Beneficiaries will be offered the option to participate with their peers in diagnosis specific, social support groups, or as a member on the CHNA Panel. 9. Maximize Physician Support - Physician recommendation is a key contributor to patient's acceptance as well as the initial presentation of the programs to beneficiaries and caregivers. Discuss all standards of care being utilized to insure understanding.										
Task 6d. Leverage RPU model to ensure consistency as well as customizability throughout PPS. RPU-specific Clinical Governance subcommittees will be used to determine strategies at the RPU level.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6e. Cross continuum team to meet (e.g., monthly or as needed) to monitor performance of participating organizations. QA Plan		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	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
reviewed by the cross continuum team would include PPS use claims and lab reporting and related data fields and be reported to the associated RPU Quality Committee as required.										
Task 6f. Adjust procedures and protocols accordingly, informed by provider performance.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 7b. Leverage telehealth platforms. (Beneficiaries suffering from chronic disease and are at an increased risk of re-hospitalization are candidates for the use of telehealth. Telemonitoring services have proven to be effective among Medicaid beneficiaries for managing such conditions as hypertension, CHF, COPD, and diabetes, with improved health outcomes and reductions in hospital admissions and emergency department usage. Telemonitoring promotes self-care behaviors and a sense of control for beneficiaries.)		Project		On Hold	04/01/2015	03/31/2017	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 7c. Care Transitions will utilize existing and new referral management technologies to enhance the patient referral process. A care management system will support the development of patient care plans across various care settings with alerts and automated follow-up reminders and Telehealth will be used to monitor patients in the community through a required and developing robust broadband/Wi-Fi network. The Care Management System will connect to the RHIOs to provide a foundation in support of the PPS Integrated Delivery System. Investment in IT is a baseline requirement for successful care coordination. Utilization of care coordination software and an integrated electronic health record with connectivity to the RHIO are essential to creating capacity within the provider network. Utilization of Office Based Case Managers, RNs and Allied Health Professionals will also be an important factor. Technology such as Telehealth and telemedicine will connect patients to providers and allow for intervention and efficient access to patient information which will simplify providers work and simplifying		Project		On Hold	04/01/2015	03/31/2017	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
processes will create capacity. To move toward a high reliability PPS, creating and imbedding disease management protocols in EHRs is a building block toward standardization and process optimization. CTI RN and PCP providers will be engaged to encourage beneficiaries to consent to the RHIOS's where providers can gain access to historical medical data; current treatments and medications, medical and surgical history, and community based organization involvement.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	sculley	Other	44_DY2Q3_PROJ2biv_MDL2biv3_PRES5_OTH_Example_flowchart_processes_9586.pdf	Remediation - example of partner flowcharts showing process	03/17/2017 11:35 AM
	sculley	Other	44_DY2Q3_PROJ2biv_MDL2biv3_PRES5_OTH_2biv_M5_Remediation_9584.docx	Milestone 5 remediation response	03/17/2017 11:32 AM
	sculley	Documentation/Certification	44_DY2Q3_PROJ2biv_MDL2biv3_PRES5_DOC_M5_PCP_communication_example_9583.pdf	Remediation - Example demonstrating how data is shared	03/17/2017 11:31 AM
	espape	Training Documentation	44_DY2Q3_PROJ2biv_MDL2biv3_PRES5_TRAIN_Milestone_5_-_Standardized_Home_Visit_Materials_9105.pdf	Care Transitions Home Visit standardized materials	01/27/2017 01:13 PM
	espape	Training Documentation	44_DY2Q3_PROJ2biv_MDL2biv3_PRES5_TRAIN_Milestone_5_-_Phone_Call_and_Home_Visit_Checklist_9104.pdf	CCN Care Transitions Phone Call and Home Visit checklist	01/27/2017 01:12 PM
	espape	Training Documentation	44_DY2Q3_PROJ2biv_MDL2biv3_PRES5_TRAIN_Milestone_5_-_CTI_Contract_and_Physician_Info_9101.pdf	CCN Care Transitions contract and physician information	01/27/2017 01:09 PM
	espape	Training Documentation	44_DY2Q3_PROJ2biv_MDL2biv3_PRES5_TRAIN_Health_Coach_Training_Care_Transitions_Overview_9098.pptx	CCN Health Coach Training overview	01/27/2017 01:07 PM
	espape	Documentation/Certification	44_DY2Q3_PROJ2biv_MDL2biv3_PRES5_DOC_CTI_workflow_for_identifying_patients_and_communication_with_PCP._9097.xlsx	CCN Care Transitions Interventions workflow. See both tabs (Existing and New workflow)	01/27/2017 01:05 PM
	espape	Training Documentation	44_DY2Q3_PROJ2biv_MDL2biv3_PRES5_TRAIN_2biv_Care_Transitions_Champion_and_Health_Coach_Training_participants_9094.xlsx	Training roster for health coach training	01/27/2017 12:59 PM
	espape	Quarterly Report (no attachment necessary)	44_DY2Q3_PROJ2biv_MDL2biv3_PRES5_QR_2biv_Milestone_5_Narrarive_9093.docx	CCN Narrative for 2biv Milestone 5	01/27/2017 12:58 PM
Use EHRs and other technical platforms to track all patients engaged in the project.	sculley	Report(s)	44_DY2Q3_PROJ2biv_MDL2biv3_PRES7_RPT_CCN_Multiple_Services_Report_DY2_-	Remediation - CCN multiple services report file 2 (csv file due to size)	03/17/2017 04:30 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
			_across_partners_9641.csv		
	sculley	Report(s)	44_DY2Q3_PROJ2biv_MDL2biv3_PRES7_RPT_CCN_Multiple_Services_Report_DY2_9640.csv	Remediation - CCN multiple services report file 1 (csv file due to size)	03/17/2017 04:28 PM
	sculley	Other	44_DY2Q3_PROJ2biv_MDL2biv3_PRES7_OTH_2biv_M7_Remediation_9629.docx	Response to milestone 7 remediation.	03/17/2017 03:49 PM
	sculley	Rosters	44_DY2Q3_PROJ2biv_MDL2biv3_PRES7_ROST_CCN_2biv_DY2Q3-Patient_Registry_Hospital_9596.xlsx	Remediation - completed patient registry from inpatient partners	03/17/2017 12:30 PM
	sculley	Rosters	44_DY2Q3_PROJ2biv_MDL2biv3_PRES7_ROST_CCN_2biv_DY2Q3-Patient_Registry_Home_Visits_9595.xlsx	Remediation - completed patient registry for home visits	03/17/2017 12:29 PM
	espape	Other	44_DY2Q3_PROJ2biv_MDL2biv3_PRES7_OTH_CTI_workflow_for_identifying_patients_and_communication_with_PCP._9114.xlsx	CCN Care Transitions Interventions workflow. Please see both tabs, exisitng workflow and new.	01/27/2017 01:25 PM
	espape	Report(s)	44_DY2Q3_PROJ2biv_MDL2biv3_PRES7_RPT_2biv_CareTran_Hospital_data_tracker_9113.xlsx	CCN Patient Roster template for Care Transitions	01/27/2017 01:24 PM
	espape	Other	44_DY2Q3_PROJ2biv_MDL2biv3_PRES7_OTH_2ai_milestone_4&6_9112.pdf	CCN Narrative for 2ai Integrated Delivery System for Milestones 4 and 6	01/27/2017 01:23 PM
	espape	Quarterly Report (no attachment necessary)	44_DY2Q3_PROJ2biv_MDL2biv3_PRES7_QR_2biv_Milestone_7_Narrative_9110.pdf	CCN Care Transitions Milestone 7 Narrative	01/27/2017 01:22 PM

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.	Milestone 1, nor the remaining tasks are due for completion in DY2Q3. However, each remains on target to be completed by their associated due dates. In preparation for an interoperable EHR (2ai Step 4i) our PPS developed and is utilizing Clinical Governance Committee approved standardized Home Visit guideline (CGC-CG-33) and a Phone Call guideline to ensure standardized protocols for gathering relevant patient data is included and updated in the patient medical record and provided to the PCP (Step 1a). As reported in earlier reports, the PPS has adopted a hybrid Care Transition Protocol coupled with nine elements to ensure effective Care Transitions. The CCN Clinical Governance Committee endorsed a Care Transition Intervention (CTI) model which includes four pillars for coordinated care, which reference an Eric Coleman-like based model for an evidence based process for Care Transitions (Step 1b – Complete DY1Q3). The four components or pillars of coordinated care are as follows: 1. Medication Management using tools from the Eric Coleman model, 2. Ensuring follow up appointment with PCP after hospital discharge, 3. Patient Understanding of "red flag" indicators of worsening condition and appropriate next steps ,4. Use of a patient-centered health record that helps guide patients through the care process. Five out of seven hospital partners completed training and are successfully submitting actively engaged numbers documenting a discharge plan accompanied with a care transition plan which contains at least the first three of the four pillars listed above (Step 1c – Complete DY2Q1). The remaining two are expected to begin implementing the CTI model during DY2Q4. Once this is accomplished, this milestone will be complete.
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.	Milestone 2 nor the respective tasks are due for completion in DY2Q3. However, this milestone remains on target to be completed by DY2Q4 and has completed steps toward that end. A cross continuum team meets every other week to discuss best practice strategies to ensure that Care Transitions are in place for the identified Medicaid recipients and there are no gaps in care (step 2e, step 2h). Additional members are added as new partners contract to provide the CTI model. Any new guidelines that are developed by the project team are presented to the RPU Clinical Governance Disease Management Subcommittees and, if approved, are presented to the PPS Clinical Governance Committee for final approval (step 2f). Step 2d is in progress and the PMO has identified an opportunity to work collaboratively with our

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	Health Home Partners to develop a strategy to improve care coordination. An integral component of the CTI workflow involves the appropriate assessment for Health Home eligibility (step 2c). As the CTI program continues to evolve across the PPS in DY2Q4, there will be increased opportunity to enter into discussions with the MCOs in regards to care coordination and risk stratification of beneficiaries to improve the overall heath and reduce disparities (step 2a). There would be benefit for CTI patients to have access to Telehealth monitoring; in particular, for patients who are at greater risk for re-admission due to certain health conditions. Telehealth is included in the IT strategy and is currently awaiting the development of an IDS strategy before it will be available to the projects (3/31/18). However, two of the hospital partners have some level of telehealth capability. The CTI project team will begin to evaluate the role of telehealth for CTI patients during DY2Q4 (step 2j).
Ensure required social services participate in the project.	This Milestone was reported as Complete in DY1, Q3. During DY2Q3, the Health Coach Training was modified to include education regarding how the Health Coaches can provide patient navigation (2ci) services to link patients to social service agencies in order to eliminate any social determinants which could impact their recovery and lead to re-hospitalization.
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.	Milestone 4, nor the respective tasks are due for completion in DY2Q3. The PPS has adopted a hybrid Care Transition Protocol coupled with nine elements to ensure effective Care Transitions. The CCN Clinical Governance Committee endorsed a Care Transition Intervention (CTI) model which includes four pillars for coordinated care, which reference an Eric Coleman-like based model for an evidence based process for Care Transitions which includes early notification of planned discharges and Health Coach visits to engage patients while still in the hospital (step 4f). The four components or pillars of coordinated care are as follows: 1. Medication Management using tools from the Eric Coleman model, 2. Ensuring follow up appointment with PCP after hospital discharge, 3. Patient Understanding of "red flag" indicators of worsening condition and appropriate next steps ,4. Use of a patient-centered health record that helps guide patients through the care process. Five out of seven hospital partners completed training and are successfully submitting actively engaged numbers documenting when a pre-discharge meeting with a Health Coach is occurring (Milestone 4). The remaining two are expected to begin implementing the CTI model during DY2Q4. During DY2Q3 four additional project champions and twelve additional health coaches were trained in the CTI model. CCN currently has executed a total of fourteen contracts with home care and community based organizations to perform the post discharge 30-day care transition follow up plan for items such as home visits, phone-follow-up and pre-discharge warm handoff meetings. In addition, as part of the CTI workflow, communication to the patient's PCP is one of three communication touchpoints that will occur with the PCP (step 4a). The PPS continues to utilize the Clinical Governance Disease Management subcommittees to ensure consistency as well as customizability throughout the PPS. Given the regional differences within our PPS, the RPU specific Disease Management Subcommittees are a valuable resource to ensure that each partner's unique needs are addressed (step 4g). While in the hospital, patients are provided information about CTI prior to discharge during the engagement process through the use of a patient contract which educates the patient regarding their role in the CTI process as well as the role of the Health Coach in the CTI process (step 4d).
Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Please refer to uploaded document 2biv Milestone 5 narrative.doc since the narrative exceeded the character limit. Documents uploaded as part of remediation.
Ensure that a 30-day transition of care period is established.	This Milestone was reported Complete in DY2, Q1. There are no changes to report.
Use EHRs and other technical platforms to track all patients engaged in the project.	Please refer to uploaded document 2biv Milestone 7 narrative.doc since the narrative exceeded the character limit. Remediation response uploaded.

Milestone Review Status

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

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Milestone Review Status

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

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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 Project Narrative	06/01/2016	06/30/2016	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

No Records Found

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 :

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Project 2.b.vii – Implementing the INTERACT project (inpatient transfer avoidance program for SNF)

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

Instructions :

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

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

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

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

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "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	684

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	137	137	274	274
	Quarterly Update	289	407	927	0
	Percent(%) of Commitment	210.95%	297.08%	338.32%	0.00%
IA Approved	Quarterly Update	0	406	0	0
	Percent(%) of Commitment	0.00%	296.35%	0.00%	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
espape	Rosters	44_DY2Q3_PROJ2bvii_MDL2bvii2_PES_ROST_CCN_2bvii_DY2Q3_-_Patient_Registry_9161.xlsx	CCN Actively Engaged report for INTERACT.	01/27/2017 08:40 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	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 INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.	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 INTERACT principles implemented at each participating SNF.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Nursing home to hospital transfers reduced.		Provider	Nursing Home	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task INTERACT 3.0 Toolkit used at each SNF.		Provider	Nursing Home	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1d. SNF INTERACT Project Champion to perform a baseline assessment of staff to identify existing INTERACT expertise within their facility and work with the Workforce Development and Transition Team (WDTT) to determine staffing needs .		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1e. Within each participating SNF, evaluate current processes and tools and compare them to the tools in the INTERACT program. Integrate INTERACT tools into the daily work flow using the INTERACT implementation guide.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1f. The PPS INTERACT Project team, PMO, and Finance Manager will incorporate the core components of the 2bvii project to the PPS budget and funds flow model. Once finalized and approved by the Finance Committee and Board of Directors the PPS will negotiate INTERACT implementation contracts with the associated SNFs.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1g. As part of the contracting process, identify an INTERACT Project Champion for each SNF to provide on-site project oversight as well as communication with the PPS PMO and Project Team for reporting purposes. PMO to draft a letter to each facility/provider outlining expected level of participation in the project as well as benefits available for collaborating in these		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	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
efforts with the PPS. If facility/provider is unable to continue the commitment required, PMO will conduct a root cause analysis to assist the affected facility(s) to determine provider specific risks and mitigation factors.										
Task 1h. INTERACT Champion at each contracted SNF facility to ensure INTERACT principles are incorporated into the facilities' Quality Assurance and Process Improvement (QAPI) process and report to PMO.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	DY2 Q4	Project	N/A	Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Facility champion identified for each SNF.		Provider	Nursing Home	Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Providers Associated with Completion: Absolut Ct Nr & Reh At Endicott; Bridgewater Ctr Rehab & Nrs; Chase Memorial Nur Home In Co; Cortland Care Center; Crown Center Nursing & Rehab; Elizabeth Church Manor Nh Inc; Groton Community Hcc Snf; James G Johnston Mem Snf										
Task 2b. Identify an INTERACT champion per facility.		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2c. Identify an INTERACT Co-Champion per facility.		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2d. Train INTERACT Champion and Co-Champion on INTERACT principles.		Project		Completed	04/02/2015	09/30/2016	04/02/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #3 Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	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 Care pathways and clinical tool(s) created to monitor chronically-ill patients.		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3c. Project team and Project Management Office to assess existing care pathways and other clinical tools for monitoring chronically ill patients. The project team and PMO will identify the common care paths and create educational tools and present		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Care Compass Network (PPS ID:44)

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for review by the Clinical Governance Committee for review and adoption.										
Task 3d. The educational tools created in Step 3c will be distributed to the SNFs and hospitals by the Provider Relations to be used as guidance in evaluating and monitoring patients. As needed additional education can be provided by the project lead and/or the trainor from the Workforce team.		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3e. Workforce team and Provider Relations will educate hospital representatives on care pathways and preventive protocols created in step 3c in effort to align these throughout the PPS.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3f. Incorporate care pathway tools into SNF daily procedures. Staff within the SNF to provide feedback as necessary to the INTERACT champion & co-champion within the SNF.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3g. The INTERACT champion, co-champions and project team will meet at a minimum of once a year to review INTERACT care paths and related practice guidelines. The project team will adjust as needed using the Clinical Governance Committee.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Educate all staff on care pathways and INTERACT principles.	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 Training program for all SNF staff established encompassing care pathways and INTERACT principles.		Provider	Nursing Home	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4b. Use INTERACT Champions in each facility to provide training sessions encompassing care pathways and INTERACT principles (e.g., annually or as seen appropriate by related parties) to all key staff including MD, FNP, PA etc. Record SNF training dates along with the number of staff trained. Review the content of the training annually with the Clinical Governance Committee and evaluate for adjustments needed.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4c. Each SNF will incorporate training of care pathways and INTERACT principles into new clinical staff orientation.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	DY2 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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Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5b. Social Services Departments within each participating SNF to evaluate current Advance Care Planning tools and validate that usage is reflected in policies and procedures.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5c. Social Services Departments within each participating SNF and facility INTERACT champion to ensure Advance Care Planning tools meet the requirements of the INTERACT program. The Social Services Department and SNF Interact Champion/Co-Champion will adjust tools as needed working with the PMO and advised by the Clinical Governance Committee. The entire Interdisciplinary Team within the SNF will be educated on any changes to the Care Planning Tools within the month following the updates.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5d. The facility INTERACT champion and/or co-champion will audit use of advance care planning tools within the SNF and provide audit results to the PMO for review with the Clinical Governance Committee. The audits must be performed annually at a minimum.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5e. Social Services Department within each participating SNF to conduct meetings with residents and family members using the facility established Advance Care Planning tools.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5f. The facility INTERACT champion and/or co-champion and Social Services Department within the SNF will reassess Advance Care Planning tools annually at a minimum. The INTERACT champion, co-champion and Social Services Department within the SNF will update the tools as required. The entire Interdisciplinary team within the SNF will be educated on any changes to the Care Planning Tools within the month following the updates.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Create coaching program to facilitate and support implementation.	DY2 Q4	Project	N/A	Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task INTERACT coaching program established at each SNF.		Provider	Nursing Home	Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Providers Associated with Completion: Chase Memorial Nur Home In Co; Elizabeth Church Manor Nh Inc; Good Shepherd-Fairview Hm Inc; Groton Community Hcc Snf; Ideal Senior Living Ctr Snf; James G Johnston Mem Snf; Willow Point Nursing Home										
Task 6b. Identify an INTERACT Champion located within each SNF. This Champion will be used for train-the-trainer programs within each respective organization to facilitate sustainability.		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 6c. Leverage Champions and facility Co-Champions in order to ensure continuity of training programs across units (facilities and RPUs).		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 6d. Integrate training efforts and needs with existing Performing Provider System (PPS) resources, such as the Workforce Strategy team and relationships built through the Provider Relations team.		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 6e. Each SNF will prepare standardized progress reports (e.g., monthly) to the Care Compass Network PMO. The progress reports will include overview of key metrics, deliverables, as well as areas of success and implementation challenges at a minimum in order to assist the SNF during the implementation process.		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	DY2 Q4	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Patients and families educated and involved in planning of care using INTERACT principles.		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7b. The Project Team, in conjunction with the PMO and Workforce Team (as needed) will create an educational strategy which will be leveraged for patient and family/caretakers distribution to supplement information found on INTERACT website regarding care planning. The strategy will outline the materials to be distributed, methods for refreshing materials for pertinence, as well as what the delivery method(s) will be for distribution. The plan will, at minimum, incorporate concepts as further outlined in the steps outlined in this plan.		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 7c. The PPS will collaborate and/or engage with local governing		Project		On Hold	04/01/2015	12/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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units (e.g., Social Service agencies) to facilitate patient and family/caretaker discussions with each participating facility.										
Task 7d. The PPS will facilitate the achievement of interdisciplinary meetings focused on advanced care planning for the PPS community of related providers.		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7e. Identify Stop and Watch tool in SNF admissions packet and discuss with family members.		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7f. The comprehensive training strategy, materials, and distribution methods (as well as targeted audiences) will be delivered on at minimum an annual basis beginning in DSRIP year 2.		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	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 connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Hospital	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Nursing Home	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 8d. The 2bvii Project Team will engage with safety net Skilled Nursing Facilities (SNFs) in the development of enhanced communication tools which will allow for increased functionality such as the generation and delivery of CCD files or delivery of system generated reports which can be aligned with acute care hospital. As required, the PPS will promote SNF staff training on use of health information exchange with assistance of systems and functionality. Training will include, as identified, education with facilities regarding the sharing of data through data agreements such as the DURSA or BAA.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 8e. SNF facilities are to receive education to inform them tracking/trending improvements in quality of care can be achieved most efficiently with an electronic health record that allows increased accessibility, sharing of data and analysis of data. Proof of education from each participating facility shall be reported to the PMO.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Task 8f. Each participating SNF to create and communicate a Nursing Home Capabilities List to local hospital emergency room staff, local hospital discharge planners and local hospital physicians at a minimum.		Project		In Progress	04/02/2015	06/30/2017	04/02/2015	06/30/2017	06/30/2017	DY3 Q1
Milestone #9 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	DY3 Q4	Project	N/A	In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Service and quality outcome measures are reported to all stakeholders.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 9e. Form a PPS quality committee that includes SNF representation.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 9f.After establishing baseline data the Interdisciplinary Team within the SNF will develop a quality improvement plan using the INTERACT quality improvement principles as a guide. Root cause analysis of transfers to hospitals to be used as data in development of the quality improvement plan. Each SNF to report out put of the quality improvement plan to the PMO office along with a timeline for implementing the quality improvement plan. A progress report to be submitted by the SNF to the PMO to communicate progress of the recommended improvements on a pre-determined basis (e.g., monthly/quarterly as appropriate).		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 9g. The project team and PMO to identify metrics to be used (such as Attachment J metrics) through the Clinical Governance Committee. Additionally, alternative or substitutive interventions		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2

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as identified during the root cause analysis process will be validated by the Clinical Governance Committee and Board of Directors prior to adoption by the 2bvii Project Team.										
Milestone #10 Use EHRs and other technical platforms to track all patients engaged in the project.	DY2 Q4	Project	N/A	Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 10b. PMO and project team will review and determine criteria and metrics for counting/tracking patient engagement--EHR data, encounter data, INTERACT tool usage, etc. as well as the associated integration efforts for population health purposes with oversight from both the Clinical Governance Committee and the IT & Data Governance Committee.		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 10c. The PPS will analyze SNFs for alignment opportunities with the identified criteria and metric requirements. As needed the PPS will pursue the facilitation of resources to track patients engaged in the project, such as the alignment of SNF EHR/EHR Lite tools with INTERACT toolkits.		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 10d. The project team in conjunction with the Workforce team and IT team to identify workflows impacted due to new technology and document new workflows for the impacted SNFs.		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 10e. Utilize the Workforce team to train staff on technology and workflow.		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Create coaching program to facilitate and support implementation.	espape	Training Documentation	44_DY2Q3_PROJ2bvii_MDL2bvii3_PRES6_TRAIN_CCN_2bvii_Milestone_6_-_Training_9164.xlsx	CCN Training document	01/27/2017 09:32 PM
	espape	Training Documentation	44_DY2Q3_PROJ2bvii_MDL2bvii3_PRES6_TRAIN_CCN_2bvii_Milestone_6_-_Groton_Training_Plan_9163.doc	CCN Training material used for Groton Health Care Center	01/27/2017 09:30 PM
	espape	Training Documentation	44_DY2Q3_PROJ2bvii_MDL2bvii3_PRES6_TRAIN_CCN_2bvii_Milestone_6_-	CCN Training material used for Good Shepherd Fairview Nursing Home.	01/27/2017 09:28 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
			_Good_Shepherd_Fairview_Training_Materials_9162.pdf		
Use EHRs and other technical platforms to track all patients engaged in the project.	sculley	Report(s)	44_DY2Q3_PROJ2bvii_MDL2bvii3_PRES10_RPT_CCN_Multiple_Services_Report_DY2_-_across_partners_9643.csv	Remediation - CCN multiple services report file 2 (csv file due to size)	03/17/2017 04:34 PM
	sculley	Report(s)	44_DY2Q3_PROJ2bvii_MDL2bvii3_PRES10_RPT_CCN_Multiple_Services_Report_DY2_9642.csv	Remediation - CCN multiple services report file 1 (csv file due to size)	03/17/2017 04:33 PM
	sculley	Rosters	44_DY2Q3_PROJ2bvii_MDL2bvii3_PRES10_ROST_CCN_2bvii_Patient_Registry_DY2Q3_9631.xlsx	Remediation - Completed patient registry.	03/17/2017 03:56 PM
	sculley	Other	44_DY2Q3_PROJ2bvii_MDL2bvii3_PRES10_OTH_2bvii_M10_Remediation_9630.docx	Remediation response for milestone 10	03/17/2017 03:55 PM
	espape	Other	44_DY2Q3_PROJ2bvii_MDL2bvii3_PRES10_OTH_CCN_2bvii_Milestone_10_-_Intervention_Report_9166.xlsx	CCN report for INTERACT interventions	01/27/2017 10:11 PM
	espape	Other	44_DY2Q3_PROJ2bvii_MDL2bvii3_PRES10_OTH_CCN_2bvii_Milestone_10_-_All_Patient_Roster_Report_9165.xlsx	CCN Actively Engaged report for INTERACT - all patient roster	01/27/2017 10:09 PM
Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	sculley	Other	44_DY2Q3_PROJ2bvii_MDL2bvii3_PRES2_OTH_CCN_2bvii_Milestone_2_-_Champion_List_9170.pdf	Documentation listing Champion and Co-Champion at each of the SNFs along with Certified INTERACT Champion 4.0 Program training sign in sheets .	01/29/2017 07:38 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.	Milestone 1 and the remaining steps are not due for completion in DY2Q3 however Care Compass Network (CCN) is continuing to assist newly contracted SNFs with the execution of this milestone. There are 16 Skilled Nursing Facilities who have signed contracts with CCN to participate in the INTERACT project, with a few others in the contract review process. To date, CCN organized three 2-day INTERACT Champion trainings in 2016. Two were held June 21-24 and the third, September 8-9. As a result of the three classes held, Care Compass Network has 14 SNFs which have had both their facility Champion and Co-Champion successfully trained in INTERACT. Additionally, there is a SNF in the PPS in the final contract review process that has trained their staff on INTERACT and actively uses INTERACT in their facility. CCN has scheduled a fourth Champion INTERACT training in our West RPU at the end of February to accommodate the SNFs in that region. Each facility Champion and Co-Champion has begun to train their respective staff on INTERACT principles. CCN has been meeting with each SNF individually to discuss a developed implementation plan checklist to assist the SNFs in identifying training and in implementing INTERACT in each facility. The implementation plan checklist is a visual and practical tool for each SNF to edit and prioritize INTERACT principles to align with their individual goals and needs.
Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	Milestone 2 and the subsequent steps were completed in DY2Q2 however we have updates to report. As of this report CCN has executed contracts with 16 Skilled Nursing Facilities to participate in INTERACT, with 14 of those having their Champion and Co-Champion completing the Certified INTERACT Champion 4.0 Program training provided by Pathway Health, a consulting firm hired by INTERACT T.E.A.M Strategies, LLC. As part of executing a contract with CCN to participate in the INTERACT project, the 14 SNFs identified a Project (Facility) Champion who will serve as the organization primary contact for CCN staff and be responsible for overall project implementation at the facility. In DY2Q2, eight SNFs were reported as meeting this milestone however six additional SNFs have met the requirements for this milestone.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	The six are: Cortland Regional Medical Center INC., Chenango Memorial HOSP INC, IDEAL Senior Living CTR SNF, Good Shepherd-Fairview HM INC, Vestal Rehabilitation and Nursing CTR, and Willow Point Nursing Home. The remaining two facilities will identify and train their Champion and Co-Champion at the INTERACT Champion training in late February. Documentation listing Champion and Co-Champion at each of the SNFs along with Certified INTERACT Champion 4.0 Program training sign in sheets have been uploaded.
Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	The milestone and the remaining steps are not due for completion in DY2Q3 however CCN continues to make progress towards completing the milestone. After a contract is executed with Care Compass Network to participate in the INTERACT project the SNF is given a binder containing the 10 INTERACT Care Paths approved by the Clinical Governance Committee. As part of the INTERACT Champion training the attendees are educated on the INTERACT principles, Care Paths as well as given awareness that all of the Care Paths and INTERACT documents are available for free on the INTERACT website. As part of the contract for participating in the project, the Champion and Co-Champion within each facility are expected to train the remaining clinical staff in the SNFs on the INTERACT principles and Care Paths they were educated on as part of the Certified INTERACT 4.0 Champion classes. Since the majority of our SNFs have identified a Champion and Co-Champion and received Certified INTERACT Champion training, many have begun internal training on Care Paths and other INTERACT principles. Additionally, as part of the CCN funds flow for this project, CCN reimburses the SNF when one of the ten Care Paths is used on a Medicaid member with the goal of early identification and intervention to avoid hospital transfer. CCN has been meeting with each SNF individually to discuss a developed implementation plan checklist to assist the SNFs in identifying training and in implementing INTERACT in each facility. The implementation plan checklist is a visual and practical tool for each SNF to edit and prioritize INTERACT principles to align with their individual goals and needs. Through one on one meetings with each SNF, it is clear one of the barriers in using the Care Paths is the lack of awareness from the hospital staff regarding INTERACT principles. CCN is addressing this barrier in DY2Q4 by hosting a 2-hour Leadership Program Overviewing INTERACT QIP at Cortland Regional Medical Center. This training session is aimed at educating hospital staff, Primary Care Physicians as well as Medical Directors working with Skilled Nursing Facilities. Training on the Care Paths is included as part of the overview.
Educate all staff on care pathways and INTERACT principles.	The milestone and the remaining steps are not due for completion in DY2Q3 however CCN continues to make progress towards completing the milestone. After a contract is executed with Care Compass Network to participate in the INTERACT project the SNF is given a binder containing the 10 INTERACT Care Paths approved by the Clinical Governance Committee. As part of the INTERACT Champion training the attendees are educated on the INTERACT principles, Care Paths as well as given awareness that all of the Care Paths and INTERACT documents are available for free on the INTERACT website. As part of the contract for participating in the project, the Champion and Co-Champion within each facility are expected to train the remaining clinical staff in the SNFs on the INTERACT principles and Care Paths they were educated on as part of the Certified INTERACT 4.0 Champion classes. Since the majority of our SNFs have identified a Champion and Co-Champion and received Certified INTERACT Champion training, many have begun internal training on Care Paths and other INTERACT principles. Additionally, as part of the CCN funds flow for this project, CCN reimburses the SNF when one of the ten Care Paths is used on a Medicaid member with the goal of early identification and intervention to avoid hospital transfer. CCN has been meeting with each SNF individually to discuss a developed implementation plan checklist to assist the SNFs in identifying training and in implementing INTERACT in each facility. The implementation plan checklist is a visual and practical tool for each SNF to edit and prioritize INTERACT principles to align with their individual goals and needs. Through one on one meetings with each SNF, it is clear one of the barriers in using the Care Paths is the lack of awareness from the hospital staff regarding INTERACT principles. CCN is addressing this barrier in DY2Q4 by hosting a 2-hour Leadership Program Overviewing INTERACT QIP at Cortland Regional Medical Center. This training session is aimed at educating hospital staff, Primary Care Physicians as well as Medical Directors working with Skilled Nursing Facilities. Training on the Care Paths is included as part of the overview.
Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	Milestone 5 and the subsequent steps are not due for completion in DY2Q3 however Care Compass Network (CCN) continues to make progress towards completing this milestone. There are Advance Directives/Advance Care Planning Regulatory and Statutory Requirements for Skilled Nursing Facilities so we know these currently are in use across the SNFs. Many facilities have adopted the INTERACT Advance Care Planning sheet and are beginning to conduct their annual and initial Advance Care Planning sessions using INTERACT tools. During DY2Q3 CCN created a family educational packet comprised of the educational worksheets found in the Champion training booklet along with a packet of family and staff educational materials regarding Advance Care Planning, Stop & Watch materials, and other family educational resources. The family educational packet can be

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	included in the SNF admissions packet, while the staff packet is a compilation of tips and tricks to conduct the difficult conversations often involved with Advance Care Planning. Additionally, the PPS will be providing an educational training within each Regional Performance Unit (RPU) on Advanced Care Planning vs Palliative Care for all organizations later this year.
Create coaching program to facilitate and support implementation.	Milestone 6 and the remaining steps are due for completion in DY2Q3 and will be marked complete with this report. As part of executing a contract with CCN to participate in the INTERACT project, the SNFs identify a Project (Facility) Champion who will serve as the organization primary contact for CCN staff and be responsible for overall project implementation at the facility. Additionally, the SNFs identified a Champion and Co-Champion to be responsible for obtaining mastery knowledge of INTERACT requirements and hold staff accountable. As part of the Appendix C contract for participating in the INTERACT project, the Champion and Co-Champion within each facility are expected to train the remaining clinical staff in the SNFs on the INTERACT principles (Step 6b – Complete DY2Q2). There are 14 SNFs who have had their Champion and Co-Champion complete the Certified INTERACT Champion 4.0 Program training provided by Pathway Health, a consulting firm hired by INTERACT T.E.A.M Strategies, LLC. The same training with the same instructor have been used to ensure continuity of training programs across units (Step 6c – Complete DY2Q2). The first two-day class was held June 21-22nd in our North RPU and was attended by 20 people from 10 different Skilled Nursing Facilities in the PPS. The second two-day class was held June 23-24th in our South RPU and was attended by 21 people from 8 different Skilled Nursing Facilities in the PPS. A third two-day class was held September 8-9th in the East RPU region with 15 people from 6 different Skilled Nursing Facilities in the PPS. CCN has scheduled a fourth Champion training in our West region at the end of February to accommodate the SNFs in those areas. Scheduling these Champion trainings is a collaborative effort between the PMO, Provider Relations team, and Workforce Strategy Team (Step 6d – Complete). CCN has begun discussions with SNFs on implementation within their facility and has drafted an implementation plan checklist that can be catered to each SNF with target due dates to assist in implementing INTERACT in each Skilled Nursing Facility. The implementation plan includes implementing a coaching program at each SNF as well as providing implementation progress reports. From this, the facility Champion and Co-Champion have created their own coaching program, catering the implementation plan to how it would effectively benefit their facility individually (Step 6a – Complete). In part of the implementation plan rollout, CCN has been meeting with each SNF individually to discuss overall areas of success, challenges, and other questions about reporting, deliverables, and key metrics. During these meetings, discussion has also taken place regarding clarification of INTERACT principles (Step 6e – Complete). Each month the SNFs report interventions as well as internal trainings held during the previous month. Most of the training reports that were submitted to CCN used the INTERACT Training booklet as training materials, which was received during the INTERACT Champion class. UMH Elizabeth Church Manor and UMH James G. Johnston both used an online webinar provided through their EHR system, MedLine. Good Shepherd Fairview Nursing Home created their own materials for training which are included in this report. We were not able to add Chenango Memorial HOSP INC in the Provider Engagement for step 6a since they are classified as a hospital in MAPP. They do have a nursing home that is meeting the requirements of this milestone.
Educate patient and family/caretakers, to facilitate participation in planning of care.	Milestone 7 and the subsequent steps are due for completion in DY2Q3, however Care Compass Network (CCN) is deferring the milestone and steps (7a, 7d-7f) to DY2Q4 to allow additional time for SNFs to continue implementing INTERACT, evaluate current family educational materials, and submit the patient/family education materials to CCN for milestone completion. Since the beginning of DY2Q3, CCN has contracted with an additional 5 SNFs totaling 16 contracted SNFs. These newly contracted SNFs have only recently begun implementing INTERACT, training staff on use of the Care Paths, Advance Care Planning, and Stop & Watch tools, along with providing monthly and quarterly reports to show progress. The other SNFs have also been implementing staff training and finalizing workflows to incorporate INTERACT principles. Due to these other priorities, this milestone is to be deferred to DY2Q4 to allow more time for evaluation of current family educational materials. However, in the individual SNF meetings Care Compass Network staff has been conducting with partners, it is a widespread identified need for patients' families to be educated in INTERACT principles as well as the disadvantages of hospitalization. Recognizing the need for family educational materials in the SNFs, CCN has created a packet of family and staff educational materials from the INTERACT Champion training booklet regarding Advance Care Planning, Stop & Watch materials, and other family educational resources. The family educational packet can be included in the SNF admissions packet, while the staff packet is a compilation of tips and tricks to conduct those difficult conversations (Step 7b – Complete). Lastly, Care Compass Network is placing Step 7c permanently on hold since family/caretaker discussions held in the SNFs will not likely involve local governing units. The

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Milestone Name	Narrative Text
	expertise to host such discussions already exists in the SNFs (Step 7c – On Hold). To enhance community awareness in Advance Care Planning the PPS will be providing an educational training within each Regional Performance Unit (RPU) on Advanced Care Planning vs Palliative Care for all organizations later this year.
Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	Milestone 8 and the subsequent steps are not due for completion in DY2Q3 however CCN continues to make progress towards completing this milestone. CCN is nearing the end of an RFP process for evaluating LTPAC EHR vendors with the goal of being able to offer the SNFs that currently do not have an EHR a product to choose from at a reasonable cost. The tentative schedule for completion of this process is the end of January 2017 so that CCN can begin the implementation process in February 2017. Once each implementation process is started these will bring needed electronic documenting services into agencies and broaden the communication between partners PPS wide. CCN will aid in the training and support of this implementation with adequate resources for each SNF to reduce the disruption as much as possible while aiding in fulfillment of the benefit of the EHR. As of December 2016, 12 of the 16 contracted SNFs have an EHR, 2 are in process of implementing an EHR and 2 do not have an EHR with some of the EHR systems already having the INTERACT module built in. The PPS is also working to connect partners to one of the three RHIOs serving the Care Compass Network nine county regions. Some of the SNFs are already connected to a RHIO at least in one direction but not bi-directional. CCN continues discussions with SNFs on project implementation within their facility and has drafted an implementation plan checklist that can be catered to each SNF with target due dates to assist in implementing INTERACT in each Skilled Nursing Facility. The implementation plan includes creation and communication of a Nursing Home Capabilities List to local hospital emergency room staff, local hospital discharge planners and local hospital physicians. This milestone and subsequent steps are on target to be completed by the end of DY3.
Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Milestone 9 and the subsequent steps are not due in DY2Q3 however the PPS remains on target to complete this milestone by the required due date. Care Compass Network has 16 contracted SNFs. Fourteen of which have had both their facility Champion and Co-Champion successfully completing the Certified INTERACT Champion training. CCN continues discussions with SNFs on project implementation within their facility and has drafted an implementation plan checklist that can be catered to each SNF with target due dates to assist in implementing INTERACT in each Skilled Nursing Facility. The implementation plan includes opportunities for quality improvement, root cause analysis, use of rapid cycle improvement methodologies, and evaluating results of quality improvement initiatives. Additionally, the framework for DY3 contracting has been developed and will include performance metrics for each of the projects CCN selected. The details of the contracting framework will be reviewed with the Clinical Governance Committee for their input and presented to the Board of Directors for their review and approval in February 2017.
Use EHRs and other technical platforms to track all patients engaged in the project.	Milestone 10 and the subsequent steps are due for completion in DY2Q3 and are being reported as complete. The requirement that partners track the actively engaged is included in Care Compass Network's contract for project work. While several of the Skilled Nursing Facility partners have EHRs, many of the EHRs do not have the current capability to easily pull the required information for each project to report patients actively engaged in the DSRIP projects (Step 10c – Complete). As a result, CCN developed a reporting template contracted partners use to track members actively engaged in the projects and to confirm services are properly reported (Step 10a – Complete). After a partner executes a contract, CCN distributes the reporting templates to the Skilled Nursing Facility partners and provides training on the use of the reporting templates in addition to use of an sFTP site created for partners to upload patient registry information. Care Compass Network partners are submitting data on a monthly basis listing actively engaged patients, information about the services they received, and outcomes of the intervention services where applicable. For 2bvii, the patient registry quantifies all Medicaid members within a SNF and tracks if they had any ED treatments, hospital admissions, or transferred to another facility. The patient registry information is imported into the CCN Data Warehouse, an integral piece of the IT systems which will support CCN's Population Health approach. The warehouse combines partner data on monthly activities; in the future, the warehouse will bring in the NY Medicaid claims data, clinical data from partners (via the RHIOs), and other sources of data on social determinants. With this data, CCN's population health analysts will use dashboards and reports to evaluate and communicate performance (Step 10b – Complete). DSRIP Year 2 data collection requirements included in the monthly reporting templates include usage of Care Paths, Advance Care Planning sessions, and eMOLST. Additionally, the SNFs report quarterly the actively engaged patient roster. The same reports (monthly and quarterly) have been uploaded as supporting documentation for milestone completion. With the CCN long-term post-acute care IT RFP process, the CCN IT department has analyzed the compatibilities of existing EHR systems used by the local Skilled Nursing Facilities. As of December 2016, 12 of the 16 contracted SNFs have an EHR, 2 are in process of implementing an EHR and 2 do not have an EHR. Many of the EHR systems already have the INTERACT module built in. CCN will aid in the training and support of the SNFs currently implementing an EHR or soon to be implementing

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Milestone Name	Narrative Text
	and will schedule trainings as needed for each SNF to reduce the disruption as much as possible while aiding in fulfillment of the benefit of the EHR (Steps 10d and 10e – Complete). Remediation response uploaded.

Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment	

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

Instructions :

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

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

Instructions :

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

Three major risks have been identified in development of the Community Based Health Navigator (CBHN) project to assist patients to access healthcare services efficiently. These include the following along with the mitigation strategy that has developed to decrease the risks identified.

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

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "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	25,175

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	3,088	6,413	5,700	19,000
	Quarterly Update	123	395	993	0
	Percent(%) of Commitment	3.98%	6.16%	17.42%	0.00%
IA Approved	Quarterly Update	0	393	0	0
	Percent(%) of Commitment	0.00%	6.13%	0.00%	0.00%

Warning: PPS Reported - Please note that your patients engaged to date (993) does not meet your committed amount (5,700) for 'DY2,Q3'

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
brosetti	Rosters	44_DY2Q3_PROJ2ci_MDL2ci2_PES_ROST_2ci_Actively_Engaged_DY2Q3_9047.xlsx	2ci Actively Engaged DY2Q3 patient roster	01/27/2017 09:09 AM

Narrative Text :

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

Care Compass Network is reporting 993 unique Medicaid members were navigated from April 1st through December 31st of 2016.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	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 Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.	DY2 Q4	Project	N/A	In Progress	04/01/2015	12/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Community-based health navigation services established.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1b. Identify PPS Partners - Care Compass Network will assess the current PPS landscape to identify existing/established CBOs who currently provide navigation services. Scope of services provided, training received, and ability to train others, potential credentialing, existing networks of navigation and navigation-related services, IT capabilities, and other pertinent areas of existing infrastructure and operations will be assessed via a Pre-Engagement Assessment created by the CBO Engagement Council.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1c. Develop Navigator Roles - Using the results of the Pre-Engagement Assessment, the Project 2ci Team, Project Management Office, and Workforce Team of Care Compass Network will work in tandem with the CBOs with established navigation services to develop and define the CCN Community Health Advocate (CCN is employing the term "community health advocate" to delineate between NYS Health Exchange Navigators and navigators specific to this project) role and the description of services provided by this role. Existing CHA competencies and functions will be modified to address any gaps in current services provided as indicated in the Community Needs Assessment. The Onboarding Quality Committees within each Regional Performing Unit (RPU) will monitor the progress and results of these roles on an ongoing basis.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1d. Training and Resources - Care Compass Network's Workforce Team and the Project 2ci Team will work in		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	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
conjunction with the contracted organizations providing navigation services to develop a robust training program/resource guide. An initial training will be mandatory for organizations who contract with the PPS to perform Project 2ci related navigation services, supplemented by a community related resource guide. An ongoing, regular training schedule will be established for quality improvement and efficiency. Inherent to ongoing training will be the cross-pollination of Community Health Advocates from across the PPS. Best practices will be discussed and assessed by CHAs from adjacent RPUs and neighboring PPSs as they are able to participate. Once this role's competencies and services provided have been approved and contracts have been executed between CCN and participating organizations, related training will delivered.										
Task 1e. Navigation Collaboration - The PPS will develop forums to assist Navigators in the identification and adoption of leading practices, lessons learned, overview of results (e.g., metrics to highlight whether navigated services resulted in reduced ED and IP admissions) and general 'tricks of the trade' which have been learned through first hand navigation experiences. Through these forums feedback on the PPS training and resources will be solicited to determine efficacy of materials, which in tandem with program metrics and results will allow the 2ci Project Team and PMO to gather suggestions to the Workforce team for plan modification (as needed).		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1f. Execute Contracts - The PPS project 2ci budget will be approved by the Finance Governance Committee and Board of Directors, after which PPS Contracts developed by the PPS leadership and Legal team will be leveraged by the PMO and Project 2ci Team to contract with organizations for community-based health navigation services.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #2 Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.	DY2 Q4	Project	N/A	Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	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 Resource guide completed, detailing medical/behavioral/social community resources and care protocols developed by program oversight committee.		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 2b. The 2ci Project Team will develop a Program Oversight Group to develop a Community Care Resource Guide. The Program Oversight Group will be comprised of members from the 2ci Project Team, PMO, Workforce Development Team, as well as representatives from medical/behavioral health, 211 centers, community nursing, and social services providers (including faith based organizations that provide support for chronic illness, etc.). Once developed the Resource Guide will be approved by the Clinical Governance Committee and be used to supplement PPS navigation related training efforts (as outlined in Milestone 1). Review of this resource will occur annually at a minimum for any potential alterations.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2c. The Clinical Governance Committee, through the responsible Onboarding Quality Committee (e.g., an oversight committee) will review performance and adherence to estasblished policies, procedures, metric outcomes, and deliverables. As needed ammendments to the Community Care Resource Guide will be identified by the Program Oversight Group and/or Quality Committee and presented to the Clinical Governance Committee for endorsement. Any resource guide changes will be directly communicated, supplemented by training (if required), and openly published (e.g., CCN website, SharePoint) to ensure all PPS partners have access to PPS guidances.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2d. The Workforce Team will work in conjunction with the Project Management Office to modify training materials to train navigators using tools such as classroom techniques, small groups, 1-on-1 training, modeling, and/or shadowing. Regularly scheduled re-training will be established to allow for new partners/CHAs to receive training.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 2e. The Workforce Team in conjunction with the Project Management Office will work to create training for community navigators in the use of the Community Resource Guide. Training will be offered in a variety of mediums such as training		Project		Completed	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	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
documents available to augment organizations existing training materials, one on one in person training when applicable for agencies new to navigation services or requesting this level of training. As the Community Resource Guide will provide information regarding the Managed Care Organizations websites training will include some navigation of those systems to better engage the non-insured and non or low utilizing members. An ongoing, regular training will be established for quality improvement and efficiency.										
Milestone #3 Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.	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 Navigators recruited by residents in the targeted area, where possible.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3b. The PPS will leverage the Workforce Development Team to provide oversight to the creation/review of community navigator job descriptions, roles/responsibilities, with consideration for regional needs of the nine county PPS (as appropriate).		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3c. The Workforce Development Team will work with the Project Management Office to provide PPS partner organizations support related to their recruitment of Community Health Advocates/Community Navigators with consideration for how to obtain input from the local community talent pool.		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3d. The Workforce Development Team and Provider Relations Team will collaborate with PPS Partners to confirm they have available tools and resources, including PPS developed resource guides to facilitate the training of new community navigators. As required by the PPS partner organization contract the existing and newly hired community navigators will receive and certify completion of PPS training materials.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Resource appropriately for the community navigators, evaluating placement and service type.	DY2 Q4	Project	N/A	Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Navigator placement implemented based upon opportunity assessment.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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
Telephonic and web-based health navigator services implemented by type.										
Task 4c. The Project 2ci Team and PMO will perform an assessment of existing community navigators, including identification of potential locations and number of required navigators based on established, navigator service type (e.g., in person, telephonic, web-based), and evolving regional needs and DSRIP requirements (e.g., project plan, speed and scale, etc.)		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 4d. The Project 2ci and PMO teams will create site location directory of navigator services by service type. As identified, staffing shortages (e.g., by skillset, staffing numbers, etc.) will be communicated to PPS partners, documented and presented to the associated Onboarding Quality Committees at the appropriate Regional Performing Unit, and a remediation plan/roadmap developed.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #5 Provide community navigators with access to non-clinical resources, such as transportation and housing services.	DY2 Q4	Project	N/A	Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Navigators have partnerships with transportation, housing, and other social services benefitting target population.		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5b. Project Management Office will assess existing non-clinical resources and their relationships to CBOs providing navigation services in order to utilize and maximize current resource base.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5c. Project Management Office will coordinate maintenance and enhancement of existing non-clinical resources in the comprehensive resource guide for navigators.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5d. Project Management Office will ensure delivery of training and orient all community navigators to non-clinical resources by partnering with the eight participating providers using existing curriculums which will be reviewed and modified to create standard protocols then used to train navigators using classroom techniques, small groups, 1-on-1 training, modeling, and shadowing. Additionally, Industry on line training through associations or contractors will be included to provide additional support and reinforcement to understand vital concepts.		Project		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
Task 5e. Project Management Office will ensure delivery of training and orient all community navigators to non-clinical resources by partnering with contracted agencies using existing curricula and the 2.d.i project team to factor in social determinants of health.		Project		Completed	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone #6 Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.	DY2 Q4	Project	N/A	Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Case loads and discharge processes established for health navigators following patients longitudinally.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6b. The 2ci Project Team and PMO will collaborate with the Program Oversight Group to identify hot spotting opportunities/approaches for where navigators are needed within the PPS. Following initial assessments, the Program Oversight Group will help to monitor the optimal patient-to-community health advocate ratio by comparing previous ratios and workflows and what is needed for meeting established Speed and Scale needs.		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 6c. The 2ci Project Team and PMO will collaborate with the Program Oversight Group to determine what constitues a 'graduation from the navigation program' to identify patients by status/buckets (e.g., Navigation services no longer required, On Watch for a certain period of time, Close Supervision Suggested, etc.). As appropriate standards and protocols, such as the definition of 'close supervision suggested' will be endorsed by the Clinical Governance Committee.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6d. The 2ci Project Team, PMO, and participating CBOs will develop discharge processes for patients who receive navigation services. Triggers for discharge, proper follow up post-discharge, and other methodological considerations will be borrowed from existing dicharge processes, synthesized with current and future needs, and/or created anew. These processes will be assessed and approved by the Clinical Governance Committee.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6e. As required, the IT & Data Governance Committee will be solicited to identify tools/resources required for the tracking of		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

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

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.	brosetti	Other	44_DY2Q3_PROJ2ci_MDL2ci3_PRES2_OTH_Program_Oversight_Group_Charter_9053.pdf	Program Oversight Group Charter	01/27/2017 09:25 AM
	brosetti	Screenshots	44_DY2Q3_PROJ2ci_MDL2ci3_PRES2_SS_CCN_Community_Resource_Guide_Screenshots_9052.pdf	Community Resource Guide Screenshots	01/27/2017 09:24 AM
	brosetti	Report(s)	44_DY2Q3_PROJ2ci_MDL2ci3_PRES2_RPT_Milestone_2_Narrative_9051.docx	DY2Q3 Milestone 2 Narrative	01/27/2017 09:22 AM
Provide community navigators with access to non-clinical resources, such as transportation and housing services.	brosetti	Contracts and Agreements	44_DY2Q3_PROJ2ci_MDL2ci3_PRES5_CONTR_DY2Q3_Non-Clinical_Organizations_Contracted_Sample_9055.pdf	DY2Q3 Non-Clinical Org Contract Sample	01/27/2017 09:38 AM
	brosetti	Other	44_DY2Q3_PROJ2ci_MDL2ci3_PRES5_OTH_2ci_Milestone_5_Attachment_B.pdf_9054.pdf	2ci Milestone 5 Attachment B	01/27/2017 09:37 AM
Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.	brosetti	Other	44_DY2Q3_PROJ2ci_MDL2ci3_PRES6_OTH_Transition_from_Navigation_Process_Diagram_9058.pdf	Transition from Navigation Process Diagram	01/27/2017 09:44 AM
	brosetti	Policies/Procedures	44_DY2Q3_PROJ2ci_MDL2ci3_PRES6_P&P_CGC-CG-22_Transition_from_Navigation_Process_9057.pdf	CGC-G-22 Transition from Navigation Process	01/27/2017 09:43 AM
	brosetti	Report(s)	44_DY2Q3_PROJ2ci_MDL2ci3_PRES6_RPT_Milestone_6_Narrative_9056.docx	Milestone 6 Narrative	01/27/2017 09:42 AM
Use EHRs and other technical platforms to track all patients engaged in the project.	sculley	Report(s)	44_DY2Q3_PROJ2ci_MDL2ci3_PRES8_RPT_CCN_Multiple_Services_Report_DY2_-_across_partners_9645.csv	Remediation - CCN multiple services report file 2 (csv file due to size)	03/17/2017 04:37 PM
	sculley	Report(s)	44_DY2Q3_PROJ2ci_MDL2ci3_PRES8_RPT_CCN_Multiple_Services_Report_DY2_9644.csv	Remediation - CCN multiple services report file 1 (csv file due to size)	03/17/2017 04:36 PM
	sculley	Rosters	44_DY2Q3_PROJ2ci_MDL2ci3_PRES8_ROST_2ci_Patient_Registry_DY2Q3_9634.xlsx	Remediation - 2ci completed patient registry	03/17/2017 04:01 PM
	sculley	Other	44_DY2Q3_PROJ2ci_MDL2ci3_PRES8_OTH_2ci_M8_Remediation_9632.docx	2ci Milestone 8 remediation response	03/17/2017 03:59 PM
	brosetti	Templates	44_DY2Q3_PROJ2ci_MDL2ci3_PRES8_TEMPL_2ci_Navigate_Navigate_9059.xlsx	2ci Navigate reporting template	01/27/2017 09:52 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.	The milestone and remaining steps are not due this quarter however we have changed the end dates for the milestone, step 1a and step 1e to align with the Prescribed Due Date in MAPP. Care Compass Network (CCN) continues to make progress in regards to completing this milestone and 3 remaining steps. As of December 31, 2016, CCN has a total of eighteen Community Based Organizations (CBOs) contracted in the PPS nine-county region which is divided in four Regional Performing Units (RPUs). Eight CBOs are located in the South RPU, two in the East RPU, five in the North RPU and three in the West RPU, five of which are new contracts to provide community-based navigation services.
Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a	Please refer to the uploaded document labeled DY2Q3 Milestone 2 Narrative.doc since the narrative exceeded the character limit.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.	
Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.	There was one step due for completion in DY2Q3, however Care Compass Network (CCN) seeks to defer the step (Step 3c) to DY2Q4 to complete the transition workforce plan for the PPS and recruitment plan for navigation services. As of 12/31/2016, we have successfully executed contracts and implemented Navigator placement for 18 Community Based Organizations (CBOs) and 3 Healthcare Systems with an additional 6 CBOs, and 1 County Health Department close to executing contracts, all of which who have currently employed Community Health Advocates. The PMO will continue to analyze placement and outcomes as detailed in 2ci Milestone 4. This analysis will facilitate collaboration between the workforce development group and 2ci Project Team regarding where new navigation services should be developed as well as focusing on regional specific recruitment of navigators from the region in need of services.
Resource appropriately for the community navigators, evaluating placement and service type.	Milestone 4 was reported as complete in DY2 Q2 and there are no changes to report.
Provide community navigators with access to non-clinical resources, such as transportation and housing services.	Milestone 5 and remaining steps (5a and 5e) are due for completion in DY2, Q3 and are being reporting as complete. As a requirement of milestone 2 in this project a Community Resource Guide was created using an existing platform, iCarol, the database current 2-1-1 First Call for Help systems use. 2-1-1 First Call for Help is a non-profit New York State and country wide navigation call center for the public to use when they have a social determinate need. iCarol holds all medical, behavioral, community nursing, and social support services at a local and regional level. In the creation of the Community Resource Guide, non-clinical services such as transportation, housing and the like were identified and included by county, for use in helping Community Navigators appropriately resource for some potential needed services outside the scope of their present agency (Step 5b – Complete). The 2-1-1 Community Resource Guide has each county within the PPS in a different color and outlined clearly so the Community Navigator and public user can easily see and click on a county, bringing them to the appropriate 2-1-1 database to search and refer resources based on the patient/client/caller need. CCN also has contracts with multiple community based organizations across our nine county PPS which provide housing and transportation services who are participating in the 2ci project. These organizations are listed in the uploaded Non-Clinical Partnerships document (Attachment B) or can be searched and found in CCN's Community Resource Guide (Milestone 5 and Step 5a - Complete). In April 2016, the Community Resource Guide oversight group was established as a result of the team deciding to use the existing iCarol database as the foundation for the Community Resource Guide. This oversight group has subject matter experts from Community Based Organizations (CBOs) and other contracted partners to provide insight and resources to the Community Resource Guide. The Community Resource Guide oversight group meets monthly to continually review and enhance the non-clinical resources that clients/callers/patients are facing, thereby targeting the highest unmet needs in each Regional Performance Unit (Step 5c - Complete). The Project Management Office (PMO) along with the Community Resource Guide oversight group will also work in collaboration with CCN's Marketing Manager on enhancing the Community Resource Guide and the non-clinical resources for the Community Navigators to use. In the next phase of the Community Resource Guide information from all the local 2-1-1s will be integrated and incorporated into the iCarol database. CCN will use the database to extract reports of the referrals made by the Community Navigators from the resource guide, track most frequent resources used per county, track the amount of calls a client makes, and finally, would provide CCN and contracted partners reports of met and unmet health-related social needs. CCN will use the social determinate data for performance management purposes, measure the problem, and evaluate the overall impact of the navigation project throughout the DSRIP years and beyond. The 2ci project team identified there is no training needed for Community Navigators with the first phase of the 2-1-1 Community Resource Guide due to CCN's approach of collaborating and using an existing service already being used by Community Navigators. Moving forward with the development and implementation of the next phase of the new database platform, CCN will continue to collaborate with the local 2-1-1s, and the workforce training team to offer additional trainings as needed for community and health navigators across the PPS to better engage and navigate the Medicaid population (Step 5e- Complete).
Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients	Please refer to the uploaded document labeled DY2Q3 Milestone 6 Narrative.doc since the narrative exceeded the character limit.

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Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
longitudinally.	
Market the availability of community-based navigation services.	Milestone 7 and the remaining step (Step 7a) are due for completion in DY2Q3, however Care Compass Network (CCN) is deferring completion of both to DY2Q4. With the go-live of the CCN 2-1-1 Community Resource Guide in December 2016, CCN along with the 2ci Project Team and Communication committee will construct a comprehensive marketing plan based on navigator placement in our nine county PPS to ensure Navigation services are marketed appropriately for the community.
Use EHRs and other technical platforms to track all patients engaged in the project.	Milestone 8 and remaining steps (Steps 8a and 8c) are not due for completion in DY2 Q3, however all are being reported as complete. The requirement partners track the actively engaged is included in Care Compass Network's contract for project work. While several of the partners have EMRs, many of the EMRs do not have the current capability to easily pull the required information for each project to report patients actively engaged in the DSRIP projects. As a result, CCN developed a reporting template contracted partners use to track members actively engaged in the projects and to confirm services are properly. After a partner executes a contract, CCN distributes the reporting templates to partners and provides training on the use of the reporting templates in addition to use of an sFTP site created for Partners to upload patient registry information (Step 8c - Complete). Care Compass Network partners are submitting data on a monthly basis listing actively engaged patients, information about the services they received, and outcomes of the intervention services where applicable. The patient registry information is imported into the CCN Data Warehouse, an integral piece of the IT systems which will support CCN's Population Health approach. The warehouse combines partner data on monthly activities; in the future, the warehouse will bring in the NY Medicaid claims data, clinical data from partners (via the RHIOs), and other sources of data on social determinants. With this data, CCN's population health analysts will develop dashboards and reports to evaluate performance (Milestone 8 and Step 8a- Complete). DSRIP Year 2 data collection requirements included in the monthly reporting templates include such information as Organization Site Name, Patient Name, DOB, Medicaid CIN, Date of Navigation Service Performed, Type 1 or Type 2 Navigation, Primary Navigation, Secondary Navigation and Warm Handoff to a PCP. CCN also incorporated in-person, telephonic, and web-based health navigator services into the monthly reporting template. With this reporting template, the Community Navigation Partner is able to document the type of navigation that took place, specifically identifying in-person, telephonic, email, or web-based. With the reports, CCN is able to identify trends by service type and the tracking of patient flows in each organization, and across the PPS as a whole (Step 8b - complete). The monthly reporting template for 2ci was uploaded as supporting documentation for completion of the milestone. Remediation response uploaded.

Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment	

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Care Compass Network (PPS ID:44)

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

Instructions :

Care Compass Network (PPS ID:44)

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

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

Instructions :

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

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

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "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	80,602

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	3,024	7,560	7,560	22,680
	Quarterly Update	92	547	983	0
	Percent(%) of Commitment	3.04%	7.24%	13.00%	0.00%
IA Approved	Quarterly Update	0	534	0	0
	Percent(%) of Commitment	0.00%	7.06%	0.00%	0.00%

Warning: PPS Reported - Please note that your patients engaged to date (983) does not meet your committed amount (7,560) for 'DY2,Q3'

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
rachaelm	Report(s)	44_DY2Q3_PROJ2di_MDL2di2_PES_RPT_DY2Q3_2di_Actively_Engaged_9214.xlsx	Patient registry for 2di.	01/30/2017 11:13 AM

Narrative Text :

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

Care Compass Network is reporting a total of 983 PAM Surveys were administered and documented in our PPS. Of those 17 are Parent PAM Surveys on the child or children which will show as duplicates on this report, but are not truly duplicates.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	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 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	DY3 Q4	Project	N/A	Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1b. Assess the knowledge and potential readiness of willing Community Based Organizations (CBOs) and other partners through Pre-Engagement Assessment.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 1c. Determine whether or not the Performing Provider System (PPS) is held to the state contracting requirements with the aid of the Care Compass Network Compliance Officer and the Compliance & Audit Committee.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1d. Develop contracts to establish PPS and CBO/partner agreements.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	DY2 Q4	Project	N/A	Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Patient Activation Measure(R) (PAM(R)) training team established.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2b. Contract with Insignia for PAM training for select individuals on Project Team or from PPS partners (e.g., health systems, hospitals, CBOs, etc.) utilizing the PAM survey.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2c. Leverage the Project 11 Planning team to identify and solicit		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2

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organizations and/or individuals to join the PAM Survey Training Team. In this effort the project planning team will leverage local expertise at the RPU level (through RPU Leads in the CBO Engagement Council) to educate and gauge partner interest and expertise for the initial round of Insignia training. In addition, the 2di Project Team will collaborate with the PPS Provider Relations team to identify CBOs for PAM survey training team/administration based on results from the PPS Pre-engagement Assessment (e.g., organizations with indicated skillsets/expertise in outreach/patient activation). Organizations attending the initial Insignia training session on 9/29/2015 will participate on the PAM training team.										
Task 2d. Members of the Care Compass Network PAM Training Team (e.g., those trained by Insignia on 9/29) will be contracted with the PPS, starting in October 2015, to receive payment for subsequently training either (a) their internal organization, or (b) training other PPS 2di participating organizations, in the utilization of the PAM Survey system. The Care Compass Network Project Management Office will centrally coordinate future training efforts, a process which will be aligned with the execution of partner contracts. The Care Compass Network Project Management team will subsequently track training and refresher course participation on an ongoing basis using a roster for individuals trained and monthly reports from partners/Trainers.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	DY2 Q4	Project	N/A	Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3b. Identify who will conduct the analysis for "hot spots".		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3c. Identify "hot spots" by analyzing utilization patterns for the uninsured using SPARCS (Statewide Planning And Research Cooperative System) "self-pay" category. Leveraging the local expertise of RPU members, assess emergency department and other utilization patterns. Additionally, focus will be given to Emergency Departments that serve a high percentage of the		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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uninsured by zip code as tracked by hospitals.										
Task 3d. Identify "hot spots" by analyzing the utilization low-utilizing and/or non-utilizing Medicaid enrollee Salient related data and reports. Leveraging the local expertise from each of the four Regional Performance Unit members, the 2di Project Team will also assess non-healthcare resource use for both non-utilizing and low-utilizing Medicaid enrollees.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3e. Identify which CBOs are geographically and organizationally aligned to outreach to these populations through responses from Pre-engagement Assessment.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3f. Contract with CBOs for outreach endeavors and track deliverables by incorporating a monthly reporting system outline in contract terms. This effort will be aligned with the performance monitoring process happening at the RPU level wherein partner efforts to administer PAM surveys and engage patients is recorded and reported up to the Project Management Office at "hot spot" locations. Course correct where appropriate as advised by the RPU-specific Onboarding Quality Subcommittees which report to the PPS Clinical Governance Committee.		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.	DY2 Q4	Project	N/A	Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Community engagement forums and other information-gathering mechanisms established and performed.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4b. Utilize a vendor (RMS) to distribute a panel which can be used to identify where community forums can be held.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 4c. Work with CBOs to facilitiate the forums to obtain input and engagement from the target populations.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4d. Identify individuals or groups who are willing to do the presentations.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	DY3 Q4	Project	N/A	Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5b. Identify and document which providers and CBOs will participate in the various components of the 2di project. Revisit this list as appropriate based on on-going Hot Spot analysis (as described later within this milestone).		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 5c. The 2di Project Team will work with the Health Literacy and Cultural Competency Committee ("CCC") to review and develop training materials which promote appropriate health literacy and engagement approaches and awareness. This will be performed in addition to or in conjunction with the annually required Partner Organization cultural competency and health literacy training which will also be coordinated by the CCC.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5d. Identify the appropriate number of individuals from the associated partners/CBOs who would need to be trained in patient activation in order for the PPS to achieve the target speed and scale population based on the findings of the "hot spot" analysis.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5e. Using the PAM Survey Training Team convened on 9/29 through the facilitated Insignia Health training session, provide training on patient activation and PAM as a PPS to participating organizations. Similarly, the Care Compass Network Project Management Office will track training and refresher course participation on an ongoing basis using a roster for individuals trained and monthly reports from partners. Additionally, the appropriateness with regards to number of trained PAM members from throughout the PPS will be evaluated (e.g., monthly) using Insignia standard reports, to determine if the PPS hot-spot and other planning models have allocated enough resources for patient activation related efforts. As needed plan modifications will be defined and coordinated through the appropriate clinical governance structures.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome	DY2 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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measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.										
Task Procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6b. Care Compass Network will develop a focus team to align the steps and deliverables associated with this milestone with HIPAA and legal requirements to receive MCO enrollee lists.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6c. Non Utilizing - The PPS project team will develop a procedure/protocol for connecting non-utilizing enrollees with PCPs. The focus will aim to identify the intial PCP (if any) previously identified by the patient, from where the CCN care coordination or navigation services will attempt to consent the patient and educate them regarding the benefits of collaboration with a PCP and utilization of other PPS benefits.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6d. Low Utilizing - The PPS project team will develop a procedure/protocol for connecting low-utilizing patients with PCPs. The focus will aim to identify the patients corresponding PCP (if any) and utilize PPS care coordinationg or navigation services to re-establish patient connectivity to PCP resources already available to the member. As appropriate available claims data on recent encounters may be utilized to promote the re-engagement process with the PCP.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6e. As required, obtain input at the RPU/PPS level through the		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Clinical Governance Committee for related procedures and protocols.										
Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2020	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).		Project		In Progress	04/01/2015	03/31/2020	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 7b. Identify cohorts using PAM survey and assess initial baselines as compared to expected results. Using these, set intervals of improvement for each beneficiary cohort leveraging the Clinical Governance Committee structure ensuring that patient activation strategies are developed and updated annually as appropriate. Initial baselines to be determined based on data and trends available from Insignia and/or other sources (e.g., Salient).		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 7c. Review results to modify cohort or baselines at the beginning of each performance period as needed and set targeted intervals toward improvement.		Project		In Progress	04/01/2015	03/31/2020	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 7d. Report changes in PAM activation level cohorts to Onboarding Subcommittees for performance monitoring. Additionally, the 2di Project Team will review ongoing PPS results and trends with experts from Insignia Health to ensure proper distribution and avoidance of false positives and/or outliers have been properly identied and remediated.		Project		In Progress	04/01/2015	03/31/2020	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #8 Include beneficiaries in development team to promote preventive care.	DY2 Q4	Project	N/A	Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 8b. Create a PPS strategy for how beneficiaries will be selected, including the utilization of the RMS vendor.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2

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Task 8c. Consult with RMS on tactics to engage beneficiaries in a manner that will result in their participation.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 8d. Identify preventive care specialists to educate beneficiaries in preventive care.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #9 Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/30/2017	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2

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- Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement										
Task 9b. Once the contract with Insignia is finalized, obtain Insignia delivered training to identify and determine the utilization of PAM components.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 9c. Develop a plan B for if a patient doesn't want to consent to the RHIO but wants to participate in the PAM.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 9d. Talk with the Performance measurement group about how to accurately monitor and report requisite data.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	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 Volume of non-emergent visits for UI, NU, and LU populations increased.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 10b. Utilize Salient data to identify changes to the NU/LU population.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 10c. Need to identify solution for tracking the UI.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 10d. Increase access and availability for non-emergent care for the target populations.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	DY3 Q4	Project	N/A	Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Community navigators identified and contracted.		Provider	PAM(R) Providers	Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Providers Associated with Completion:										

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Chenango Health Network, Inc.; Family And Childrens Society Inc; Family Hlth Netwrk Central Ny; Mothers And Babies Perinatal Network Of Scny, Inc.; Rural Health Network Of South Central New York, Inc.; Seven Valleys Health Coalition										
Task Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.		Provider	PAM(R) Providers	Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Providers Associated with Completion: Chenango Health Network, Inc.; Family And Childrens Society Inc; Family Hlth Netwrk Central Ny; Mothers And Babies Perinatal Network Of Scny, Inc.; Rural Health Network Of South Central New York, Inc.; Seven Valleys Health Coalition										
Task 11c. Discuss with Project 2.c.i team on the details of patient navigation.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 11d. Determine in conjunction with both Project 2.c.i team and the results of the Pre-engagement assessment which CBOs are willing and able to function as a group of community navigators.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 11e. Contract with selected CBOs.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	DY2 Q4	Project	N/A	Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Policies and procedures for customer service complaints and appeals developed.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 12b. Develop a PPS-wide patient-relations function.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 12c. Develop a communications channel between Medicaid recipients and PPS's patient-relations staff.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 12d. Organize regular meetings between patients-relations staff and project team participants to analyze complaints and establish methods of remediating complaints.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task List of community navigators formally trained in the PAM(R).		Provider	PAM(R) Providers	Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Providers Associated with Completion: Chenango Health Network, Inc.; Family And Childrens Society Inc; Family Hlth Netwrk Central Ny; Mothers And Babies Perinatal Network Of Scny, Inc.; Rural Health Network Of South Central New York, Inc.; Seven Valleys Health Coalition										
Task		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2

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13b. Get patient activation training for the CHAs and 211 staff (if needed)										
Task 13c. Organize regular meetings between community navigators and PAM surveyers for best practices and ongoing dialogue.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	DY3 Q4	Project	N/A	Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.		Provider	PAM(R) Providers	Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Providers Associated with Completion: Access To Independence Of Cortland County, Inc.; Bridgewater Ctr Rehab & Nrs; Catholic Charities Chenango; Catholic Charities Cortland; Chenango Memorial Hosp Inc; Chenango Memorial Hosp Inc; Chenango Health Network, Inc.; Family And Childrens Society Inc; Geroulds Prof Pharm Inc; Our Lady Of Lourdes Mem; Our Lady Of Lourdes Mem; Our Lady Of Lourdes Mem; Rural Health Network Of South Central New York, Inc.; S2ay Rural Health Network										
Task 14b. Assess "hot spots" locales.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 14c. Analyze Pre-Engagement assessment for CBOs located within "hot spots."		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 14d. Contract with CBOs in "hot spots" to allow navigators' placement.		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	DY3 Q4	Project	N/A	Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Navigators educated about insurance options and healthcare resources available to populations in this project.		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 15b. Research the current landscape of insurance through NYS Health Exchange and other insurance providers/resources.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 15c. The 2di Project Team will leverage existing PPS information, such as the Pre-engagement assessment for partners who provide services specifically to these populations.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 15d. Organize forum between navigators and PPS partners		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Care Compass Network (PPS ID:44)

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
providing services specifically to these populations for education and informative purposes.										
Task 15e. Obtain and/or develop training for navigators on insurance options and healthcare resources specific to UI, NU, and LU populations. Execution of training for navigators related to the 2di project will be incorporated to training also provided as a result of the 2ci project. Through the Project Management Office, Care Compass Network will track training and refresher course participation on an ongoing basis using a roster for individuals trained and monthly reports from partners.		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 15f. At a minimum, PPS protocols will be reviewed on an annual basis. During this time, the 2di Project team will also review the current insurance options landscape and adjust the impacted training strategies accordingly.		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	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 Timely access for navigator when connecting members to services.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 16b. Develop a priority matrix to assist with referring patients to necessary primary and preventative services in conjunction with the Clinical Governance Committee.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 16c. Analyze social determinants and mitigation strategies utilizing the expertise of the Clinical Governance Committee.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 16d. Execute the steps of Project 2.c.i including, but not limited to, developing protocols, training, and utilizing technical platforms to track patients in order to ensure appropriate and timely access for navigators.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #17 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	DY2 Q4	Project	N/A	Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS identifies targeted patients through patient registries and is		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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able to track actively engaged patients for project milestone reporting.										
Task 17b. Develop PPS-wide IT Vision and Strategy, including assessment of EHRs and other IT platforms and their utilization within all partners, through IT vendor.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 17c. Develop PPS-wide Population health management strategy via Population Health team, including patient registries for tracking purposes.		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 17c. Collaborate among project participants to determine whether or not a patient has taken the PAM by both screening participants as well as coding appropriately for LUs, NUs, and the uninsured by using a shared IT resource.		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	sculley	Contracts and Agreements	44_DY2Q3_PROJ2di_MDL2di3_PRES1_CONTR_CCN_Executed_Contracts_2di_DY2Q3_8667.pdf	Sample of executed contracts.	01/25/2017 02:02 PM
Survey the targeted population about healthcare needs in the PPS' region.	sculley	Other	44_DY2Q3_PROJ2di_MDL2di3_PRES4_OTH_Patient_Engagement_Survey_Report_11112016.PACExec.01.20.2017_8685.pptx	RMS Panel Patient Engagement Survey Report	01/25/2017 02:58 PM
Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	sculley	Training Documentation	44_DY2Q3_PROJ2di_MDL2di3_PRES5_TRAIN_PPS_Providers_Trained_in_PAM_8752.xlsx	List of PPS providers trained in PAM	01/26/2017 09:01 AM
	sculley	Training Documentation	44_DY2Q3_PROJ2di_MDL2di3_PRES5_TRAIN_Training_Materials_Template_8751.xlsx	Training materials template for PAM training	01/26/2017 09:00 AM
Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	sculley	Baseline or Performance Documentation	44_DY2Q3_PROJ2di_MDL2di3_PRES7_BASE_CCN_PAM_Reporting_Template_MY1&2_8855.xlsx	CCN PAM Reporting Template MY1&MY2	01/26/2017 10:46 AM
Include beneficiaries in development team to promote preventive care.	sculley	Other	44_DY2Q3_PROJ2di_MDL2di3_PRES8_OTH_RMS_Group_1_List_8753.xlsx	List of beneficiaries utilized as a resource in program development.	01/26/2017 09:08 AM

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Milestone Name	User ID	File Type	File Name	Description	Upload Date
Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	sculley	Training Documentation	44_DY2Q3_PROJ2di_MDL2di3_PRES11_TRAIN_Training_Materials_Template_8756.xlsx	Training materials template.	01/26/2017 09:13 AM
	sculley	Training Documentation	44_DY2Q3_PROJ2di_MDL2di3_PRES11_TRAIN_Navigator_Training_Roster_+_Credentials_8755.xlsx	Navigator training roster and credentials.	01/26/2017 09:13 AM
Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	sculley	Training Documentation	44_DY2Q3_PROJ2di_MDL2di3_PRES13_TRAIN_Training_Materials_Template_8760.xlsx	Training materials template.	01/26/2017 09:25 AM
	sculley	Training Documentation	44_DY2Q3_PROJ2di_MDL2di3_PRES13_TRAIN_Navigator_Training_Roster_8759.xlsx	Navigator training roster	01/26/2017 09:24 AM
	sculley	Training Documentation	44_DY2Q3_PROJ2di_MDL2di3_PRES13_TRAIN_DSRIP_Training_Deck_September_2015_8757.pdf	PAM training material.	01/26/2017 09:21 AM
Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	sculley	Contracts and Agreements	44_DY2Q3_PROJ2di_MDL2di3_PRES14_CONTR_CCN_Executed_contract_2ci_DY2Q3_8763.pdf	CCN Executed contracts for 2ci DY2Q3	01/26/2017 09:28 AM
	sculley	Contracts and Agreements	44_DY2Q3_PROJ2di_MDL2di3_PRES14_CONTR_CCN_Exectued_contract_2di_DY2Q3_8762.pdf	CCN Executed contracts for 2di DY2Q3	01/26/2017 09:28 AM
Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	sculley	Other	44_DY2Q3_PROJ2di_MDL2di3_PRES15_OTH_Insurance_Navigator_Organizations_8765.pdf	List of insurance navigator organizations in the PPS.	01/26/2017 09:32 AM
	sculley	Other	44_DY2Q3_PROJ2di_MDL2di3_PRES15_OTH_Qualified_Health_Plans_by_County_8764.xlsx	List of qualified health plans by county.	01/26/2017 09:31 AM
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	sculley	Report(s)	44_DY2Q3_PROJ2di_MDL2di3_PRES17_RPT_CCN_Multiple_Services_Report_DY2_-_across_partners_9647.csv	Remediation - CCN multiple services report file 2 (csv file due to size)	03/17/2017 04:41 PM
	sculley	Report(s)	44_DY2Q3_PROJ2di_MDL2di3_PRES17_RPT_CCN_Multiple_Services_Report_DY2_9646.csv	Remediation - CCN multiple services report file 1 (csv file due to size)	03/17/2017 04:40 PM
	sculley	Rosters	44_DY2Q3_PROJ2di_MDL2di3_PRES17_ROST_2di_Patient_Registry_DY2Q3_9639.xlsx	Remediation - completed patient registry for 2di.	03/17/2017 04:11 PM
	sculley	Other	44_DY2Q3_PROJ2di_MDL2di3_PRES17_OTH_2di_M17_Remediation_9638.docx	Remediation response for 2di milestone 17.	03/17/2017 04:11 PM
	sculley	Other	44_DY2Q3_PROJ2di_MDL2di3_PRES17_OTH_M1_Item1_Pop_Health_Roadmap_8770.pdf	CCN Population Health Roadmap.	01/26/2017 09:39 AM
	sculley	Other	44_DY2Q3_PROJ2di_MDL2di3_PRES17_OTH_030816_IT_Strategic_Plan_Final_8769.pptx	CCN IT Strategic plan	01/26/2017 09:38 AM

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Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	This Milestone was reported as Complete in DY1, Q3. During the DY2, Q3 reporting period, the PPS has engaged seven additional Community Based Organizations with executed contracts for 2di which are as follows: -American Civic Association - Mothers and Babies Perinatal Network of SCNY -Challenge Industries, Inc. -United Way of Broome County -Monroe Plan Medical Care -Finger Lakes Addiction Counseling and Referral Agency - Planned Parenthood of the Southern Finger Lakes These new contracts are incorporated in this report. Consistent with the statewide approach for the PAM® survey, completed survey information from these organizations is being uploaded to Flourish® and will be reported for speed and scale purposes for the DY2, Q3 timeframe. Additional contracts are in draft and will be reported through this Milestone for future quarterly reports.
Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	This Milestone was reported as Complete in DY1, Q3 and there are no changes to report.
Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	This milestone was reported as Complete in DY2, Q2. During the DY2, Q3 reporting period, there have been no changes to the tracking deliverables or the monthly reporting system. CCN continues to monitor, track performance, and generate reports for each organization administering the PAM survey in the hot spot areas using Insignia Flourish database system. Each contracted partner submits an attestation letter each month, reporting the number of PAM Surveys administered in their organization for the previous month. This allows CCN to monitor process, and performance to share at each Regional Performance Unit (RPU) on-boarding committee, and across our PPS as an entirety.
Survey the targeted population about healthcare needs in the PPS' region.	This Milestone was reported as Complete in DY1, Q3. During the DY2, Q3 reporting period, there have been one new survey administered by RMS. As of DY2, Q3, the total Medicaid or uninsured members engaged in participating in RMS surveys included 276 members. During DY2Q2 a Patient Engagement Survey was done by RMS Panel October 11-24, 2016 with a response rate of 21%. The survey informed us of the following: □ 61% indicated that they are very involved with healthcare provider(s) when making personal healthcare decisions. □ Responses from Medicaid and uninsured respondents are similar, with 60% indicating that they are very involved with healthcare provider(s) when making personal healthcare decisions. □ 74% have tried to change the way they manage a health condition with the help of a healthcare provider. □ Medicaid and uninsured respondents (76%) have tried to change the way they manage a health condition with the help of a healthcare provider. □ When healthcare providers were asked what could be done to better help patients engage in their health, common themes included: personalized attention, follow-up, and encouragement . □ When community organization employees were asked what could be done to help patients better engage in their health, common themes included: make accessing care easier/more affordable, better communication, and more personalized attention. □ Of respondents who worked with a provider to change the way a health condition was managed, many indicated that the provider kept them motivated and engaged by listening, following-up, and providing personal attention. □ These results are similar to Medicaid and uninsured respondents. □ When asked if there was anything else that motivated respondents to change the way a health condition was managed, many indicated that personal reasons (such as bettering oneself or family) were sources of motivation. □ This result is similar to Medicaid and uninsured respondents.

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	□ Nearly all respondents (95%) reported that they have a primary care physician (PCP). Of those that do not have a PCP, some followed-up by saying that their provider moved away, or that they are healthy and do not want to go to the doctor. □ Most Medicaid and uninsured respondents have a PCP (88%), slightly less than other panel groups. □ Reasons for no PCP were: lack of provider trust, providers do not understand mental health issues, lack of insurance, and retirement. □ 87% reported that their PCP effectively works with them to manage their heath. □ Of respondents who indicated that their PCP did not work with them effectively, the doctor's lack of personal attention was a common theme. □ Nearly all Medicaid and uninsured respondents (91%) reported that their PCP effectively works with them to manage their health. CCN has engaged a multi-year engagement with RMS for the continued engagement of the panel members and will continue reporting panel engagement progress in future quarters.
Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	This Milestone was reported as Complete in DY1, Q3, however we have changes to report. A total of 46 people was trained in patient activation techniques in DY2Q3 representing contracted partners (Planned Parenthood of Southern Finger Lakes, JM Murray, Mothers and Babies Perinatal Network, YWCA of Binghamton, Cornerstone Family Health, Bridgewater Rehab and Nursing Facility, American Civic Association, Cayuga Addiction and Recovery Services, Finger Lakes Addictions Counseling and Referral Association, Family Enrichment Network, Chenango County Mental/Behavioral Health and Challenge Industries) as a result of having executed a contract with CCN to participate in the Patient Activation project.
Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.	The Milestone and subsequent steps are not due in DY3Q2, however Care Compass Network (CCN) continues to make progress in completing this milestone and its five associated steps. As of May 2016, CCN is participating in the Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey to capture the uninsured population experience with health care. One of the data elements to be collected will be the Primary Care Provider (PCP) associated with the uninsured patient's visit or visits and their experience with that PCP. With that information, CCN will collaborate and compare the PAM Survey data capturing patient engagement, and the CG-CAHPS survey data capturing patient experience, with overall efforts focusing on the PCP's activity with engaging their patients. The Project Manager and the regional Provider Relations team continue to work with engaging Primary Care Providers and Managed Care Organizations (MCOs) to establish, reconnect and re-engage the uninsured, non-utilizing, and low-utilizing population.
Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	The Milestone and subsequent steps are not due in DY2Q3, however after receiving the DOH methodology from NYS DOH on 1/17/2017, Care Compass Network (CCN) on is moving Milestone 7 and remaining steps from an "On Hold" status to an "In progress" status and modifying the end dates to align with the Prescribed Milestone due date. For Measurement Year 1, CCN had zero PAM surveys administered therefore there is no cohort or baseline to measure. For Measurement Year 2, CCN conducted 92 PAM surveys across the nine-county region, 11 scoring as a level one, 17 scoring as a level two, 52 scoring as a level three, and 14 scoring as a level 4 resulting in a mean score of 61.00. CCN continues to make progress administering the PAM survey across the nine-county region and will be in the process of re-administering the PAM survey to see if scores increase over time with coaching and navigating the patient. The PAM reporting template requested by DOH has been uploaded as part of this milestone even though we are not completing the milestone and remaining steps at this time.
Include beneficiaries in development team to promote preventive care.	This Milestone was reported as Complete in DY1Q3 however we have updates to report. As of the DY2Q3, the RMS panel is comprised of 276 Medicaid Members and uninsured individuals who reside in the PPS nine county regions, 18 of which began participating in our surveys in the DY2Q3 timeframe. Ongoing panel management continues to be an effort of the PPS in DY2Q3 to account for variation and changes in Medicaid enrollment status. The RMS vendor has been engaged to continually look for new group participation from Medicaid members to ensure consistent participation levels are retained.

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	In addition to existing efforts to recruit new members, CCN engaged RMS to outreach to beneficiaries via provider office "intercept sign-ups", telephonic calls to solicit participation in the refer-a-friend program, and Facebook boosts. Additionally, CCN printed panel card handouts with information and the link to the Care Compass Network website and distributed these to provider/practice sites and continue to attract new membership. Lastly, the panel continues to be asked about their needs and access to preventative care.
Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.	Milestone 9 for the Patient Activation Measure project (PAM) is not due for completion in DY2Q3 however Care Compass Network (CCN) continues to make progress in regards to completing this milestone on time. Care Compass Network has begun to engage Managed Care Organizations (MCOs) in a PPS-wide strategy to build lasting relationships beyond the end of DSRIP. We have met with four MCOs thus far, including Fidelis, Excellus, United Health Care, and Total Care. We are organizing our approach to each MCO in our service area. The approach will address specific project needs, organizational needs and overall integrated delivery system reforms. Ultimately the goal is to establish a Memorandum of Understanding or other agreement between Care Compass Network and the MCO for coverage of DSRIP services that are not currently part of the Medicaid benefit. Care Compass Network is in a position to develop services that deliver a large impact on the total value of health care provided to Medicaid members. This impact will come through the development of the Integrated Delivery System, development of Population Health services, and through new services developed through the implementation of the eleven projects CCN selected.
Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	Milestone 10 for the Patient Activation Measure project (PAM) is not due for completion in DY2Q3 however Care Compass Network (CCN) continues to make progress in regards to completing this milestone on time. CCN recognizes and values the importance of social determinants which impacts the health and community it serves. We have engaged with partners who contribute and participate actively throughout our PPS. Currently, the partners contracted to do both PAM and the Community Navigation (2ci) project, have taken the opportunity to utilize the use of non-emergent services such as primary, dental, and preventative screenings at community events. This approach has helped market both projects, as well as implement and increase the non-emergent care in a public community setting for the low- utilizers, non-utilizers, and uninsured.
Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	This Milestone was reported as Complete in DY1, Q3 however we have changes to report for the DY2, Q3 period. The PPS has engaged eight additional CBOs contracted for Community Navigation who have been trained in administering the PAM survey (YWCA of Binghamton, American Civic Association, Family Enrichment Network, Mothers and Babies Perinatal Network, and JM Murray). Provider Engagement: Add the following providers for this milestone:

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	-YWCA of Binghamton -American Civic Association -Family Enrichment Network -Mothers and Babies Perinatal Network -JM Murray -Cayuga Addiction Recovery Serves (CARS) -Challenge Industries -Finger Lakes Addictions Counseling and Referral Agency
Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	This Milestone was reported as Complete in DY1, Q2, however there are no changes to report as there have been no changes to the CCN process for reporting complaints. Additionally, there have been no complaints.
Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	This Milestone was reported as Complete in DY1, Q3. During the DY2, Q3 reporting period, a total of 23 people from YWCA of Binghamton, American Civic Association, Family Enrichment Network, Mothers and Babies Perinatal Network, JM Murray (organization's providing community navigation services) have been trained in administering the PAM® Survey as well as how to appropriately assist project beneficiaries using the PAM. To date, a total of 56 Community Navigators have been trained in administering the PAM® Survey as well as how to appropriately assist project beneficiaries using the PAM. The following providers are now included in provider engagement for meeting this milestone: YWCA of Binghamton, American Civic Association, Family Enrichment Network, Mothers and Babies Perinatal Network, and JM Murray.
Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	This Milestone was reported as Complete in DY2, Q2. For DY2, Q3, CCN continues to contract for the Community Navigation project (2ci), including eight new Community Based Organizations (CBOs) in our nine county hot spot regions to ensure a direct handoff is made to a Navigator after the PAM survey is administered.
Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	Milestone 15 and remaining steps (15a, 15d, 15e and 15f) are due for completion in DY2, Q3 and all are being reported as complete. Care Compass Network (CCN) along with the 2di project team identified organizations across the PPS that are contracted to implement and perform the PAM Survey as well as those that would employ Insurance Navigators within their organizations. These Insurance Navigators are placed in hot spot areas by county in order to provide insurance options and perform insurance enrollment for the population identified in this project. The NYS of Health (The Official Health Plan Market Place) currently hosts and provides certified health insurance navigator training for organizations in New York State to certified Insurance Navigators, and to Patient Financial Assistants since it is a requirement to assist in enrollment and/or review services available to the uninsured (UI), non-utilizer(NU) and low-utilizer member (Milestone 15 - Complete). It is also worth mentioning Managed Care Organizations have marketing representatives who are certified Insurance Navigators working in the communities to facilitate, enroll and educate the population. In December 2015, CCN researched the current landscape of insurance through the NYS Health Exchange with the help of its partners, compiling a list of Qualified Health Plans by county as a resource (Step 15b - Complete). Additionally, Care Compass Network's Pre-Engagement Assessment was used to make note of Community Based Organizations (CBOs) aligned to reach the target population. After eliminating organizations who provide qualifying services, CBOs that self-identified as seeing uninsured, non-utilizing, and low-utilizing individuals were noted and compiled in addition to those collected based on input from the Regional Performing Units (RPUs) (Step 15c - Complete). As of December 2016, CCN has three contracted organizations who have NYS certified insurance navigator placement in multiple entities and counties throughout our PPS (Attachment A). Those organizations are Mothers and Babies Perinatal Network, S2AY Rural Health Network and Chenango Health Network. These three organizations having Insurance Navigator placement within CBOs are also contracted to administer the PAM survey, and are contracted to implement and report for the Community Navigation Project (2ci). This process ensures a warm handoff is made to an Insurance Navigator within the organization(s) since these organizations use the same workforce to do both Community Navigation and Insurance Navigation (Step 15a - Complete). CCN along with the 2di project team, and workforce committee decided not to duplicate its effort of creating a training for navigators on insurance options but to leverage use of Insurance Navigator's placement and expertise along with the 2-1-1 Community Resource Guide for Community Navigators to warrant insurance options and healthcare resource needs are met specific to UI, NU and LU population. Meetings take place on a monthly basis at each RPU on-boarding quality committees, the 2ci

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	project team and the Resource Guide Workgroup consisting of both PPS partners and insurance navigators to discuss, and share knowledge of services specifically to the UI, LU and NU population. CCN will continue to review approved protocols through our Clinical Governance Committee, Insurance Navigators and 2di project team to utilize the most up to date insurance options and will adjust training strategies accordingly (Steps 15d, 15e and 15f - Complete). A list of organizations trained about insurance options and healthcare resources available to UI, NU and LU populations is uploaded as supporting documentation of milestone completion (refer to document Insurance Navigator Organizations.pdf).
Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	There are no steps due in the DY2Q3 reporting period for this Milestone, however Care Compass Network (CCN) continues to make progress in regards to completing this milestone and two remaining steps. Care Compass Network is continuing the partnership with the current system 2-1-1 First Call for Help for the Community Resource Guide. Once the next phase of the Community Resource Guide is completed, integrating all three local 2-1-1 information, CCN will collaborate with the 2-1-1s on training for the navigators and the PPS as a whole. Training will include how to navigate using the Community Resource Guide along with strengthening knowledge of social determinants as well as how to refer and facilitate the appropriate level of services in the community. The Community Resource Guide powered by 2-1-1, the Project Management Office (PMO) and the 2ci project team, will also be able to track and report unmet non-clinical resources that clients/callers/patients are facing targeting the highest unmet needs in each Regional Performance Unit (RPU) in order to enhance those resources. The Project Management Office (PMO) along with the Community Resource Guide oversight group will also work in collaboration with CCN's Marketing Manager on marketing and enhancing the Community Resource Guide and the non-clinical resources for the navigators to use. Lastly, CCN is also in process of selecting a Population Health/Care Management platform to use across the PPS which will ensure appropriate and timely access for navigators to use when attempting to establish primary and preventative services such as behavioral health and substance abuse for the patient and community member.
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	Milestone 17 and the remaining steps (Steps 17a, 17c and 17d) are due for completion in DY2Q3 and all are being reported as complete. In November 2015, a screening tool was developed to assist partners in determining an individual's eligibility to take the PAM®. Flourish®, Insignia's database tracking tool, is assisting the PPS with tracking patients and informing population health management. Flourish® and the Department of Health have dictated the use of unique identifiers to assist in distinguishing Medicaid beneficiaries from the uninsured for this project (Step 17a - Complete). Care Compass Network has an Analytics Team lead by a CCN staff member who has been designated to review population health data. In March 2016, the PPS-wide IT Strategic Plan was approved by the Board of Directors including the vision of EHR assessment and other IT platforms for utilization with partners. An initial task of the analytics team was to enumerate information needs of partners in each DSRIP project as well as the overall informational needs to self-evaluate along the DSRIP Performance Metrics. The analytics team is in the initial stages of developing the project performance dashboards and DSRIP performance dashboards (to be maintained based on data stored in the CCN data warehouse). The team's current mandate is to support project implementation and support design of the Population Health Roadmap with information and data. Care Compass Network considers the work of this team to be a beta version of the future Population Health initiatives—using data currently available to support DSRIP work. In addition to the work of the analytics team, the IT Roadmap is being implemented by our IT Team, including overseeing the Population Health Management platform selection process (Step 17b - Complete). In December 2016, the CCN Data Warehouse went live to capture the quarterly report for the Population Health work stream. While several of the partners have EMRs, many of the EMRs do not have the current capability to easily pull the required information for each project to report patients actively engaged in the DSRIP projects. Tracking the actively engaged is included in Care Compass Network's contract for project work and is aggregated monthly from the Flourish database for quarterly reporting. The patient registry information is imported into the CCN Data Warehouse, an integral piece of the IT systems which will support CCN's Population Health approach. The warehouse combines partner data on monthly activities; in the future, the warehouse will bring in the NY Medicaid claims data, clinical data from partners (via the RHIOs), and other sources of data on social determinants. With this data, CCN's population health analysts will develop dashboards and reports to evaluate performance. These details are encompassed in the Population Health Roadmap which was presented and approved by the CCN Board of Directors on September 13, 2016 as part of completing the Domain 1 Population Health Milestone of which was passed in the DY2Q2 report (Milestone 17 and Step 17c - Complete). With current HIPAA and Compliance policies in place with the PPS and NYS DOH, CCN cannot currently share patient data across EHRS or other IT platforms, however CCN will continue to utilize Flourish®, Insignia's database tracking tool, to assist the PPS in tracking patients to inform population health management and continue to use the Low Utilizer (LU), Non-Utilizer (NU) and the Uninsured (UI) screening tool to determine and code appropriately prior to administering PAM survey (Step 17d - Complete). Remediation response uploaded.

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Milestone Review Status

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

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Mid-Point Assessment	Completed	Mid-Point Assessment Project Narrative	06/01/2016	06/30/2016	06/01/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone CG-CAHPS 2016 Survey Results of Uninsured	Completed	Submission of CG-CAHPS 2016 Survey Results of Uninsured.			10/01/2016	12/31/2016	12/31/2016	DY2 Q3

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
CG-CAHPS 2016 Survey Results of Uninsured	sculley	Other	44_DY2Q3_PROJ2di_MDL2di4_PPS1671_OTH_Care_Compass_Network_DY2_[070115-063016]_CG-CAHPS_FINAL_Report_8637.pdf	RMS details of the process used to collect the CG-CAHPS data as well as a summary of the results.	01/25/2017 11:51 AM
	sculley	Rosters	44_DY2Q3_PROJ2di_MDL2di4_PPS1671_ROST_CCN_2016_CG-CAHPS_Survey_Results_8636.xlsx	CG-CAHPS Survey results of the uninsured for Measurement Year 1.	01/25/2017 11:50 AM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment	
CG-CAHPS 2016 Survey Results of Uninsured	Care Compass Network(CCN) completed the CG-CAHPS Survey of the uninsured for Measurement Year 1 with 147 surveys complete. CCN partnered with RMS to telephonically administer the survey in order to reach the minimum of 30 complete surveys. The complete narrative report can be found in the attachment labeled Care Compass Network DY2.pdf.

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

Instructions :

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

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

Instructions :

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

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

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "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	48,573

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	7,514	13,500	11,597	23,196
	Quarterly Update	82	555	1,509	0
	Percent(%) of Commitment	1.09%	4.11%	13.01%	0.00%
IA Approved	Quarterly Update	0	555	0	0
	Percent(%) of Commitment	0.00%	4.11%	0.00%	0.00%

Warning: PPS Reported - Please note that your patients engaged to date (1,509) does not meet your committed amount (11,597) for 'DY2,Q3'

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
brosetti	Rosters	44_DY2Q3_PROJ3ai_MDL3ai2_PES_ROST_Actively_Engaged_DY2Q3_9115.xlsx	DY2Q3 Actively Engaged	01/27/2017 01:29 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Models Selected		
Model 1 ✓	Model 2 ✓	Model 3 ✗

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 eligible 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 eligible 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 1c. The 3ai Project Team will perform a review of PPS partners to understand the number of Medicaid recipients, facility PCMH status, and overall readiness/interest level of the site to participate in project 3ai. Following the assessment, a series of primary care (PC) pilot sites will be identified for project 3ai.			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1d. The PPS will engage with the associated partners and provide support and/or incentives to PC sites to attain Level 3 PCMH status (for example, by developing a PCMH Quality Committee in the North Regional Performance Unit (RPU) to facilitate the region's attainment of Level 3 PCMH status, by contracting with a consultant as mentioned in Project 2.a.i's Implementation Plan, and/or via the Change			Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	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
Management Subcommittee of the IT Committee). The 3ai Project Team and associated Behavioral Health Quality Committees will develop and monitor performance metrics on productivity and health outcomes to support and encourage attainment of PCMH status (to address Risk #1).											
Task 1e. The 3ai Project Team and CCN PMO will work with PC sites to confirm necessary waivers, licensure, and/or certification or inclusion of new services on operating certificate and/or designation an Integrated Outpatient Services Clinic are in place.			Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1f. The 3ai Project Team and CCN will confirm and document each integrated site has negotiated contracts with Managed Care Organizations (as required) to reflect delivery of on site behavioral health (BH) services.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1g. The CCN PMO will promote the integration of differing cultures in primary and Behavioral Health (BH) care by developing and disseminating training, and encouraging cross specialty shadowing and collaboration. (Risk #5) The PMO will leverage the training functionality developed by the Workforce Development team as well as the Provider Relations team to assist with program development and program dissemination.			Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1h. The 3ai Project Team and CCN PMO to develop a strategy to engage partner Emergency Departments and Walk-In Clinics in project plans in order to address patients not being captured due to seeking primary care in ED or Walk-In clinics (Risk #2). Implement strategies to address this issue, as appropriate.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2018	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	Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	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 Regularly scheduled formal meetings are held to develop collaborative care practices.			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2c. Develop collaborative care protocols for integrating evidence based Behavioral Health screening tools into PC sites. Protocols will be approved by the Clinical Governance Committee and recertified on an annual basis.			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2d. Develop protocols for assessment, crisis/high risk response plan, and treatment, including integrated care plan, follow-up, and management/monitoring of response to treatment in the case of positive screening results. Protocols will be endorsed by the Clinical Governance Committee and approved by the Board of Directors and be recertified by Clinical Governance Committee at minimum annually.			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2e. Protocols will be endorsed by the Clinical Governance Committee and approved by the Board of Directors and be recertified by Clinical Governance Committee at minimum annually to allow continuous process improvement, as indicated.			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
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.	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 Policies and procedures are in place to facilitate and document completion of screenings.			Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Screenings are documented in Electronic Health Record.			Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task			Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	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
At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).											
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.			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 3e. 3ai Team to identify leading evidenced-based standardized BH screening tools (including PHQ-2, PHQ-9, SBIRT and OASAS-approved tools for SA). Submit tool(s) for approval to the Clinical Governance Committee for PPS-wide adoption. Clinical Governance to recertify annually.			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3f. 3ai Team to identify appropriate staffing models based on NYS guidelines and regulations. Contracts with PC sites will reflect the recommendations from the 3ai Team.			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3g.Client-facing staff will receive training on basic behavioral health challenges most commonly seen in primary care, including depression, substance use and anxiety, as well as recognizing the signs and symptoms of more complex conditions. PMO will coordinate development of training material with approval from the Clinical Governance Committee. Workforce Committee will implement training.			Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 3h. Client-facing staff will receive PPS facilitated training on BH screening tool, how to integrate screening into patient work flow, add information to patient chart, referral and follow up. The 3ai project team, PMO, and Workforce Development team will coordinate development of training material with approval from the Clinical Governance Committee with special consideration for how planning and implementation efforts can be achieved without			Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	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
interfering with existing practice flows. The Workforce Project Manager and Provider Relations team will oversee the direct implementation and delivery of training.											
Task 3i. The Care Compass Network PMO will perform implementation related reviews and/or reporting requirements to confirm and document PC sites incorporate into policies the implementation of BH screenings for clients.			Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	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 4c. The Care Compass Network PMO and PC sites will develop timelines for waiver approval to integrate BH and PC Medical Record.			Project		On Hold	04/01/2015	03/31/2017	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 4d. The 3ai Project Team, in collaboration with the Workforce Development and PMO teams will develop training material to educate PC staff regarding elements of a BH Medical Record with approval from the Clinical Governance Committee. Workforce Committee and Provider Relations teams will subsequently implement training.			Project		On Hold	04/01/2015	03/31/2017	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 4e. CCN will engage with the PC site to develop efficient flow of clinical information between providers using CQI principals.			Project		On Hold	04/01/2015	03/31/2017	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 4f. CCN engages with PC site to track actively engaged patients by reporting on frequency of			Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	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
screening, referral, and follow up for milestone reporting using the EHR.											
Milestone #5 Co-locate primary care services at behavioral health sites.	DY3 Q4	Model 2	Project	N/A	In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Primary care services are co-located within behavioral Health practices and are available.			Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Primary care services are co-located within behavioral Health practices and are available.			Provider	Mental Health	In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 5d. The 3ai Project Team will perform a review of PPS BH partners to understand the number of Medicaid recipients, facility PCMH status, and overall readiness/interest level of the site to participate in project 3ai. Following the assessment, a series of BH pilot sites will be identified for project 3ai. Potential Article 31 Clinics offer a combination of mental health services, substance abuse treatment, and services for the developmentally disabled. CCN PMO and BH sites will identify space for medical procedures in accordance with DOH/OMH/OASAS regulations and/or Integrated Outpatient Services requirements, and apply for waivers/licenses as appropriate.			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5e. The PPS will engage with the associated partners and provide support and/or incentives to ensure integrated sites have negotiated contracts with Managed Care Organizations (MCOs) to reflect delivery of on site primary care services with no medically unreasonable treatment limits and in keeping with state parity and other insurance laws. CCN PMO and Behavioral Health Subcommittee to support integrated sites' development through the development and dissemination of best practices. Note: Article 31 sites have authority or secured waivers that allow for on-site preventative and evaluation and management (E/M) services.			Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 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 5f. Logistics of Integration - BH sites will complete necessary physical space and/or workflow accommodations to provide integrated services. CCN PMO, CCN Compliance, IT and Change Management committees will assist sites in completing logistical requirements of integration.			Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5g. BH sites will offer primary care services during all practice hours. CCN will ensure behavioral health clinic policies and procedures reflect U.S. Preventive Services Task Force recommended screenings for all clinic clients, such as: lipids, hypertension, tobacco, alcohol, and breast/colon/cervical cancer. Related clinical standards adopted by the PPS will be prepared by the 3ai Project Team and PMO and presented to the Clinical Governance Committee and Board of Directors for approval.			Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
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	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6c. CCN PMO/Provider Relations will reach out to partners to gather information regarding existing practice protocols for care engagement, screening, assessment, medication management, and treatment.			Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 6d. RPU Behavioral Health Subcommittees to adopt/develop protocols for care engagement, screening, assessment, crisis/high risk response plan, medication management and treatment including development of an integrated care plan, follow - up,			Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	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
and management for at least one target condition (e.g. diabetes, hypertension, obesity, chronic pain). Protocols will be based on the US Preventative Task Force Guidances. Clinical Governance will approve protocols and recertify annually.											
Task 6e. Develop collaborative care models for integrated services. Establish criteria for collaboration between providers, including opporunities for cross training in PC and BH settings, to ensure a comprehensive care plan is developed and executed for patients. CCN RPU leaders, in their roles on the Behavioral Health Subcommittees, will initiate and implement opportunities for cross training.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Conduct preventive care screenings, including physical and behavioral health screenings.	DY3 Q4	Model 2	Project	N/A	In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.			Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Screenings are documented in Electronic Health Record.			Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task At least 90% of patients receive primary care services, as defined by preventive care screenings at the established project sites (Screenings are defined as physical health screenings for primary care services and industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT for behavioral health).			Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Positive screenings result in "warm transfer" to behavioral health or primary care provider as indicated by screening as measured by documentation in Electronic Health Record (EHR).			Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Positive screenings result in "warm transfer" to behavioral health or primary care provider as indicated			Provider	Mental Health	In Progress	07/01/2016	06/30/2017	07/01/2016	06/30/2017	06/30/2017	DY3 Q1

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Care Compass Network (PPS ID:44)

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by screening as measured by documentation in Electronic Health Record (EHR).											
Task 7e. The 3ai Project Team and Care Compass Network PMO/Provider Relations to survey PPS Partners to identify existing evidence-based screening tools leveraged by participating providers. The 3ai Project Team will propose a minimum level of screening required of PPS Partners, for approval and annual recertification by the CCN Clinical Governance Committee and PPS-wide adoption.			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 7f. Client facing staff will complete training on chronic illness management including common physical health medications, preventive care, and chronic conditions. PMO will coordinate development of training material with approval from the Clinical Governance Committee. Workforce Project Manager and Provider Relations will facilitate the delivery and tracking of training.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 7g. The Care Compass Network PMO will perform implementation related reviews and/or reporting requirements to confirm and document BH sites have incorporated into policies the implementation of U.S. Preventive Task Force recommended screenings for all clients.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 7h. Client-facing staff receives training on Preventive screening tool(s), how to integrate screening into patient work flow, add information to patient chart, referral and follow up. PMO will coordinate development of training material with approval from the Clinical Governance Committee. Workforce Project Manager and Provider Relations will facilitate the delivery and tracking of training.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 7i. CCN PMO will do a gap analysis of CCN Model 2 partners (Article 31 and 32 sites) to understand how			Project		Completed	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2

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many are currently using industry standard behavioral health screening tools in their patient assessments.											
Task 7j. CCN Project team complete a feasibility analysis of transitioning existing non-industry behavioral health screenings to industry standards.			Project		Completed	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 7k. CCN Project Team to develop a screening protocol for approval by the Clinical Governance Committee, which ensures at least 90% of Medicaid patients are screened using an industry standard behavioral health screening tool and/or an CCN Clinical Governance Committee approved physical health screening.			Project		Completed	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 7l. CCN Project Team to develop a Warm hand-off protocol, developed by Project Team and adopted by CCN partners for use at project sites. Warm hand-off protocol will cover warm hand-off between Mental Health and Substance Abuse providers, and from the behavioral health staff to primary care providers integrated in the sites. Protocol will be approved by the Clinical Governance Committee.			Project		Completed	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	Model 2	Project	N/A	Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.			Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.			Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 8c. The 3ai Project Team and CCN PMO will work with PC sites to confirm BH sites have obtained necessary waivers to be able to integrate BH and PC Medical Record.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 8d. CCN PMO to develop educational tools for BH staff			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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regarding elements of a PC Medical Record with approval from the Clinical Governance Committee. Workforce Project Manager and Provider Relations will facilitate the delivery and tracking of training.											
Task 8e. CCN will engage with the PC site to develop efficient flow of clinical information between providers using CQI principals.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 8f. CCN engages with PC site to track actively engaged patients by reporting on frequency of screening, referral, and follow up for milestone reporting using the EHR.			Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #9 Implement IMPACT Model at Primary Care Sites.	DY3 Q4	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has implemented IMPACT Model at Primary Care Sites.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	DY2 Q4	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Policies and procedures include process for consulting with Psychiatrist.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	DY2 Q4	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Depression care manager meets requirements of			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.											
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	DY2 Q4	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task All IMPACT participants in PPS have a designated Psychiatrist.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #13 Measure outcomes as required in the IMPACT Model.	DY3 Q4	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #14 Provide "stepped care" as required by the IMPACT Model.	DY3 Q4	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	DY2 Q4	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop collaborative evidence-based standards of care including medication management and care engagement process.	brosetti	Meeting Materials	44_DY2Q3_PROJ3ai_MDL3ai3_PRES2_MM_2._CGC_Minutes_10272016_-_Project_TEACH_9039.docx	CGC Meeting Minutes - Project TEACH	01/27/2017 08:40 AM
	brosetti	Policies/Procedures	44_DY2Q3_PROJ3ai_MDL3ai3_PRES2_P&P_CGC-CG-30-_Project_TEACH_-_Connecting_Primary_Care_Providers_with_Child_Psychiatry_9038.pdf	CGC-CG-30 Project TEACH - CAP-PC	01/27/2017 08:39 AM
Use EHRs or other technical platforms to track all patients engaged in this project.	sculley	Report(s)	44_DY2Q3_PROJ3ai_MDL3ai3_PRES8_RPT_CCN_Multiple_Services_Report_DY2_-_across_partners_9651.csv	Remediation - CCN multiple services report file 2 (csv file due to size)	03/17/2017 04:46 PM
	sculley	Report(s)	44_DY2Q3_PROJ3ai_MDL3ai3_PRES8_RPT_CCN_Multiple_Services_Report_DY2_9650.csv	Remediation - CCN multiple services report file 1 (csv file due to size)	03/17/2017 04:46 PM
	sculley	Rosters	44_DY2Q3_PROJ3ai_MDL3ai3_PRES8_ROST_3ai_Model_2_Patient_Registry_DY2Q3_9649.xlsx	Remediation - 3ai Model 2 completed patient registry.	03/17/2017 04:45 PM
	sculley	Other	44_DY2Q3_PROJ3ai_MDL3ai3_PRES8_OTH_3ai_M8_Remediation_9648.docx	Remediation response for 3ai milestone 8.	03/17/2017 04:44 PM
	brosetti	Screenshots	44_DY2Q3_PROJ3ai_MDL3ai3_PRES8_SS_Integrated_EHR_9118.pdf	Screenshot of Integrated EHR	01/27/2017 01:55 PM
	brosetti	Templates	44_DY2Q3_PROJ3ai_MDL3ai3_PRES8_TEMPL_3ai_Integrate_BHModel2_Data_tracker_9117.xlsx	Model 2 patient data tracker	01/27/2017 01:51 PM
	brosetti	Contracts and Agreements	44_DY2Q3_PROJ3ai_MDL3ai3_PRES8_CONTR_Appendix_C_Project_3ai_MODEL_2_9116.docx	3ai Model 2 appendix C	01/27/2017 01:50 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Co-locate behavioral health services at primary care practice sites. All participating eligible primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Care Compass Network is on track in meeting this milestone by the deadline. There are no milestones or steps due for completion for DY2, Q3. CCN continues to support our contracted partners to provide implementation resources and guidelines for integration. One stipulation in the project contract is for our partners to obtain the necessary licenses, waivers and certifications and/or inclusion of new services on their operating certificate to be able to offer behavioral health services on site. The PMO is in communication with individual contracted partners to review the MCO's contracting process such as BH covered services and credentialing process to reflect the delivery of onsite behavioral health services, however it is the responsibility of each contracted partner to negotiate and contract with the Managed Care Organizations (Step 1f – Complete). Furthermore, CCN has hosted different forums with COPE Health Solutions and MCOs (specifically with Excellus, Fidelis, UHC, MVP and Total Care) to facilitate education and support our partners on value based initiatives. CCN made an administrative update to the end date for Milestone 1 in the DY1, Q4 report to align with the DOH completion date of DY3, Q4. The milestone was updated however the steps also should have been updated to align with the DY3, Q4 completion date. As part of this report steps have been deferred to DY3Q4 to align with the Milestone 1 due date. CCN continues to support partners on achieving NCQA 2014 Level 3 Patient-Centered Medical Home recognition and/or roadmap which is stipulated in the 3ai Model 1 contract. Due to our continuous communication with partners and recognizing the heavy lift associated with PCMH achievement, we released a PCMH contract intended to

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Milestone Name	Narrative Text
	provide up to $40,000 to each practice site depending on their current PCMH status level. The additional funding is intended to further support ongoing efforts and provider engagement toward practice transformation; to demonstrate CCN's commitment to the importance of care coordination and facets of the PCMH model in improving the overall delivery of health care service to Medicaid members while avoiding costly and potentially unnecessary hospitalization/avoidable Emergency Department utilization. CCN will continue to track PCMH achievement as part of our overall project performance.
Develop collaborative evidence-based standards of care including medication management and care engagement process.	Milestone 2 was reported as complete in DY2Q1 however we have changes to report. In keeping with our strategy to strengthen and support our primary care providers across the nine rural counties, CCN endorsed and approved Project TEACH as a resource to be utilized for clinicians implementing the 3ai and 4aiii projects. Project TEACH offered through CAP-PC provides a free psychiatry consultation for clinicians who are caring for children and adolescent up to age 21 with mild to moderate mental health disorders. Project TEACH is intended to bridge the gap in mental health care for children especially due to the shortage of behavioral health specialty in the nation and in the rural areas. This resource has been reviewed by the Regional Performing Unit (RPU) quality subcommittees, endorsed by our Clinical Governance Committee and approved by the Board of Directors in December 2016. Additionally, the project team has been working on incorporating Project ECHO (Expanding Capacity for Health Outcomes Act) with the 3ai and 4aiii projects. It has been reviewed by our four RPU (regional performing unit) quality subcommittees for feedback and recommendation. Project ECHO will be presented to the Clinical Governance Committee and Board of Directors for review and approval in early 2017. CCN has been proactive in researching and identifying evidence based or best practice resources to transform the clinical practices. CCN's work and dedication has been rewarded with the passing of Project ECHO and Telehealth Legislation - S-2873 by the president on December 14th, 2016. The legislation will fund the examination and report of on the technology based collaborative learning and its impact capacity. These include many of the same initiatives and challenges facing DSRIP implementation: mental health, substance abuse, chronic disorders, workforce shortages in primary care and specialty services, rural medically underserved areas.
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.	Care Compass Network (CCN) is on track for completing this milestone and subsequent steps by the required due date. CCN continues to make progress as additional partners have signed on to implement the projects at various primary care sites. The 3ai project team has identified Mental Health First Aid evidence based public education program as supported in the Prevention Agenda Action Plan as the required training for client facing staff and partners to better understand and recognize the signs and symptoms of the most common mental health issues such as depression, substance abuse, anxiety and more complex conditions. CCN anticipates the training to be offered regionally by Regional Performing Unit (RPU) to ensure optimal participation from our partners. The PMO is in the process of reviewing funding mechanisms to cover the cost of the trainer, training materials and venue to offer the training at no charge to the partners who are participating in 3ai and 4aiii projects. The Mental Health First Aid training will be presented to the RPU quality subcommittees and the Clinical Governance Committee for approval. (Step 3g – in process) CCN is in the process of developing a 3ai – model 1 project toolkit which will incorporate a workflow process map on how partners can integrate the screenings into their workflow, PHQ2/PHQ9 treatment guidelines and actions, warm hand -off, Screening for Clinical Depression and follow up quality measure, Health Home referral criteria and Crisis stabilization services. Once this toolkit is approved by our Clinical Governance Committee and the Board of Directors, we will be reporting step 3h as complete. As each collaborative model of care develops, CCN will support partners and provide resources and opportunities for cross training between the behavioral health and primary care staff. (Step 3h-3i – In progress).
Use EHRs or other technical platforms to track all patients engaged in this project.	Care Compass Network is on track to meeting Milestone 4 and its associated steps. All the materials for this milestone have been defined and distributed to partners in the form of an executed 3ai Model 1 contract which stipulates the basic EMR and/or other platforms requirements, including documenting both physical health and behavioral health information of the patient, reflect collaboration between the primary care provider and behavioral health staff in the care plan, and have the ability to track actively engaged patients. CCN's DSRIP Year 2 data collection requirements have been identified and include such information as screening, referral, and patient outcomes following primary care services. We have received reports from our partners via a secured FTP site. This process was automated with the data warehouse going "live" in

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	December 2016. Once we received the required EMR documentations, we will be reporting this Milestone as complete. (Milestone 4 – In Process) Care Compass Network is placing steps 4c, 4d and 4e on hold since neither of these are a necessary component to meeting the milestone requirements. Secondly, the project team is in the process of developing a 3ai workflow process map which will support the PC site in the facilitation of the flow of clinical information thus enabling the collaboration between the behavioral health staff and the primary care providers. The 3ai Project team anticipates the 3ai Project toolkit, in development under Milestone 3, will address the effective flow of how clinical information (screening, screening results, referrals and follow ups) should be shared between the primary care providers, behavioral health staff, outpatient clinic services and community based organizations.
Co-locate primary care services at behavioral health sites.	Care Compass Network (CCN) is on track in completing this milestone and remaining steps. Step 5a was removed as a requirement for this project as it does not apply to the Article 31 and Article 32 clinics. CCN is working with several partners in implementing this project and has two executed contracts and several others in development. CCN is actively engaged in contract discussions with other partners in the PPS and continues to support our partners on the License Threshold applications and submitting data for the newly created rate codes. All contracted partners have been provided with startup funds to develop the physical space and IT infrastructure to implement co-location. For partners who execute an Appendix C during this contract year, these startup funds will be carried over into the new contract year.
Develop collaborative evidence-based standards of care including medication management and care engagement process.	There is one step (Step 6d) due for completion in DY2Q3 and it is being reported as complete. CCN developed a Clinical Guideline for approved screenings based on the US Preventative Task Force Guidelines and the American Psychiatric Association; CCN - CG-04 was approved by the CCN Board of Directors on 12/8/15. According to CCN policy, this Clinical Guideline shall be reviewed periodically and updated consistent with the requirements established by the Board of Directors, Care Compass Network's senior management, Federal and State law(s) and regulations, and applicable accrediting and review organizations (Step 6d – Complete). In the case of our Article 31 and 32 partners, they currently have regulations they must follow in regards to care engagement, screening, assessment, crisis/high risk response plan, medication management and treatment including follow-up and management of physical health conditions which are identified during the assessment process. In addition, these same partners have applied for the Integrated License under the DSRIP Project 3.a.i Licensure Threshold (10 NYCRR Part 404, 14 NYCRR Part 598). Once their applications are approved, they will be required to develop an integrated care plan under section 598.143, "Recordkeeping" which will incorporate behavioral health and primary care services into one integrated record. The CCN Behavioral Health Clinical Governance Subcommittees will continue to provide support and technical assistance once our partners are approved to provide services under the new integrated license. In the South Regional Performing Unit, where the majority of Medicaid Recipients reside, CCN is reviewing the Clinical Governance quality committee structure to encourage information sharing across all projects to best inform cross training opportunities (Step 6e.)
Conduct preventive care screenings, including physical and behavioral health screenings.	There is one step (Step 7k) due for completion in DY2Q3 and it is being reported as complete. In DY1Q3 CCN created a guideline to establish a list of approved primary care screenings for use in the 3ai Model 2 project. The Clinical Governance Committee endorsed the guideline in November 2015 which was subsequently approved by the Board of Directors on December 8, 2015. In addition to the CCN clinical guidelines for physical health screens, all partners also adhere to industry standard behavioral health screening and assessment tools which are required by the New York State Office of Mental Health Bureau of Inspection and Certification Clinic Standards of Care Anchor Elements. As per OMH guidelines, assessment should include: Evaluation of history and current status, needs, goals and desires in the following areas (Additional required areas are listed under other Anchors): Recipient's reasons for seeking services; Recipient and family's current strengths; supports, and stressors; Mental status; Physical health (see 1.25); Mental health services; Traumatic experiences; Perception of own risks and safety; Legal and/or forensic involvement; Family, significant others, social function, finances, housing; Education, employment, and other community roles and Literacy needs (Step 7k – Complete). Partners are in the process of applying for the DSRIP 3ai Integrated License. A requirement of the license is that the Behavioral Clinic will need to have an integrated patient record which will be a requirement under section 598.143 of 10 NYCRR Part 404, 14 NYCRR Part 598. In an effort to support our partners in this effort, CCN is providing funding for EHR purchase and development. Care Compass Network Clinical Governance Committee approved guidelines related to screening compliance and warm handoff transfer of care will be recommended elements to include in clinic workflow and documentation, In addition, the CCN PMO will serve as an advocate with OASAS and OMH to advance our partner's license applications.

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Milestone Name	Narrative Text
Use EHRs or other technical platforms to track all patients engaged in this project.	Milestone 8 and the remaining steps are due for completion in DY2Q3 and all are being reported as complete. We are working with our partners in this project to ensure the existing Electronic Medical Records (EMR) have the capabilities to meet the basic requirements of the project, including reflecting both physical health and behavioral health information of the patient, reflect collaboration between the primary care provider and behavioral health staff in the care plan, and have the ability to track actively engaged patients. As supporting documentation for completing this milestone we have uploaded some sample EMR screenshots demonstrating both medical and behavioral health project requirements (Step 8a – Complete). As outlined in the contract for participating in 3ai Model 2, startup funds have been provided to existing partners to meet this milestone. Thus far, most partners in this project are integrating primary care by expanding the primary care services they already provide, using the existing providers. They will continue to bill for these services. As such, CCN does not feel that steps 8c, 8d, and 8e are necessary components to meeting the milestone requirements. For this reason, CCN previously placed steps 8c, 8d and 8e on hold. The requirement that partners track the actively engaged is included in Care Compass Network's contract for project work. While several of the partners have EMRs, many of the EMRs do not have the current capability to easily pull the required information for each project to report patients actively engaged in the DSRIP projects. As a result, CCN developed a reporting template contracted partners use to track members actively engaged in the projects and to confirm services are properly recorded. After a partner executes a contract, CCN distributes the reporting templates to partners and provides training on the use of the reporting templates in addition to use of an sFTP site created for Partners to upload patient registry information. Care Compass Network partners are submitting data on a monthly basis listing actively engaged patients, information about the services they received, and outcomes of the intervention services where applicable. The patient registry information is imported into the CCN Data Warehouse, an integral piece of the IT systems which will support CCN's Population Health approach. The warehouse combines partner data on monthly activities; in the future, the warehouse will bring in the NY Medicaid claims data, clinical data from partners (via the RHIOs), and other sources of data on social determinants. With this data, CCN's population health analysts will develop dashboards and reports to evaluate performance. DSRIP Year 2 data collection requirements included in the monthly reporting templates include such information as the screening, referral, and patient outcomes following primary care services (Step 8b - Complete). All the material for the final step has been defined and distributed to partners and we have begun receiving reports from our partners (Step 8f – Complete). The monthly reporting template for providers integrating primary care in the behavioral health setting has been uploaded as supporting documentation for milestone completion. Remediation response uploaded.
Implement IMPACT Model at Primary Care Sites.	
Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	
Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	
Designate a Psychiatrist meeting requirements of the IMPACT Model.	
Measure outcomes as required in the IMPACT Model.	
Provide "stepped care" as required by the IMPACT Model.	
Use EHRs or other technical platforms to track all patients engaged in this project.	

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Milestone Review Status

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

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

Instructions :

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

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

No Records Found

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.a.ii – Behavioral health community crisis stabilization services

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

Instructions :

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

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

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "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	2,880

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	338	432	810	1,152
	Quarterly Update	0	31	91	0
	Percent(%) of Commitment	0.00%	7.18%	11.23%	0.00%
IA Approved	Quarterly Update	0	31	0	0
	Percent(%) of Commitment	0.00%	7.18%	0.00%	0.00%

Warning: PPS Reported - Please note that your patients engaged to date (91) does not meet your committed amount (810) for 'DY2,Q3'

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
espape	Rosters	44_DY2Q3_PROJ3aii_MDL3aii2_PES_ROST_Actively_Engaged_3aii_8981.xlsx	Roster of actively engaged for Crisis Stabilization	01/26/2017 04:03 PM

Narrative Text :

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

Care Compass Network continues to make progress.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	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 a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.	DY3 Q4	Project	N/A	Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS has established a crisis intervention program that includes outreach, mobile crisis, and intensive crisis services.		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1b. 3aii Team will develop a crisis intervention program and perform an assessment to determine, for each Regional Performance Unit (RPU) as well as overlapping PPSs, which agencies (including the respective local governance units "LGUs" for each of the nine counties) or individual provider(s) can best meet the project needs. Project components will include mobile crisis intervention, phone triage, observation beds, and community respite services. Engaged agencies/individuals are expected to include county mental health agencies, Directors of Community Services, law enforcement, and CBOs offering behavioral health and respite services. Program will create alternative ways (compared to ED admission) for patients and families to seek out crisis stabilization services, especially in cases when patient does not require intensive inpatient care. Program approaches for each RPU are listed in steps 1c-1f within this milestone.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1c. Based on initial assessments of overall PPS partner readiness and willingness to participate in the project, the 3aii Project Team will initially pursue engaging a crisis intervention program through a mobilized Southern RPU (Broome/Tioga Counties) to fully implement a total Crisis Stabilization Service built on the existing CPEP services housed by PPS member United Health Services Hospitals (UHSH). Engaged services are expected to include a minimum of phone triage, mobile crisis, and observation beds. The PPS will also collaborate with Catholic		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	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
Charities for the development of community based crisis respite beds/apartments.										
Task 1d. Repeat model for the North RPU by identifying available resources, readiness, and adjusting plan as necessary for local needs. CCN PMO will coordinate services with PPSs with overlapping coverage to identify economies of scale.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1e. Repeat model for the West RPU by identifying available resources, readiness, and adjusting plan as necessary for local needs. CCN PMO will coordinate services with PPSs with overlapping coverage to identify economies of scale.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1f. Repeat model for the East RPU by identifying available resources, readiness, and adjusting plan as necessary for local needs. CCN PMO will coordinate services with PPSs with overlapping coverage to identify economies of scale.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #2 Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.	DY3 Q4	Project	N/A	In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task PPS has implemented diversion management protocol with PPS Hospitals (specifically Emergency Departments).		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 2b. The 3aii Project Team will develop a PPS profiling map of health homes, emergency room, and hospital services to understand existing linkages and workflows for each RPU. As a result of the assessment, a phased approach for remediation of missing or enhanced linkages, including communication requirements will be prepared.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2c. Using the profiling map the 3aii Project Team will engage CBOs, ED, and hospitals to develop and implement diversion protocols from ED and inpatient services. Protocols prepared by these workgroups will be presented to the Clinical Governance Committee and Board of Directors for approval - and recertified annually for pertinence. The 3aii Project Team and PMO will develop educational material related to Crisis Stabilization Services offered under this program for law enforcement and the medical community (e.g., barrier identified as Risk #1) and		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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leverage the Workforce Team and Provider Relations to distribute and communicate education/training. Materials prepared will also be made centrally available to all PPS members by posting to the CCN website, SharePoint, etc.										
Milestone #3 Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has engaged MCO in negotiating coverage of services under this project and/or MCO provides coverage for services in project.		Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 3b. The PPS would have an initial conversation with the MCOs to discuss the approach on how to include services not currently covered today. The discussion will outline a framework which will include a summary whereby the the CCN PMO will conduct a quantitative and qualitative needs assessment of the affected population to understand service array utilization of the continuum of care, the organizations providing them, and corresponding expected level of effort. In addition, the PPS will seek to understand needed services to address related issues of the affected population not currently covered by Medicaid. For example, this will help to understand what services in the community would effectively help to avoid utilization of more expensive services.		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3c. With an understanding on the approach, the PPS PMO and Analytics team will perform a review of available data to identify trends and understand the continuum of care to develop a prototype model for crisis management whose intent is to reduce hospital leverage / ED use. Other key stakeholders to include in this review include police departments, EMT transports, etc. Upon completion the PPS will meet with MCOs to share the data and analysis and work together to develop a payment methodology to include currently uncovered services that are found to be essential in avoiding hopsital use for this population.		Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Develop written treatment protocols with consensus from participating providers and facilities.	DY2 Q4	Project	N/A	Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Regularly scheduled formal meetings are held to develop consensus on treatment protocols.										
Task Coordinated treatment care protocols are in place.		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4c. Develop written Crisis Stabilization protocols in tandem with the 3aii Project Team, participating agencies, providers, CBOs, and collaboration with other PPSs. Once developed, the protocols will be submitted to the Clinical Governance Committee (CGC) and Board of Directors for approval. Each year, the CGC will approve and recertify previously adopted protocols. (Risk #3) On an ongoing basis, the respective regional performance unit Behavioral Health Subcommittee will provide oversight and monitoring for adherence and efficacy of plans. Provider remediation or protocol amendment (e.g., based on regional customization or alignment with new leading practices) will be made available to the Clinical Governance Committee.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4d. CCN will require participating agencies, providers, and CBOs to follow the adopted training related to the agreed upon protocols as part of the contracting process.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #5 Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.	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 includes at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services in provider network		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS evaluates access to psychiatric services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.		Provider	Safety Net Hospital	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5c. The 3aii Project Team and CCN PMO will pursue contracting with identified hospitals within the PPS based off evaluation of implementation criteria such as offering of specialty psychiatric services/crisis oriented-psychiatric services, and overall readiness/willingness to engage in 3aii related work. Based on the initial assessments, the 3aii Project Team expects to engage		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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with United Health Services, Inc., Cayuga Medical Center, and Cortland Regional Medical Center for this project.										
Task 5d. On at least an annual basis, the 3aii Project Team and PMO will present to each regional performance unit Behavioral Health Subcommittee (e.g., 3aii Quality Committee) an evaluation and report of crisis-oriented psychiatric services availability, geographic access, wait times, etc. to identify areas for improved access. As required and advised by the BH Quality Committee, the PMO will implement improvement plans (e.g., such as improvement efforts or program expansion efforts).		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS includes hospitals with observation unit or off campus crisis residence locations for crisis monitoring.		Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.		Provider	Safety Net Hospital	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.		Provider	Safety Net Clinic	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.		Provider	Safety Net Mental Health	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 6e. Using the review performed of 3aii related health care linkages and workflows, the Project 3aii Team and PMO will pursue contracts (as necessary) with PPS health care providers to offer observation beds in Safety Net Hospitals. Team has initially identified a Phase I approach for collaboration with Cortland Regional Medical Center and Cayuga Medical Center for the expansion of access to observation units. In Phase II the		Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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3aii Project Team will identify strategies for the remaining regions/providers.										
Task 6f. CCN PMO to contract with PPS CBOs to maintain community-based respite beds (safety net clinics and/or safety net behavioral health providers) that offer crisis intervention and observation services within the community for those individuals who can be stabilized outside of hospital setting.		Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 6g. Annually, PMO will present to RPU Behavioral Health Subcommittees an evaluation of off-campus residence service availability, geographic access, wait times, etc. to identify areas for improved access. PMO implements improvement plans.		Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #7 Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.	DY3 Q4	Project	N/A	Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS includes mobile crisis teams to help meet crisis stabilization needs of the community.		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Coordinated evidence-based care protocols for mobile crisis teams are in place.		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 7c. The 3aii Project Team to perform an assessment of PPS needs (e.g., based on community needs assessment, Salient data, etc.) as well as PPS Partner service offerings, capabilities, and readiness/ability to partner with CCN in the deployment of mobile crisis teams to provide crisis stabilization services using evidenced-based protocols developed by medical staff. Based on initial reviews the 3aii Project Team has identified the UHS Comprehensive Psychiatric Emergency Program (CPEP) as a pilot in delivery of the mobile intervention services to the PPS.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 7d. The PPS, in collaboration with existing leading practices and partner protocols will develop/adopt evidence-based protocols for mobile intervention for use by mobile intervention teams. Identified protocol(s) will be endorsed by the Clinical Governance Committee, approved by the Board of Directors, and subsequently recertified on, at minimum, an annual basis by the Clinical Governance Committee.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Task 7e. The 3aii Project Team will identify strategies to provide/deliver mobile crisis teams/services throughout the PPS as needs exist (e.g., by RPU.)		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 7f. Annually, the PMO will present to RPU Behavioral Health Subcommittees (e.g., 3aii Quality Committees by region) an evaluation of mobile crisis service availability, geographic access, wait times, etc. to identify areas for improved access. The PMO will collaborate with partners to implement improvement plans identified by the quality committees (as required by PPS partner contracts).		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #8 Ensure that all PPS safety net providers have actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.	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 demonstrates integration of medical and behavioral health record within individual patient records.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Hospital	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Alerts and secure messaging functionality are used to facilitate crisis intervention services.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 8g. 3aii Team to identify EHR or other IT platform(s) for behavioral health screening/assessment tool, collection, sharing and storage of data. EHR or other IT platform(s) to meets several		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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requirements which facilitate intervention services (for example, integrated medical/behavioral health record, ability to track patients, ability to report agency-level performance metrics, RHIO/SHIN-NY connectivity, alerts and secure messaging). CCN PMO to coordinate review and approval of IT solutions with the IT Committee (and the associated review processes) and align vendor solutions with project needs as well as the broader IT Vision of the PPS.										
Task 8h. The PPS will execute a contract with the selected vendor for the delivery of services. The CCN PMO/Provider Relations to oversee roll out of EHR or other IT platform to contracted agencies, providers, and CBOs offering crisis stabilization services. Rollout includes readiness assessment, training, workflow optimization, and go live. (Risk #3) As part of the implementation process, PPS Partners will be required to submit documentation such as certifications, training attestations/rosters, or system reports to confirm achievement of key implementation/integration milestones.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #9 Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.	DY3 Q4	Project	N/A	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has implemented central triage service among psychiatrists and behavioral health providers.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 9b. The PPS (through collaboration by the project team as well as stakeholders) will identify potential providers of a central triage service crisis stabilization services, as outlined by the PPS and/or by the respective regional performance unit. As part of this process, the 3aii Project Team will perform an assessment to align project requirements with the availability and needs of the community (e.g., central triage service). A strategy will be developed to connect triage service provider(s) identified with participating providers of behavioral health services, mobile intervention, inpatient observation, and community respite services. The finalized plans will serve as a baseline for operating/contractual agreements with PPS members participating in project 3aii.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	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 9c. As part of the Care Compass Network contract, the centralized phone triage provider(s) will be required to use a standard assessment tool, approved by the Clinical Governance Committee and recertified annually.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #10 Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.	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 created an active quality subcommittee that reports to PPS quality committee that is representative of medical and behavioral health staff and is specifically focused on integration of primary care and behavioral health services within practice sites and other behavioral health project initiatives. Note: Only one quality sub-committee is required for medical and behavioral health integration projects in Domain 3a.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics listed in Attachment J Domain 3 Behavioral Health Metrics.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS quality subcommittee conducts and/or reviews self-audits to ensure compliance with processes and procedures developed for this project.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Service and quality outcome measures are reported to all stakeholders including PPS quality committee.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 10f. CCN to seat Regional Performance Unit Behavioral Health Subcommittees. Each committee will be comprised of local medical and behavioral health experts who can evaluate the crisis stabilization program and integration of primary care and behavioral health services.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 10g. CCN PMO regularly reports key quality metrics (including Appendix J metrics Domain 3 Behavioral Health metrics) to RPU		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	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
Behavioral Health Subcommittees. Behavioral Health Subcommittees identifies opportunities for quality improvement; PMO develops implementation plans, committee and PMO evaluate results of quality improvement initiatives. CCN to distribute service and quality outcome measures to Care Compass Network quality committee(s) as well as to the stakeholders through platforms such as the Stakeholders meeting and/or website.										
Milestone #11 Use EHRs or other technical platforms to track all patients engaged in this project.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 11b. 3aii Team to identify EHR or other IT platform(s) for behavioral health screening/assessment tool, collection, sharing and storage of data. EHR or other IT platform(s) to meets several requirements which facilitate intervention services (for example, integrated medical/behavioral health record, ability to track patients, ability to report agency-level performance metrics, RHIO/SHIN-NY connectivity, alerts and secure messaging). CCN PMO to execute a contract with the selected vendor.		Project		Completed	04/01/2016	03/31/2017	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 11c. CCN PMO/Provider Relations to oversee roll out of EHR or other IT platform to contracted agencies, providers, and CBOs offering crisis stabilization services. Rollout includes readiness assessment, training, workflow optimization, and go live. (Risk #3)		Project		Completed	04/01/2015	03/31/2017	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 11d. The IT Project Manager and 3aii Project Team will prepare a validation checklist to be used as each partner completes implementation and related connectivity requirements. After the initial assessment, the PPS Population Health team will provide feedback regarding the accuracy/validity of data to PPS partners to promote the accuracy, completion, timeliness, and validity of data transmitted and gathered/reported in the EHR/technical platform and related interfaces.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Use EHRs or other technical platforms to track all patients engaged in this project.	sculley	Report(s)	44_DY2Q3_PROJ3aii_MDL3aii3_PRES11_RPT_CCN_Multiple_Services_Report_DY2_-_across_partners_9656.csv	Remediation - CCN multiple services report file 2 (csv file due to size)	03/17/2017 04:57 PM
	sculley	Report(s)	44_DY2Q3_PROJ3aii_MDL3aii3_PRES11_RPT_CCN_Multiple_Services_Report_DY2_9655.csv	Remediation - CCN multiple services report file 1 (csv file due to size)	03/17/2017 04:56 PM
	sculley	Rosters	44_DY2Q3_PROJ3aii_MDL3aii3_PRES11_ROST_DY2Q3_crisis_phone_patientregistry_9654.xlsx	Remediation - 3aii completed patient registry for phone based crisis services.	03/17/2017 04:55 PM
	sculley	Rosters	44_DY2Q3_PROJ3aii_MDL3aii3_PRES11_ROST_DY2Q3_crisis_mobile_patientregistry_9653.xlsx	Remediation - 3aii completed patient registry for mobile crisis.	03/17/2017 04:51 PM
	sculley	Other	44_DY2Q3_PROJ3aii_MDL3aii3_PRES11_OTH_3aii_M11_Remediation_9652.docx	Remediation response for 3aii milestone 11.	03/17/2017 04:50 PM
	espape	EHR/HIE Reports and Documentation	44_DY2Q3_PROJ3aii_MDL3aii3_PRES11_EHR_M11_M1_3aii_Crisis_Phone_9003.xlsx	Monthly patient roster from partners providing phone-based crisis intervention services under Crisis Stabilization.	01/26/2017 04:33 PM
	espape	EHR/HIE Reports and Documentation	44_DY2Q3_PROJ3aii_MDL3aii3_PRES11_EHR_M11_M1_3aii_Crisis_Mobile_9002.xlsx	Monthly patient roster from partners providing mobile crisis intervention services under Crisis Stabilization.	01/26/2017 04:32 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.	This milestone was completed in DY2Q2. Care Compass Network has successfully established a Crisis Stabilization program which serves CCN's service area. The purpose of this community-wide network of intensive crisis service providers is to de-escalate behavioral health crises in the community, as opposed to using more traditional, hospital based services (either Emergency Departments or inpatient psychiatric services). The Care Compass Network program includes a centralized crisis line which provides crisis services and phone triage services as well as mobile crisis teams to provide both phone based and intensive in-person crisis interventions and follow up care. Progress made over the last quarter includes contracting work with two additional mobile teams, which serve Tompkins County, Delaware, and Chenango Counties. These contracts are still in progress, but are expected to be executed in the coming weeks. In addition, Care Compass Network released a Request for Proposals (RFP) for providers of short term crisis respite services. The RFP was sent to agencies who provide housing services to those with serious mental illness and all agencies who are approved to provide the short-term crisis respite under the Home and Community Based Services waiver program. Care Compass Network is in the process of contracting with two such agencies and is doing additional outreach to others. The 3aii Project Team continues to work toward incorporating this service into community meetings which involve key stakeholders, including law enforcement, Medicaid Health Home downstream providers, providers of intensive case management services, and other behavioral health services. This forum will help bridge connections across different types of behavioral health providers in each county.
Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.	Care Compass Network is on track to complete the milestone establishing clear linkages between our network of crisis stabilization services and existing health homes, emergency department and hospital services. We have identified health home providers, hospital emergency rooms, and Law Enforcement efforts aligned with Crisis Stabilization in each of the nine Care Compass Network counties. The Behavioral Health Subcommittees (subcommittees of the Clinical Governance Committee) in each of our four Regional Performance Units (RPUs) represent behavioral health providers in our community, including Health Homes, CPEP service, Mental Health clinics, substance abuse treatment, behavioral residential and hospitals. The committees have contributed to 3aii project planning by helping to identify the existing linkages and gaps in connecting patients to appropriate resources. The Project Team has addressed these linkages and gaps in connecting patients to appropriate resources through our Crisis Stabilization definition, intervention and follow up guidelines. A central component of both the initial intervention and follow up services is to connect the Medicaid member back to any existing providers or case managers, including therapists and Health Home care coordinators. Care Compass Network is working to incorporate this

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Milestone Name	Narrative Text
	service into community meetings which involve key stakeholders, including law enforcement, Medicaid Health Home downstream providers, providers of intensive case management services, and other behavioral health services. This forum will help bridge connections across different types of behavioral health providers in each county.
Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.	Care Compass Network has begun to engage Managed Care Organizations (MCOs) in a PPS-wide strategy to build relationships which will last beyond the end of DSRIP. This endeavor initially focused on developing educational resources for partners regarding value-based payment contracting. Care Compass Network has met with four MCOs thus far, including Fidelis, Excellus, United Health Care, and Total Care. We are organizing our approach to each MCO in our service area. The approach will include addressing specific project needs and organizational needs. Ultimately the goal is to establish a Memorandum of Understanding or other agreement between Care Compass Network and the MCO for coverage of DSRIP services that are not currently part of the Medicaid benefit. Care Compass Network is in a position to develop services that can have a large impact on the total value of health care provided to Medicaid members. This impact will come through the development of the Integrated Delivery System, development of Population Health services, and through new services developed through the implementation of Domain 2 and 3 projects. With the MCO United Health Care, Care Compass Network engaged our contact there in a conversation regarding coverage of mobile crisis services, as for some agencies, this service is not currently billable, and for others who can bill, there are many limitations on the ability to bill under Medicaid (Step 3b– Complete). United Health Care was open to further discussions, but not hugely interested in expanding coverage of services. Instead, a potentially preferred approach would be to develop a population health management agreement between Care Compass Network that could fund mobile crisis services. As the Crisis Stabilization project continues, the Care Compass Network Analytics Team will be developing quantitative and qualitative analysis to show the impact of DSRIP projects on unnecessary hospitalizations and Emergency Department visits. This analysis will begin with an assessment of the current continuum of crisis related services, and the gaps therein. The next step is to show how new crisis services under this project can have a direct impact on costly and unnecessary utilization. This base analysis will allow us to model the impact of expanding crisis stabilization services (mobile, crisis respite, crisis phone triage) beyond what is currently covered by Medicaid. We will share the results of this study with MCOs and work together to develop a payment methodology which supports stabilization outside of the hospital setting (Step 3c – In progress).
Develop written treatment protocols with consensus from participating providers and facilities.	This milestone was completed in DY2Q2. The 3aii Project Team, along with the Behavioral Health Quality Subcommittees, finalized the Crisis Stabilization Definition and Guideline which serves as a diversionary treatment protocol. This policy (M4_Metric2_item1_CGC-CG-16.pdf) was approved by the Clinical Governance Committee (March 28, 2016) and by the Board of Directors (April 12, 2016). The guideline defines a behavioral health crisis (including acuity levels), defines the core crisis services and deliverables in the Crisis Stabilization project, recommends specific evidence-based assessment tools, and outlines a triage process and how patients would access crisis services. There are no updates to this milestone.
Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.	Care Compass Network is on track to complete this Milestone on time. No steps are currently due, but work on this Milestone is underway. The Care Compass Network Analytics Team will design an evaluation of crisis services in terms of their availability, geographic access, wait times, and patient outcomes for each Regional Performance Unit (RPU)—Care Compass Network's geographic division of service counties (Step 5d- In progress). Using the results of this study, the Behavioral Health Quality Committees in each RPU will begin to design improvement plans and begin engaging crisis service providers to develop new services to address gaps. In our project planning one such need has already been identified and a new service is in development. Care Compass Network's hospital system partner, UHS, is devising a new telehealth service for mobile teams in the UHS service area (Chenango, Delaware, Broome, and Tioga), whereby a UHS-based crisis team and psychiatrist would be available for evaluations of patient for use in CCN's more rural areas. Individuals in crisis from our more rural areas are often transported to UHS CPEP for evaluations because of a lack of alternatives. Not only are these billed as ED visits that are likely to be considered unnecessary, there are significant transportation costs associated to them as patients must be returned home. We expect that other hospital partners with behavioral health units (Cayuga Medical Center and Cortland Regional Medical Center) would be willing to tailor services to meet identified local psychiatric needs (Step 5c – In progress).
Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).	Care Compass Network is on track to expand access to hospital-based observation and community-based crisis respite. The Project Team completed an assessment of existing hospital observation and community-based observation across the PPS, including availability, geographical access, and funding structure. Our contracting approach is based on this assessment. Two PPS hospitals have observation capacity that is dedicated to serving patients with behavioral health needs. First, United Health Services has Extended Observation Beds associated with their Comprehensive Psychiatric Emergency Program (CPEP) unit. Second, Cayuga Medical Center has an observation unit attached to its Emergency Department that can be used for extended observation. In each case, the observation units are useful in providing a level of supervision and support for patients who do not meet the criteria for admission. Contracts for these services are in progress (Step 6e- In progress). In addition, Care

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	Compass Network released a Request for Proposals for community-based crisis respite services. Care Compass Network has designed this service to align the short-term crisis respite in the Home and Community Based Services waiver program. We are reaching out to organizations who provide residential behavioral health services to provide the new service; ideally the organization is approved to provide the HCBS services. Two contracts are currently underway, but not yet executed. The 3aii Project Team expects this service to be offered in Tioga County in early Spring 2017 and Broome County in the April-May 2017 timeframe (Step 6f – In progress). The Care Compass Network Analytics Team is devising an approach to annually assess access to hospital-based observation and community-based crisis respite services, in terms of its geographic availability, wait times, funding mechanisms, and success in diverting from Emergency Departments and hospital admission. This report will be presented to the Behavioral Health Committees on an annual basis (Step 6g – In progress).
Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.	This milestone was completed in DY2Q2. Care Compass Network successfully deployed three mobile teams to provide crisis stabilization services using evidence-based protocols in the following counties: Broome (two teams), Chemung, Schuyler, and Tioga. We are working on bringing on additional teams which will serve Tompkins, Delaware, and Chenango counties. Those contracts are underway, but not yet executed.
Ensure that all PPS safety net providers have actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.	Care Compass Network is on track to ensure all PPS safety-net providers have EMRs connected to local RHIOs and share information among clinical partners, including using Direct exchange, alerts and patient look ups. The IT roadmap has been written and is now being executed as part of the IT work stream. This milestone is related to work being completed under development of the Integrated Delivery System. Within this quarter, Care Compass Network has selected two preferred vendors for behavioral health screening platforms for use in the Crisis Stabilization project, as well as 3ai Model 1 (Integrating Primary Care and Behavioral Health) and 4aiii (Strengthening the Mental Health and Substance Abuse Infrastructure). For this project, the screening platform is intended to facilitate information sharing and streamline the assessment process in providing crisis services. Care Compass Network is in the process of contract negotiations with vendors; once this stage is complete, Care Compass Network will oversee implementation and roll out to the appropriate agencies. (Step 8h—In progress).
Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.	Care Compass Network is on track to establish a centralized phone triage and crisis phone service with agreements with participating psychiatrists, mental health, behavioral health, and substance abuse providers. The 3aii Project Team completed an assessment of existing crisis phone services across the PPS, including availability, geographical coverage, and funding structure. Care Compass Network has contracted with Suicide Prevention and Crisis Service to provide this service because it currently covers all of the Care Compass Network service area. Suicide Prevention and Crisis Service is part of the National Lifeline Network, a national suicide crisis line, and offers after-hours coverage for the Tompkins County Mental Health Clinic and private therapy practices. This coverage is expected to expand in the coming months as an additional mental health clinic (Family Services of Chemung (Elmira, NY)) turns its after-hours crisis line over to Suicide Prevention and Crisis Service. As this program develops further, Suicide Prevention and Crisis Service will strengthen its relationships with the mobile crisis teams. In the Crisis Stabilization Definition and Intervention and Follow Up Guidelines, Care Compass Network has defined the expected services to be provided during an initial phone-based crisis intervention, including assessment, stabilization, safety planning, level of care determination, and triage (or warm handoff) to higher levels of care, including mobile crisis teams or law enforcement if necessary. There are several recommended evidence-based assessments (suicide, violence, substance use) for use during these interventions. Further development of this service over the next few months will focus on developing referral streams to the service from mental health clinics and other behavioral health providers and strengthening the relationship between Suicide Prevention and the various mobile teams.
Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.	Care Compass Network has a well-established Behavioral Health Quality Committee structure with active engagement. Each Regional Performance Unit within the Care Compass Network area (North, East, South, and West) has its own committee. The charters for each includes such functions as overseeing project execution and implementing standardized metrics to monitor service quality, project performance, and DSRIP performance measures. These committees will provide input on quality improvement plans, review of self-audits on service quality, and review root-cause analyses related to project execution and performance metric target achievement. Care Compass Network has begun to regularly report on the Appendix J metrics, including those related to the Behavioral Health Projects. Typically, these have been extracts from the MAPP Dashboards, either focusing on the PPS as a whole, or digging into county-level data to provide an RPU focus. Care Compass Network will consider this milestone to be complete after one or more quality committees has been able to identify a gap in performance, formulate an improvement plan, engage the relevant stakeholders for plan execution, and monitor progress towards meeting the goal.
Use EHRs or other technical platforms to track all patients engaged in this project.	The requirement that partners track the actively engaged is included in Care Compass Network's contract for project work. While several of the partners have EMRs, many of the EMRs do not have the current capability to easily pull the required information for each project to report patients actively engaged in the DSRIP projects. As a result,

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	CCN developed a reporting template contracted partners use to track members actively engaged in the projects and to confirm services are properly. After a partner executes a contract, CCN distributes the reporting templates to partners and provides training on the use of the reporting templates in addition to use of an sFTP site created for Partners to upload patient registry information. This support covers the readiness assessment, training, workflow optimization, and rollout (Step 11c – Complete). Care Compass Network partners are submitting data on a monthly basis listing actively engaged patients, information about the services they received, and outcomes of the intervention services where applicable. The monthly intake process includes submission support, data validation, and feedback to partners (Step 11d – Complete). The patient registry information is imported into the CCN Data Warehouse, an integral piece of the IT systems which will support CCN's Population Health approach. The warehouse combines partner data on monthly activities; in the future, the warehouse will bring in the NY Medicaid claims data, clinical data from partners (via the RHIOs), and other sources of data on social determinants. With this data, CCN's population health analysts will develop dashboards and reports to evaluate performance. For Crisis Stabilization, DSRIP Year 2 data collection requirements included in the monthly reporting templates include such information as patient identifiers (First Name, Last Name, Date of Birth, Medicaid Client Identification Number), date of service, type of service (phone-based crisis intervention, in person crisis intervention, crisis respite, hospital observation), Level of Acuity (Low, Medium, High, which is defined in our clinical guideline), and outcome of the crisis intervention (de-escalation, transport to ED, or referral to another service). With this information, CCN is able to track the actively engaged as well as services provided by different partners under the project (Milestone 11 and Step 11a – Complete). The monthly reporting templates for mobile crisis and phone triage providers have been uploaded as supporting documentation for milestone completion. Remediation response uploaded.

Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment	

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

Instructions :

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

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

Instructions :

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

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

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "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	4,137

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	200	621	340	1,448
	Quarterly Update	0	0	44	0
	Percent(%) of Commitment	0.00%	0.00%	12.94%	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 (44) does not meet your committed amount (340) for 'DY2,Q3'

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
rachaelm	Rosters	44_DY2Q3_PROJ3bi_MDL3bi2_PES_ROST_CVD_Goal_DY2Q3_9190.xlsx	Roster of 44 actively engaged Medicaid Members within Project 3bi.	01/30/2017 09:12 AM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 3.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	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1b. Assess system readiness for population health providers, IT infrastructure, and CBOs through the PPS' Pre-Engagement Assessment to be disseminated by the CBO Engagement Council as well as each respective Regional Perfomance Unit (RPU) Operating Group.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1c. Data Analytics - The PPS Salient team will work in conjunction with the Population Health workgroup in order to identify patients with cardiovascular disease within our PPS region. The associated methodologies, assumptions, and results will be presented to the respective Disease Management subcommittees of the Clinical Governance Committee for review and identification of potential gaps in the analysis.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1d. Interventions - The PPS will adopt and/or develop evidence based strategies - such as the Million Hearts Campaign, JNC-8, AHA 2013, ACC - for implementation based on benficiary risk in conjunction with the 3bi Project Team and the Clinical Governance Committee. These interventions will be used in tandem with other industry standards such as blood pressure checks, lipids, smoking and other health assessment screenings at primary care provider visits to determine criteria for patient risk stratification.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1e. Identify process to risk stratify beneficiaries with		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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

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respective facility to the related support staff, including topics such as care coordination processes, blood pressure measurement, protocol regarding patients with repeated elevated blood pressure, patient self-management, follow-up procedures, home blood pressure monitoring, and Million Lives Campaign strategies. As required by partner contract agreements the champion will also be responsible for the provision of training date(s), attendees, and written materials (as well as Q/A items) to the PMO.										
Task 1i. IT Tools and Support - The Project 3bi Team will collaborate with the IT Workgroup to develop necessary IT Tools and support such as provider alerts and patient reminders as per defined care management goals within EHRs. These metrics will be created to align with 2014 PCMH Level 3 standards and/or Meaningful Use requirements.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	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 connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 2e. Assess connectivity of PPS providers in all settings- to RHIO, secure messaging capability, etc through the PPS' Pre-Engagement Assessment to be disseminated by the CBO Engagement Council as well as each respective Regional Perfomance Unit (RPU) Operating Group.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 2f. Develop plan to connect all providers- begin with high volume		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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/ well engaged providers.										
Task 2g. Develop outreach plans and a PPS consent for patients to participate in the exchange.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 2h. Develop standards for provider alerts in the EMR in conjunction with the Clinical Governance and IT & Data Governance Committees .		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	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	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 3c. Conduct a readiness assessment including MU and PCMH status of participating safety net providers.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 3d. Develop plan to support providers in the attainment of MU.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 3e. Develop plan to support providers in the attainment of PCMH level 3 - 2014 standards.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 4b. Develop a methodology and requirements to identify the data elements to collect on the population for reporting in order to establish a baseline in conjunction with the IT & Data Governance Committee as well as the Analytics Team.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 4c. The Project Management Office will work with partners and/or alongside EHR vendors to acquire required validation of EHR		Project		Completed	04/01/2015	03/31/2017	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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connectivity and capabilities, including formal documentation/retention of certification related documents and EHR reminder functionality. The PPS IT Project Manager will review and monitor the IT environment to confirm EHR system capabilities are in place and used and functioning as designed, ensuring access to real-time data to improve interoperability. Periodic reviews will be performed and include evidence of alerts/secure messaging, availability of training materials, and status of prior review remediation status. The status of these reviews will be reported to the IT & Data Governance Committee and/or Clinical Governance Committee as appropriate.										
Task 4d. As required and appropriate, partners will be contracted with for achievement of specific tasks (e.g., build and maintenance of EMR modification to provide reminders), which will be monitored for completion as reported to the project team and PMO. Upon completion, validity of system enhancements will be reviewed and validated as described in step 4c.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has implemented an automated scheduling system to facilitate tobacco control protocols.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 5c. Educate providers and office staff on the "5A's" - Ask, Assess, Advise, Assist, and Arrange.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 5d. Develop 5As assessment tool in the EMRs including hard stop prompts.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 5e. Develop process for smoking cessation referrals through EMR secure messaging .		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 5f. Develop process for provider feedback.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	DY2 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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Task Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6b. Obtain PPS approval for hypertension protocol from the Clinical Governance Committee - suggest existing guidance such as "JNC8".		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6c. Obtain PPS approval for cholesterol protocol from the Clinical Governance Committee- suggest existing guidance such as "AHA 2013" guidelines.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6d. Educate providers on these protocols .		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	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		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination processes are in place.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7d. The 3bi Project Team and PMO will develop care coordination teams by achieving four core foundational requirements: assessing available resources, assessing the patient demographics, providing education where required, and adopting applicable standards.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7e. Assess Resources - The 3bi Project Team and PMO will work in tandem with the Population Health workgroup to assess availability of current care coordination and disease management resources in the PPS. Assess Patients - The 3bi Project Team, in conjunction with the PPS Analytics Team will develop a process to risk stratify		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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beneficiaries for connection with care coordination based on the results of the Population Health data results and risk stratification review.										
Task 7f. Education - The Workforce team along with the Project Management Office will create Care Coordination teams within each office/practice and will include nurses, pharmacists, dieticians, community health workers, health home care managers, and others where applicable. Once established, the Workforce team will oversee the education to providers on these resources and create referral processes through the EMR to connect with providers of care coordination.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7g. Standards - Adopt/develop standards for cardiovascular disease management / care coordination in conjunction with the Clinical Governance Committee and, more specificly, disease management subcommittees.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	DY3 Q4	Project	N/A	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 8b. Assess availability of current practice for blood pressure checks with no copay or appointment required .		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 8c. Develop PPS protocol for the provision of this service as a standard of care in conjunction with the Clinical Governance Committee.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 8d. Identify the support needed for practices to offer this service and document in the EMRs.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	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 protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1

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9b. Identify evidence based practice for blood pressure measurement in conjunction with the Clinical Governance Committee and, more specifically, the disease management subcommittees.										
Task 9c. Create the competency for staff training and annual assessment.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 9d. Create PPS protocol to require all staff taking blood pressures take/pass an annual competency test.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 9e. Create the competency for staff training and assessment.		Project		Completed	04/30/2016	06/30/2016	04/30/2016	06/30/2016	06/30/2016	DY2 Q1
Task 9f. Create PPS protocol to require all staff taking blood pressures take/pass a competency test.		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
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.	DY3 Q4	Project	N/A	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 10d. Create risk stratification tool to identify beneficiaries in need of follow-up appointments for BP management.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 10e. Develop alert in the EMR for beneficiaries with repeat elevated blood pressure readings.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 10f. Utilize "measure up, pressure down" for BP management (Million Hearts Campaign).		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	DY2 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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Task PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11b. Establish alert in the EMRs as reminders for once daily regimens.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11c. Engage pharmacists in recommending once daily regimens as substitutions for other regimens.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11d. Engage managed care payers in offering once daily regimens as formulary options.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	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 Self-management goals are documented in the clinical record.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 12c. The education of staff on the development of self management goals with beneficiaries will be done by the collaborative efforts of the Project Management Office, the Provider Relations team, and the Communications Team. Forums will be held within each RPU for the participating providers.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 12d. The 3bi Project Team will collaborate with the PPS IT Committee and/or Clinical Governance Committee to develop standards of data elements to identify partner EMR capability of reaching the required elements of the standard of care (e.g., documentation of benficiary self management goals.)		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 12e. Once approved, the 3bi Project Team and PMO will conduct a survey/assessment with partners to understand current system capabilities. As identified, system functionality deficiencies or gaps will be reported to the IT Committee and PPS partner 3bi Project Champion for identification of remediation solutions.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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12f. The IT Workgroup will identify EMR reporting requirements to document and verify utilization and implementation of standards of care within the EMR which are in place to document patient driven self-management goals in the medical record and review of said goals.										
Task 12g. PPS Partner status reports will be reported to the PPS Disease Management Quality Committee for review and any necessary improvements to be pursued as appropriate.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	DY3 Q4	Project	N/A	In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task PPS has developed referral and follow-up process and adheres to process.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task PPS provides periodic training to staff on warm referral and follow-up process.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 13d. Identify resources to provide beneficiary support for lifestyle changes- CDSMP.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 13e. Develop a 2 way referral process from the EMR: provider to CBO and CBO feedback to provider.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 13f. Train staff on the referral process including appropriate beneficiaries for referral.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	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 developed and implemented protocols for home blood pressure monitoring.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	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-		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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up if blood pressure results are abnormal.										
Task PPS provides periodic training to staff on warm referral and follow-up process.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 14d. Develop protocols for home BP monitoring based on risk (self monitor vs telehealth) in conjunction with the Clinical Governance Committee and, more specifically, the disease management subcommittees.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 14e. Identify resource for home BP cuffs if needed to support compliance .		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 14f. Develop method for beneficiary follow up reporting- phone, web program, telehealth, etc.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	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	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 15b. Identify benficiaries through EMR functionality and/or claims data.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 15c. Develop process for scheduling patients for office visit.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 15d. Develop process for BP screening outside of office setting in a community "hot spot".		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	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 developed referral and follow-up process and adheres to process.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 16b. Develop process for referral to quitline preferably through EMR.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 16c. Develop process for provider feedback on referral.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 16d. Educate providers and office staff on referral process and		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Care Compass Network (PPS ID:44)

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
beneficiary education.										
Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	DY3 Q4	Project	N/A	In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task If applicable, PPS has established linkages to health homes for targeted patient populations.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 17d. Identification of high risk neighborhoods and development of strategies to engage beneficiaries.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 17e. Develop processes to link with patients through Medicaid health home relationships.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 17f. Utilize CDSMP for beneficiary engagement in lifestyle changes .		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Milestone #18 Adopt strategies from the Million Hearts Campaign.	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 Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.		Provider	Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.		Provider	Mental Health	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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18d. Develop methods to risk stratify the population with CV or potential CV disease.										
Task 18e. Create processes to screen BPs with beneficiary health care contact and in the community in conjunction with the Clinical Governance Committee and, more specifically, the disease management subcommittees.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 18f. Utilize "measure up, pressure down" planks as the standards for BP management by providers.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 19b. Define Population - As defined in the 3bi project plan the affected population includes cardiovascular patients. As such, the first step towards achievement of this milestone will involve the PMO and Population Health team performing a defined population review to understand the affected cardiovascular disease population in the PPS by associated MCO.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 19c. Risk Statify - Following the affected patient review, the population will be risk stratified to identify high risk versus rising risk cardiovascular populations.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 19d. Organize - Organize a PPS approach for care coordation efforts by the affeted population. For each, arrange an associated provider network comprised of primary care physicians and medical cardiologists who are willing to serve this high risk population. The provider network should isolate (as possible) a narrow high performance network of providers (e.g., low cost/high volume) based on available metrics.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 19e. Meet with MCOs to discuss the utilization of narrow high performing network for the definted affected population based on		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	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
the PPS allocation of rising versus high risk populations. Note that this will need to be performed in for each Managed Care Organizations network.										
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	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 20b. Identify PCPs and evaluate their ability to meet the project requirements.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 20c. Educate providers on the projects and seek their input on implementation.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Use EHRs or other technical platforms to track all patients engaged in this project.	sculley	Report(s)	44_DY2Q3_PROJ3bi_MDL3bi3_PRES4_RPT_CCN_Multiple_Services_Report_DY2_-_across_partners_9660.csv	Remediation - CCN multiple services report file 2 (csv file due to size)	03/17/2017 05:03 PM
	sculley	Report(s)	44_DY2Q3_PROJ3bi_MDL3bi3_PRES4_RPT_CCN_Multiple_Services_Report_DY2_9659.csv	Remediation - CCN multiple services report file 1 (csv file due to size)	03/17/2017 05:02 PM
	sculley	Rosters	44_DY2Q3_PROJ3bi_MDL3bi3_PRES4_ROST_CVD_Goal_Patient_Registry_DY2Q3_9658.xlsx	Remediation - 3bi completed patient registry	03/17/2017 05:01 PM
	sculley	Other	44_DY2Q3_PROJ3bi_MDL3bi3_PRES4_OTH_3bi_M4_Remediation_9657.docx	Remediation response to 3bi milestone 4.	03/17/2017 05:00 PM
	rachaelm	Templates	44_DY2Q3_PROJ3bi_MDL3bi3_PRES4_TEMPL_3bi_CVDGoal_Goal_9191.xlsx	Sample data collection and tracking system.	01/30/2017 09:25 AM

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 project team has continued to meet on a monthly basis. During DY2, Q3, the team discussed training requirements and contracting ramp up, exploring different strategies to increase engagement for this project. With many clinical guidelines having been approved, much of DY2, Q4 is focused on engaging providers and identifying trainings (either in the form of attestation or roll-out at provider sites to supplement existing efforts). Some additional processes and guidelines will need to be developed and vetted through the Clinical Governance Committee during this quarter. Care Compass Network anticipates most major health systems and their associated provider groups to be contracted for this project before the end of DY2, with ramp up as contracts are revised to reflect VBP values in DY3.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	The project team has continued to meet on a monthly basis. During DY2, Q3, the team discussed training requirements and contracting ramp up, exploring different strategies to increase engagement for this project. With many clinical guidelines having been approved, much of DY2, Q4 is focused on engaging providers and identifying trainings (either in the form of attestation or roll-out at provider sites to supplement existing efforts). Some additional processes and guidelines will need to be developed and vetted through the Clinical Governance Committee during this quarter. Care Compass Network anticipates most major health systems and their associated provider groups to be contracted for this project before the end of DY2, with ramp up as contracts are revised to reflect VBP values in DY3.
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	The project team has continued to meet on a monthly basis. During DY2, Q3, the team discussed training requirements and contracting ramp up, exploring different strategies to increase engagement for this project. With many clinical guidelines having been approved, much of DY2, Q4 is focused on engaging providers and identifying trainings (either in the form of attestation or roll-out at provider sites to supplement existing efforts). Some additional processes and guidelines will need to be developed and vetted through the Clinical Governance Committee during this quarter. Care Compass Network anticipates most major health systems and their associated provider groups to be contracted for this project before the end of DY2, with ramp up as contracts are revised to reflect VBP values in DY3.
Use EHRs or other technical platforms to track all patients engaged in this project.	Milestone 4 and the associated steps are not due for completion in DY2Q3 however we are reporting all as complete with this report. The requirement that partners track the actively engaged is included in Care Compass Network's (CCN) contract for project work. While several of the partners have EMRs, many of the EMRs do not have the current capability to easily pull the required information for each project to report patients actively engaged in the DSRIP projects. As a result, CCN developed a reporting template contracted partners use to track members actively engaged in the projects and to confirm services are properly. After a partner executes a contract, CCN distributes the reporting templates to partners and provides training on the use of the reporting templates in addition to use of an sFTP site created for Partners to upload patient registry information. Care Compass Network partners are submitting data on a monthly basis listing actively engaged patients, information about the services they received, and outcomes of the intervention services where applicable. The patient registry information is imported into the CCN Data Warehouse, an integral piece of the IT systems which will support CCN's Population Health approach. The warehouse combines partner data on monthly activities; in the future, the warehouse will bring in the NY Medicaid claims data, clinical data from partners (via the RHIOs), and other sources of data on social determinants. With this data, CCN's population health analysts will develop dashboards and reports to evaluate performance (Milestone 4 and Step 4a – Complete). DSRIP Year 2 data collection requirements in the monthly reporting templates include such information as the Medicaid Client Identification Number (CIN), date of birth, first name, last name, site name, and date of establishment or review of self-management goal. These fields were identified based on New York State Department of Health's requirements for reporting by the PPS (Step 4b. - Complete). Other reports under this project include the same basic identifiers but also request information about home blood pressure monitoring, instances of follow-up with patients monitoring their blood pressure at home who report abnormal readings, and follow-up with hypertensive or hyperlipidemic patients who go more than 6 months without visiting their primary care physician (recorded as the practice site reporting). CCN also collects information on other efforts associated with this project including Chronic Disease Self-Management Program (CDSMP). Each of these reports correlates with efforts detailed in Milestones throughout the project plan. Contracting within this project requires organizations to have valid, Meaningful Use certified EHRs. Existing capacity was initially assessed back in 2015, through CCN's Pre-Engagement Assessment. The IT & Data Governance Committee is also currently reviewing vendor proposals for ambulatory care EHRs for partner organizations that do not currently have EHRs in order to ensure the technical platforms necessary to execute this project are in place (Step 4c. - Complete). As of DY2, Q3, no attested partner organizations have expressed interest in the project that have identified lack of an EMR as a barrier to implementation. Generally, there has been some difficulty generating reports of the establishment and review of self-management goals in the EHR. Care Compass Network is in the process of identifying solutions to this issue by engaging its currently contracted partner organizations to ask about barriers to implementation (Step 4d. - Complete). Attached is a reporting template used to detail their engagement in establishing and reviewing self-management goals as described above supporting completion of this Milestone. Remediation response uploaded.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	Neither Milestone 5 nor its associated tasks are due for completion in DY2, Q3. Nonetheless, Care Compass Network seeks to defer this Milestone and the tasks associated to DY3, Q4 to reflect the DSRIP Updates and Announcements on January 17, 2017. As a clinical guideline, the 5 A's of tobacco control were endorsed by the Clinical Governance Committee and approved by the Board of Directors on December 8th, 2015. Since then, Care Compass Network has connected with St. Joseph's Tobacco Cessation program to identify partner organizations that may need assistance implementing in their EHRs. Some of our partner organizations seeking to execute contracts for work under this project have worked with St. Joseph's to meet the requirements of this Milestone while others will be outreached to for the remainder of DY2 in order to leverage the available resources in the community to promote this transformation.
Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	As of DY2, Q3, none of the tasks associated with Milestone 6 are due for completion. However, during DY1, Q4, two guidelines were brought to the Clinical Governance Committee (November 30, 2015) for their endorsement and subsequently approved by the Board of Directors on December 8, 2015 – both the Algorithm based on Joint National Committee (JNC) 8 for hypertension (Complete - Step 6b) and the Algorithm based on American Heart Association (AHA) 13 for hyperlipidemia (Complete - Step 6c). In DY2, Q3, the focus continues to be contracting with partner organizations and either having them attest to having education on these standards or making this available. Language has been incorporated into agreements to ensure these standards are adopted by each organization Care Compass Network contracts with. Care Compass Network is allowing partner organizations to train their own staff on these as long as the training deployed meets the requirements. For others that prefer the PPS obtain training for them, the 3bi project team will be identifying this and making it available through the HWapps platform during DY2, Q4. Currently, the American Medical Association's (AMA) STEPSforward program offers training the PPS may endorse.
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 project team has continued to meet on a monthly basis. During DY2, Q3, the team discussed training requirements and contracting ramp up, exploring different strategies to increase engagement for this project. With many clinical guidelines having been approved, much of DY2, Q4 is focused on engaging providers and identifying trainings (either in the form of attestation or roll-out at provider sites to supplement existing efforts). Some additional processes and guidelines will need to be developed and vetted through the Clinical Governance Committee during this quarter. Care Compass Network anticipates most major health systems and their associated provider groups to be contracted for this project before the end of DY2, with ramp up as contracts are revised to reflect VBP values in DY3.
Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	The project team has continued to meet on a monthly basis. During DY2, Q3, the team discussed training requirements and contracting ramp up, exploring different strategies to increase engagement for this project. With many clinical guidelines having been approved, much of DY2, Q4 is focused on engaging providers and identifying trainings (either in the form of attestation or roll-out at provider sites to supplement existing efforts). Some additional processes and guidelines will need to be developed and vetted through the Clinical Governance Committee during this quarter. Care Compass Network anticipates most major health systems and their associated provider groups to be contracted for this project before the end of DY2, with ramp up as contracts are revised to reflect VBP values in DY3.
Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	As of DY2, Q3, Milestone 9 and its associated tasks are not yet due for completion. During DY2, Q1, clinical competencies for taking a manual blood pressure and general blood pressure guidelines were brought to the Clinical Governance Committee and the Board of Directors and approved on June 14, 2016 (Complete – Step 9b.). These guidelines cover both procedural step-by-step instructions as well as equipment requirements. During the course of their approval, the Clinical Governance Committee provided some feedback regarding the approach to this Milestone in that mandating an annual competency was not feasible. Therefore, Steps 9c. and 9d. have been permanently placed On Hold and replaced with Steps 9e. and 9f. in previous reporting quarters in accordance with the feedback provided. Language has been incorporated into agreements to ensure that these guidelines are adopted by each organization Care Compass Network contracts with. Care Compass Network anticipates receiving training reports in relation to this Milestone during the DY2, Q4 timeframe.
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 project team has continued to meet on a monthly basis. During DY2, Q3, the team discussed training requirements and contracting ramp up, exploring different strategies to increase engagement for this project. With many clinical guidelines having been approved, much of DY2, Q4 is focused on engaging providers and identifying trainings (either in the form of attestation or roll-out at provider sites to supplement existing efforts). Some additional processes and guidelines will need to be developed and vetted through the Clinical Governance Committee during this quarter. Care Compass Network anticipates most major health systems and their associated provider groups to be contracted for this project before the end of DY2, with ramp up as contracts are revised to reflect VBP values in DY3.
Prescribe once-daily regimens or fixed-dose combination pills when	Neither Milestone 11 nor its associated tasks are due for completion in DY2, Q3. In DY2, Q4, the project team will be reviewing the steps to completion for this Milestone

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appropriate.	considering the speed at which the PPSs and MCOs have engaged in collaborative work. The PPS will also be reviewing its existing guidelines which include some medication guidelines to determine where more work needs to be done in order to mark this Milestone as complete by the end of DY2.
Document patient driven self-management goals in the medical record and review with patients at each visit.	The project team has continued to meet on a monthly basis. During DY2, Q3, the team discussed training requirements and contracting ramp up, exploring different strategies to increase engagement for this project. With many clinical guidelines having been approved, much of DY2, Q4 is focused on engaging providers and identifying trainings (either in the form of attestation or roll-out at provider sites to supplement existing efforts). Some additional processes and guidelines will need to be developed and vetted through the Clinical Governance Committee during this quarter. Care Compass Network anticipates most major health systems and their associated provider groups to be contracted for this project before the end of DY2, with ramp up as contracts are revised to reflect VBP values in DY3.
Follow up with referrals to community based programs to document participation and behavioral and health status changes.	The project team has continued to meet on a monthly basis. During DY2, Q3, the team discussed training requirements and contracting ramp up, exploring different strategies to increase engagement for this project. With many clinical guidelines having been approved, much of DY2, Q4 is focused on engaging providers and identifying trainings (either in the form of attestation or roll-out at provider sites to supplement existing efforts). Some additional processes and guidelines will need to be developed and vetted through the Clinical Governance Committee during this quarter. Care Compass Network anticipates most major health systems and their associated provider groups to be contracted for this project before the end of DY2, with ramp up as contracts are revised to reflect VBP values in DY3.
Develop and implement protocols for home blood pressure monitoring with follow up support.	While Milestone 14 and its associated tasks are not due for completion at this time, during DY2, Q1, a home blood pressure monitoring guideline was bought to the Clinical Governance Committee and Board of Directors, approved on June 14, 2016 (Complete – Step 14d.). As mentioned in previous quarterly reports, Step 14e. remains "On Hold" for the foreseeable future due to compliance concerns. During DY2, Q2, the PPS developed a "warm hand-off" clinical guideline that spans multiple projects in order to clarify terms. This was endorsed by the Clinical Governance Committee in September and adopted by the Board of Directors on October 11, 2016. Care Compass Network is allowing partner organizations to train their own staff on the protocols for home blood pressure monitoring as long as the training deployed meets the requirements to be determined by the project team. For others that prefer the PPS obtain training for them, the 3bi project team will be identifying this wherever possible and making it available through the HWapps platform.
Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	While none of Milestone 15's tasks are currently due for completion this quarter, Care Compass Network has developed contracts for work requiring partner organizations develop lists of hypertensive patients and schedule follow-up. The organization must also report the method by which they initiated follow-up. While the PPS cannot develop processes and mandate them for its partner organizations, it can work with them throughout the rest of DY2 to identify their individual processes for scheduling patients and conducting BP screenings in community "hot spots" wherever possible.
Facilitate referrals to NYS Smoker's Quitline.	Milestone 16 and its associated tasks are not due for completion in DY2, Q3. Currently, Care Compass Network reimburses providers for warm hand-offs to tobacco cessation programs, the NYS Quitline being one of them. Care Compass Network intends to complement the work done by St. Joseph's Tobacco Cessation program to work on implementing this in the EMR wherever possible. In the meantime, providers will continue to be incentivized for connecting patients to the NYS Quitline and other tobacco cessation resources. Much like this project's other education requirements, the intent is to allow partner organizations to train their own staff or make this available through the PPS if desired. In DY2, Q4, the PPS will work towards implementing the remainder of the steps such as including provider feedback on the process, through Clinical Governance Committee or otherwise, and rolling out education.
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 project team has continued to meet on a monthly basis. During DY2, Q3, the team discussed training requirements and contracting ramp up, exploring different strategies to increase engagement for this project. With many clinical guidelines having been approved, much of DY2, Q4 is focused on engaging providers and identifying trainings (either in the form of attestation or roll-out at provider sites to supplement existing efforts). Some additional processes and guidelines will need to be developed and vetted through the Clinical Governance Committee during this quarter. Care Compass Network anticipates most major health systems and their associated provider groups to be contracted for this project before the end of DY2, with ramp up as contracts are revised to reflect VBP values in DY3.
Adopt strategies from the Million Hearts Campaign.	Neither Milestone 18 nor its associated tasks are due for completion in DY2, Q3. Many aspects of the Million Lives campaign are reflected in the Joint National Committee (JNC) 8 and American Heart Association (AHA) 13-based guidelines described under Milestone 6. As mentioned in the narrative there, in DY2, Q3, the focus continues to be contracting with partner organizations and either having them attest to having education on these standards or making this available. Language has been incorporated

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Milestone Name	Narrative Text
	into agreements to ensure these standards are adopted by each organization Care Compass Network contracts with. Care Compass Network is allowing partner organizations to train their own staff on these as long as the training deployed meets the requirements. For others that prefer the PPS obtain training for them, the 3bi project team will be identifying this and making it available through the HWapps platform during DY2, Q4. Currently, the American Medical Association's (AMA) STEPSforward program offers training that the PPS may endorse. This training specifically includes references and links to the Million Hearts program, ensuring its inclusion in HWapps training.
Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	Care Compass Network seeks to defer Milestone 19 and its associated steps to DY3, Q4. Efforts to date to engage Managed Care Organizations (MCOs) have not included much discussion about project-specific needs. MCOs have been slow to come to the table and while progress is certainly being made, the PPS does not anticipate addressing Project 3bi-specific needs with them in the DY2 timeframe.
Engage a majority (at least 80%) of primary care providers in this project.	During DY2Q4 Care Compass Network is focusing on engaging the Primary Care Providers which are part of the medical groups in the major health systems in an effort to engage at least 80% of primary care providers. The remaining healthcare systems are anticipated to execute contracts in the next few quarters and will begin implementing this project at their associated primary care practices.

Milestone Review Status

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

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #17	Pass & Ongoing	
Milestone #18	Pass & Ongoing	
Milestone #19	Pass & Ongoing	
Milestone #20	Pass & Ongoing	

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

Instructions :

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

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

No Records Found

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 :

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

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

Instructions :

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

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

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "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	1,853

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	71	166	190	451
	Quarterly Update	0	0	0	0
	Percent(%) of Commitment	0.00%	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 (0) does not meet your committed amount (190) for 'DY2,Q3'

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.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	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 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.	DY2 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 has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH and/or APCM have been included. The PPS has received agreement from those eligible PCPs not PCMH and/or APCM certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	12/31/2016	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1b. Develop Pre-Engagement Assessment and disperse among potential partners within PPS.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 1c. Analyze data from Pre-Engagement Assessment to ascertain what Primary Care Providers (PCPs) are currently PCMH certified and those who are in the process of obtaining certification.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 1d. Develop agreements with PCPs committing to integrate palliative care into their practice model.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	DY2 Q4	Project	N/A	In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice.		Project		Completed	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 2b. Develop Pre-Engagement Assessment and disperse among potential partners within PPS.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2

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

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from all partners is met. Re-assessment of clinical guidelines will formally occur annually by the Clinical Governance Committee, or more frequently as identified by the project team and/or regional PPS 3gi quality committees (e.g., Disease Management).										
Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	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 Staff has received appropriate palliative care skills training, including training on PPS care protocols.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4b. Train PCP staff to identify established "clinical triggers" in patients and how to refer these to appropriate PCMH.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4c. Develop PPS care protocols in conjunction with the Clinical Governance Committee.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4d. Train PCMH staff on PPS care protocols.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.		Project		On Hold	04/01/2015	03/31/2018	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 5b. Identify MCOs within the Care Compass Network nine county region.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5c. Initiate discussions with MCOs, legal counsel, compliance, and/or the Department of Health (as required) to identify approaches and solutions relative to palliative care supports and offerings provided by MCOs as aligned with DSRIP goals.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5d. Engage with MCOs to understand, for palliative care services not currently covered, how to build associated rates into existing programs.		Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Use EHRs or other IT 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		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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engaged patients for project milestone reporting.										
Task 6b. Partner the 3gi Project Team with IT consultants and the PPS IT Project Manager in order to develop appropriate platforms for tracking 3gi patients in conjunction with the IT & Data Governance Committee and overall infrastructure/IT Vision developed by the PPS.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6c. Identify feasible, complete, and appropriate use of e-MOLST system to satisfactorily meet core IT requirements, including the need to monitor partner performance and track actively engaged patients.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6d. Implement eMOLST, or other supporting applications as needed, where appropriate.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	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
Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.	Milestone 1 and step 1a are due for completion this quarter however we are deferring both to DY2Q4 in order to engage additional providers in the project and to educate on services that are considered "palliative care services". The PPS has mapped all participating Primary Care Providers (PCPs) across the nine-county region who have obtained PCMH 2014 Level 3 certification, or, are in process of completing their certification prior to March 31, 2018. With this mapping the project management office can target contracting strategies to the sites specifically interested in obtaining their PCMH certification, as well as, offering palliative care services within the PCP office setting. Palliative care, while offered within many PCP offices without formally being classified as palliative, has been a difficult sell to the PCP practice sites and larger medical groups. Many PCPs are not board certified Palliative Care Physicians nor Pain Management experts. With this feedback the PPS has entered into a contract with The Center to Advance Palliative Care (CAPC) for membership into the CAPC interactive website. The project team has identified specific modules within the CAPC Learning Module Library that are required elements to complete while actively participating within the 3.g.i project. These learning modules will give PCPs and other clinical staff in the PCMH setting a starting point in the integration of palliative care. The project management office in its ongoing discussions has focused on clarifying to the physician groups the advantages of participating in the project. They do not need to become a Palliative Care Specialist, Pain management clinic nor Community Based Palliative Care team as these are still viable options for referrals to aid in the team work needed at the PCMH PCP site. Guthrie Healthcare Systems has contracted with Care Compass Network to integrate palliative care within the PCMH setting and has identified an initial site to do a pilot project in conjunction with CareFirst as the community based provider. Guthrie has identified two physicians and is working on mining data to identify a cohort of patients. Once the CAPC memberships go live in January of 2017 to the participating members, Guthrie personnel will pull the implementation plan guidelines that CAPC offers to begin mapping out their work flow. Several more medical groups, as well as, independent physicians, are in the process of contracting for the project expected to be

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Milestone Name	Narrative Text
	contracted by the end of DY2Q4. Through project 2.a.i, incentivizing for PCMH 2014 Level 3 certification has greatly pushed the efforts across the PPS and identified more eligible practice sites for inclusion within the 3.g.i project. The PMO is setting up follow up contracting discussions with targeted practice sites for implementation of the project by end of DY2Q4. Also, two major health care systems, Our Lady of Lourdes Memorial Hospital and United Medical Associates (through UHS) are in contracting discussions to start implementation of palliative care services at select practice sites in DY2Q4.
Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	The Milestone is due for completion in DY2Q4 and is in process and on track for completion. Initially four Hospice and Palliative Care agencies were identified in the nine-county region: CareFirst, Hospicare & Palliative Care Services of Tompkins County, Lourdes Hospice and Hospicare & Palliative Care of Chenango County. Since the submission of the DSRIP application a fifth hospice, Catskill Area Hospice & Palliative Care, was identified in the East Region overlapping with the Leatherstocking PPS. At this time, Care Compass Network has executed contracts with three of the five Hospice and Palliative Care agencies. Catskill Area Hospice & Palliative Care services contract was held up as they recently saw the retirement of their executive director along with their director of quality and compliance. However, their contract is in the final stages of review and should be executed prior to the completion of DY2Q4. Additionally, Our Lady of Lourdes Memorial Hospital has a contract in review and should be executed prior to the completion of DY2Q4. CCN is also working with Leatherstocking PPS to align a similar fee schedule to enhance inclusion of the community based palliative care providers. Catskill Area Hospice & Palliative Care will then be a partnering organization with 2 PPSs and will provide a continuum of care across PPSs for all eligible members. Project 3.g.i has a very active project team comprised of 1-2 members form each area Hospice and Palliative care agency, the Palliative Care Medical Director from Our Lady of Lourdes Memorial Hospital, the VP of operations from Chenango memorial Hospital (a sister site under UHS), the director of Quality and Risk Management from Cortland Regional Medical Center and subject matter experts in the clinical field who review project related materials as needed. The partnership with the community based Palliative care agencies is strengthened by their inclusion in this project team, which meets every other week to keep the workflow and momentum. CareFirst is in active discussions with Guthrie HealthCare Systems in setting up a pilot to develop a robust workflow within the PCP setting and incorporating community based referrals to the palliative care organization. This pilot will help develop a work flow for completion of the Integrated Palliative Care Outcome Score (IPOS) and a possible set up and completion of eMOLST.
Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	The Milestone is due for completion in DY2Q4 and is on track for completion. As well, step 3c is due for completion in DY2Q3 and is being marked as complete. From October of 2015 to present, the project team has actively worked on the creation and adoption of ten clinical guidelines agreed upon by all members of the PPS. In this timeframe, the Board of Directors has approved CGC-CG-06: MOLST/eMOLST forms, CGC-CG-09: Palliative Care Triggers, CGC-CG-017: WHO Definition of Palliative Care, CGC-CG-18-21 The Conversation Project Starter kits, CGC-CG-32 CAPC Training Requirements and CGC-CG-33/34 The Standardized Home Visit check list with training documentation. Each of these guidelines were created in conjunction with the subject matter experts of the 3.g.i project team and then vetted through all Clinical Governance Quality Subcommittees, primary care groups, the PPS Coordinating council, PAC Executive council and the main stakeholders group before final approval through the Clinical Governance Committee and then the Board of Directors. Each clinical guideline has an associated training through the agency that provides the services, such as eMOLST through Compassion and Support (Excellus and Dr. Bomba) or has an approved training guideline created by CCN. CCN management, population health and project management engaged in a conversation with Dr. Bomba and the Excellus group at Compassion and Support, regarding a PPS wide in person training for all clinical and non-clinical staff within the PPS on advance care planning as well as use of MOLST and eMOLST. This invitation would be extended to contracted and non-contracted partners and organizes as well as local colleges and agencies to aid in educating students, instructors and the community at large. Discussions continue with this group to roll out a PPS wide training and education forum. In December of 2016 CCN entered into contract with the Center to Advance Palliative Care (CAPC) to obtain a PPS wide CAPC membership. This membership is being offered, free of charge to partners, to all Palliative Care community based organizations, all primary care staff including case managers, practice managers, nurses, mid-levels and physicians, to major medical groups and hospitals as well as social workers within all these agencies, that do not currently have their own CAPC membership. Through the CAPC membership all participants will have access to the CAPC interactive web portal allowing for training forums, office hours with subject matter experts, evidence based materials and supports for implementation plans and more. Also, the CAPC training modules which will aid in the site obtaining continuing education credits as well as a standardized learning platform for all contracted partners participating in the 3.g.i project. CAPC will continue to offer this membership to PPSs through the DSRIP waiver period and CCN will continue to allow access to contracted partners across the PPS to use as a training and education forum. As more sites contract for the

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	project the 3.g.i project team has discussed setting up a PPS wide forum specific to practice managers between systems to ensure standardization of protocols, best practices and gap analysis.
Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	The Milestone is due for completion in DY2Q4 and is on track for completion. As well, step 3c is due for completion in DY2Q3 and is being marked as complete. From October of 2015 to present, the project team has actively worked on the creation and adoption of ten clinical guidelines agreed upon by all members of the PPS. In this timeframe, the Board of Directors has approved CGC-CG-06: MOLST/eMOLST forms, CGC-CG-09: Palliative Care Triggers, CGC-CG-017: WHO Definition of Palliative Care, CGC-CG-18-21 The Conversation Project Starter kits, CGC-CG-32 CAPC Training Requirements and CGC-CG-33/34 The Standardized Home Visit check list with training documentation. Each of these guidelines were created in conjunction with the subject matter experts of the 3.g.i project team and then vetted through all Clinical Governance Quality Subcommittees, primary care groups, the PPS Coordinating council, PAC Executive council and the main stakeholders group before final approval through the Clinical Governance Committee and then the Board of Directors. Each clinical guideline has an associated training through the agency that provides the services, such as eMOLST through Compassion and Support (Excellus and Dr. Bomba) or has an approved training guideline created by CCN. CCN management, population health and project management engaged in a conversation with Dr. Bomba and the Excellus group at Compassion and Support, regarding a PPS wide in person training for all clinical and non-clinical staff within the PPS on advance care planning as well as use of MOLST and eMOLST. This invitation would be extended to contracted and non-contracted partners and organizes as well as local colleges and agencies to aid in educating students, instructors and the community at large. Discussions continue with this group to roll out a PPS wide training and education forum. In December of 2016 CCN entered into contract with the Center to Advance Palliative Care (CAPC) to obtain a PPS wide CAPC membership. This membership is being offered, free of charge to partners, to all Palliative Care community based organizations, all primary care staff including case managers, practice managers, nurses, mid-levels and physicians, to major medical groups and hospitals as well as social workers within all these agencies, that do not currently have their own CAPC membership. Through the CAPC membership all participants will have access to the CAPC interactive web portal allowing for training forums, office hours with subject matter experts, evidence based materials and supports for implementation plans and more. Also, the CAPC training modules which will aid in the site obtaining continuing education credits as well as a standardized learning platform for all contracted partners participating in the 3.g.i project. CAPC will continue to offer this membership to PPSs through the DSRIP waiver period and CCN will continue to allow access to contracted partners across the PPS to use as a training and education forum. As more sites contract for the project the 3.g.i project team has discussed setting up a PPS wide forum specific to practice managers between systems to ensure standardization of protocols, best practices and gap analysis.
Engage with Medicaid Managed Care to address coverage of services.	The milestone and remaining steps are due for completion in DY4Q4, however CCN is changing the end date to DY2Q4 to align with the Prescribed Due Date in MAPP. The milestone and all steps, with the exception of step 5a, are in process and on track for completion in DY2Q4. While the PPS has been successful in setting up MCO initial discussions and meetings, solutions relative to palliative care supports and offerings provided by MCOs have not been discussed to date. Accomplishing this step will involve collaboration between adjoining PPSs across the state to fully discuss the need for services to be covered under existing plans from the listed MCOs. The joint initiative will help to ensure the members' health care needs are seamless and have uniformed coverage across the state. CCN is working with a group of upstate PPSs through UNYHealth in Syracuse, and most recently got Fidelis to agree to a meeting with the six PPSs involved in the group. This is a positive indicator, as Fidelis, the largest MCO in the six PPSs, has been very difficult to get involved. Regular meetings are established with Excellus which operates in Broome County, and United HealthCare which operates across the PPS. Discussions with Total Care, which operates in three of the nine PPS counties, are ongoing. CCN is hosting payer forums so that partners across the network can further learn how they can play a role in the Value-Based Payment contracting arrangements. The United Healthcare forum was held in Binghamton. It was attended by 39 individuals representing approximately 30 organizations. There is no plan for a forum with Excellus as they only operate in Broome County and will be contracting with Lourdes and UHS. Care Compass Network is working to schedule the remaining forums with TotalCare (recently purchased by Melena) and Fidelis. Involvement of the payers continues to be a work in progress with no agreements in place. On December 14th, 2016 CCN had a phone call with United Health Care to discuss the palliative care project and tasks the PPS could start to help formulate with partners to aid in the service of palliative care being included within the payment methodology for the MCOs. For example, what would an MCO be looking for in regards to including this in a fee schedule either in fee for service and then going into value based payments. The representative felt this discussion would best be held with a medical director from United Health Care. While three dates were set aside in January to hold this discussion with the medical director, no discussions have been formalized with United Health Care as of yet.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	While the milestone does not specifically state that the PPS will enter into contractual agreements with the MCOs for inclusion of palliative care, the state defined associated step (step 5a) does reference that agreements in writing are required between the PPS and the MCOs. Active engagement is ongoing between Care Compass Network and the MCOs yet no formal agreements will be forthcoming between the PPS and MCOs. At the March 8, 2016 CCN Board of Directors meeting, the Board of Directors approved a VBP strategy whereby the managed care organizations would contract directly with providers. The PPS would not be involved in negotiating risks or terms. As a result, we are placing step 5a on hold for consideration from DOH to remove the associated step from the project implementation plan.
Use EHRs or other IT platforms to track all patients engaged in this project.	Milestone 6 and the remaining steps are in process and on track for completion in DY2Q4. The PPS is in the process of evaluating vendors for an EHR system for Long Term Post-Acute Care which will aid in the tracking of patients requiring and entering Palliative Care Services. In addition, the incentive for participation within the eMOLST system utilizes an existing infrastructure designed for electronic tracking so the PPS does not need to further invest time and money into recreating a system to mimic what has already been developed and is of use state wide. The funds flow model reflects our support for both electronic tracking of a patient within a PCMH location as well as use of the eMOLST system. Along with facilitating cross-training opportunities for partners, CCN will support EHR training opportunities to meet these goals. Finally, the requirement that partners track the actively engaged is included in Care Compass Network's contract for project work; DSRIP Year 2 data collection requirements have been identified and include such information as referred for palliative care services, IPOS completion, and eMOLST completion.

Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment	

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

Instructions :

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

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

Instructions :

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

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

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Milestone 1 - Participate in MEB health promotion and MEB disorder prevention partnerships.	In Progress	Participate in MEB health promotion and MEB disorder prevention partnerships.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1a. Leveraging the 4aiii MEB project team, identify evidence-based screening tools which can meet DSRIP goals of strengthening mental health and substance abuse infrastructure of the PPS. Identified tools should be validated by the PPS Clinical Governance Committee and approved for PPS adoption by the Board of Directors.	Completed	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1b. Identify those primary and specialty care providers in each of the four regions of the PPS with whom the PPS can engage in the screening process and the associated staff education.	Completed	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1c. Identify and procure the evidence based targeted intervention services, for approval by CCN Clinical Governance Committee and Board of Directors.	In Progress	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1d. Engage with partner agencies across the PPS region to provide the targeted intervention services and associated training requirements.	Completed	See Narrative.	04/01/2015	03/31/2017	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone Milestone 2 - Expand efforts with DOH and OMH to implement 'Collaborative Care' in primary care settings throughout NYS.	In Progress	2. Expand efforts with DOH and OMH to implement 'Collaborative Care' in primary care settings throughout NYS.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2a. On an as needed basis, engage DOH / OMH/ OASAS for feedback and recommendations on	In Progress	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
best practice documents developed by the PPS as a result of this project.								
Task 2b. RPU Leads, Behavioral Health Subcommittees, and CCN Provider Relations to identify opportunities to enhance coordination of care across the MEB system (BH providers, PC providers, CBOs providing ancillary social services). Collaborative efforts will be in conjunction with collaborative care development for PC and BH integration (project 3ai).	Completed	See Narrative.	04/01/2015	03/31/2017	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone Milestone 3 - Share data and information on MEB health promotion and MEB disorder prevention and treatment.	In Progress	Share data and information on MEB health promotion and MEB disorder prevention and treatment.	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 3a. Leveraging the 4aiii MEB project team, develop the mechanism for collection and aggregation of all data as the project components are implemented, informed by the IT & Data Governance Committee for alignment (where appropriate) with other behavioral health initiatives and/or PPS integrated delivery system roadmaps.	In Progress	See Narrative.	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 3b. Behavioral Health quality subcommittee in place at each Regional Performance Unit (RPU) will evaluate program function and efficacy and report results to the PPS level Clinical Governance Committee. Identified quality improvement metrics, if any, as identified by the quality subcommittees will be presented to the Clinical Governance Committee and implemented with the associated providers facilitated by PPS Provider Relations, Project Champion(s), Behavioral Health Project Managers, and/or Workforce Transition Project Manager.	In Progress	See Narrative.	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Milestone Mid-Point Assessment	Completed	Mid-Point Assessment Project Narrative	06/01/2016	06/30/2016	06/01/2016	06/30/2016	06/30/2016	DY2 Q1

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PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Milestone 1 - Participate in MEB health promotion and MEB disorder prevention partnerships.	Milestone 1 and remaining steps are not due for completion in DY2Q3 however, Care Compass Network continues to make progress towards early identification and intervention. Our primary strategy is to focus on improving the health and well-being of our community while making progress towards early identification and intervention by standardizing evidence based screenings, protocols on interventions and follow up guidelines and medication management across the PPS. The PMO is actively involved in the MEB health and prevention partnerships across the region including the Southern Tier Regional Planning Consortium and Health Action Priorities Network Steering Committee working on the Mental Health Anti Stigma Toolkit. The PMO is coordinating a Primary Care – Behavioral Health resources event in the West Regional Performing Unit to educate primary care clinicians and office staff regarding the available behavioral health and community resources to improve care coordination and promote partnerships between OMH, DOH, PCP and OASAS in the region. We anticipate this provider event to take place in March 2017. Furthermore, the MAX – Lourdes Robinson Pilot Team also hosted their final findings on PHQ9 screening data, lessons learned and rapid improvement processes on integrating behavioral health in primary care to the Care Compass Network partners. The MAX team encouraged early PHQ9 screenings to promote early detection and interventions. Some of the identified barriers to administering the screenings that was shared by our providers were the time constraints of the clinic and the staffing to be able to address the patient's behavioral health needs if the result is positive. Based on the data that was collected during a 10-month period, approximately 68% of patients screened scored 0-9 which means the patient requires none or minimal intervention on the part of the primary care office. This partnership and collaboration is an ongoing process and CCN will continue to support and expand its reach in the community and regionally (Milestone 1 – In Process). The PMO, 3ai and 4aiii project team has identified Mental Health First Aid Training as the evidence based educational program to incorporate as the mandatory training for contracted partners participating in the 3ai and 4aiii projects. The training will be free to contracted partners and offered regionally to ensure optimal attendance and participation. CCN anticipate the training will assist the providers, clinic staff and community based organizations on how to respond and recognize the signs and symptoms of individuals who are experiencing acute mental health crises or the early stages of a mental health chronic disorders such as depression. The Mental Health First Aid Training will be presented to the RPU quality subcommittee, Clinical Governance Committee and the Board of Directors for their review and approval. Once this is approved, we will be reporting step 1c as complete (Step 1c – In Process). Care Compass Network is reporting step 1d as complete since we have contracted with partners including clinics and community based organizations to perform screenings for the 4aiii project and follow up care. All the materials and requirements for this step have been defined and distributed to partners in the project contract. We have received reports from our partners which include such information as patient name, CIN, date of service, screening, referral and patient outcomes (Step 1d – Complete).
Milestone 2 - Expand efforts with DOH and OMH to implement 'Collaborative Care' in primary care settings throughout NYS.	Milestone 2 and remaining steps are not due for completion in DY2Q3 however, Care Compass Network has contracted with primary care providers (DOH) and mental health agencies (OMH) to implement "collaborate care" in primary care settings across our 9-county region. We have contracted with both DOH and OMH to implement the 3ai Integration of behavioral Health in Primary care settings (Model 1) and Integrating primary care in behavioral health settings (Model 2). The PMO is working to support a true integration model of care which requires primary care sites to meet PCMH 2014 Level 3. We are supporting our contracted partners with up to $50,000 in 3ai startup funds and an additional PCMH contract funding up to $40,000 based on the partners' current PCMH level. By providing this upfront funding for PCMH certification, we acknowledge the heavy lift administratively and financially that is required and we want to ensure our partners continue to be engaged in practice transformation (Milestone 2 –In Process). The 3ai and 4aiii Project team along with the Regional Performing Unit (RPU) Behavioral Health/Substance Abuse quality subcommittees meet regularly to review, support and provide guidance on how to enhance collaborative efforts to improve care coordination for behavioral health members from primary care access to crisis stabilization and

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Milestone Name	Narrative Text
	community based services. One such opportunity was for the project team to create a workflow chart to assist contracted partners on how to incorporate the evidence based screenings into their daily workflow. The quality subcommittees will continue to play a critical role as we transition into pay for performance and population health management. (Step 2b – Complete). The PMO and project team acknowledge our contracted partners will require additional support and resources to implement these systematic transformations therefore we have developed the 4aiii workflow process map which will assist partners with the implementation roll out related to screening protocols, interventions, community resources, Health Home and follow up functions. Feedback and recommendations from each RPU (Regional Performing Unit) quality subcommittees were incorporated. The final document will be presented to the Clinical Governance Committee and Board of Directors for approval. The toolkit will be incorporated as part of the post contracting training. Once this is complete, we will report the milestone and step 2a as complete.
Milestone 3 - Share data and information on MEB health promotion and MEB disorder prevention and treatment.	Milestone 3 and the remaining steps are not due for completion in DY2Q3 however, the project team and IT & Data Governance Committee team is working on creating a behavioral health IT platform justification template which will outline each provider's IT needs, organizational readiness and benefits to achieving DSRIP milestones and goals. CCN anticipates the template to be presented at the next IT committee meeting in February. The contracted provider's needs justification requirement for each technology will include: □ Estimated one-time & annual ongoing costs □ Clinical need □ Target patient population □ Sustainability business aspects of technologies □ Impact on clinical processes □ ROI/support for DSRIP financial incentives □ Potential workforce impact considerations The above is outlined in our IT Strategic Plan. The IT, Informatics and Data Governance Committee has endorsed two Behavioral Health IT solution platforms for use across the PPS. The 3ai/4aiii project team is planning to pilot a tablet solution under the 3ai - Integrating Behavioral Health and Primary Care project and 4aiii – Strengthening Mental Health and Substance Abuse across systems. The project team anticipates the IT solution will assist Behavioral Health and primary care providers to efficiently screen/identify, treat, refer, and track patients with behavioral and mental health diagnoses. Furthermore, the collection of the data will help us to facilitate and evaluate treatment protocols based on the members' outcomes and frequency of ED visits. We anticipate at least one pilot site to be roll out with 3ai or 4aiii contracted partners by DY3, Q4. Care Compass Network has developed and distributed a monthly reporting template to our contracted partners. Participating partners have submitted project reports via the sFTP site with information such as First/Last Name, Medicaid ID, type of screenings, results of screenings, and post-screening activities. With the data warehouse going "live" in December 2016, the process will become automated monthly reports will be submitted and retrieved by the data warehouse for de duplication and payments. While we can report this as complete to simply check off the box, we will wait on the implementation/pilot of the behavioral health IT platform rollout (Step 3a – In process). CCN is looking to create targeted dashboards of the quality performance metrics for the quality subcommittees so the data is meaningful to facilitate the change needed. CCN has developed a framework for DY3 contracting which will include the selection and incorporation of quality measure metrics. Through the use of various existing committees, CCN will be presenting the contract framework to Stakeholders for feedback and recommendations. Furthermore, Care Compass Network has a clinical governance structure in place to evaluate the program functions, efficacy and analyze results to determine the best practices for implementation across the PPS (Milestone 3, 3b – In progress).

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment	

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

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

Instructions :

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

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

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Milestone 1 - Increase community partner participation in COPD prevention and management.	In Progress	Increase community partner participation in COPD prevention and management.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1a. The CBO Engagement Council will produce and disseminate a Pre-Engagement Assessment wherein providers' scope of services will be gathered. The Provider Relations team will engage community partners in planning for PPS wide COPD prevention and management activities.	Completed	See narrative	04/01/2015	03/31/2017	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1b. The 4bii Project Team, Project Management Office, Providers Relations team, and CCN Communications team will work collaboratively with tobacco free coalitions to establish consistent messaging for smoking cessation for patients and smoke free environments for facilities participating in the project. This will include COPD specific materials and disease management materials in related agendas with focused review on at least an annual basis for QA/QI opportunities.	In Progress	See narrative	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1c. Educate COPD patients and smokers about available options for Chronic Disease Self Management (CDSMP) evidence based interventions.	In Progress	See narrative	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone Milestone 2 - Establish PPS wide COPD screening protocols and clinical practice guidelines.	In Progress	Establish PPS wide COPD screening protocols and clinical practice guidelines.	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 2a. Engage clinical and community based	In Progress	See narrative	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
providers in the establishment of PPS wide screening protocols and clinical practice guidelines for COPD in conjunction with the Clinical Governance Committee and, more specifically, the Disease Management Subcommittees within each Regional Performance Unit (RPU). Established protocols, particularly GOLD Standards, will be taken into consideration as PPS wide protocols are adopted and/or developed by the Clinical Governance Committee and Board of Directors. Review and alteration to said protocols will occur annually at a minimum for effectiveness and relevance.								
Task 2b. The 4bii project team will pursue the standardized utilization of the 5As (Ask, Assess, Advise, Assist, and Arrange) for tobacco cessation and appropriate referrals to NYS Quit line. The PMO and the IT & Data Governance Committee will work in conjunction to locate the 5As within providers' EMRs and implement strategies to fill identified gaps. Smoking history, willingness to self-manage goals, and other pertinent clinical interventions will be sought to be included in EMR.	In Progress	See narrative	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 2c. As part of the engagement of clinical and community based partners, the PPS will include a focused effort for increased adult immunization rates (influenza, pneumococcal, pertussis). Measured and monitored success of this effort to be measured by reported numbers provided by NYS DOH.	In Progress	See narrative	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone Milestone 3 - Increase pulmonary function testing (PFT)for COPD at risk adults.	In Progress	Increase pulmonary function testing (PFT)for COPD at risk adults.	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 3a. The IT & Data Governance Committee work group will establish a PPS wide approach for provider alerts of patients requiring PFT screening	In Progress	See narrative	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
in conjunction with the Clinical Governance Committee and, more specifically, the Disease Management Subcommittees within each Regional Performance Unit (RPU). Patients will be assessed for their COPD-related health conditions, risk stratified via screening protocols and guidelines (i.e. GOLD Standards and/or PAM Survey), and then receive appropriate health management interventions. This framework will be reviewed, altered if need be, and approved by the Disease Management Subcommittee to then be fully adopted by the Clinical Governance Committee annually at a minimum.								
Task 3b. Utilize the population health management screening model to identify opportunities for distribution of patient reminders PFT screening needed, as applicable, such as text message reminders for spyrometry in the office or pulmonary function screening.	In Progress	See narrative	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone Milestone 4 - Improve adherence to timely follow up of abnormal PFT screening results.	In Progress	Improve adherence to timely follow up of abnormal PFT screening results.	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 4a. The IT & Data Governance Committee will establish a PPS wide approach for provider alerts to conduct follow up appointments with patients with abnormal PFT screening results. Care coordination teams will be utilized and/or patients with abnormal PFT screening results will be assigned to a COPD care coordinator.	In Progress	See narrative	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 4b. Establish PPS-wide approach for patient reminders of need for follow up on abnormal PFT screening results.	In Progress	See narrative	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone Mid-Point Assessment	Completed	Mid-Point Assessment Project Narrative	06/01/2016	06/30/2016	06/01/2016	06/30/2016	06/30/2016	DY2 Q1

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PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Milestone 1 - Increase community partner participation in COPD prevention and management.	There are four milestones for project 4.b.ii with no tasks due for the DY2, Q3 submission. Still, Step 1a. is being marked as complete this quarter since a Pre-Engagement Assessment was released in June 2015 with partner organizations beginning to contract for Project 4.b.ii in DY2, Q3. As DY2, Q4 commences, Care Compass Network seeks to complete the remaining two steps to complete Milestone 1 on time. This shifts project focus to patient education and awareness which we hope to leverage our Tobacco Free Coalitions (Step 1b.) and our partner organizations with CDSMP Master Trainers and Peer Leaders to achieve (Step 1c.). The project team will be looking to identify ways to direct COPD patients and smokers to CDSMP workshops in a feasible yet meaningful way (Step 1c.).
Milestone 2 - Establish PPS wide COPD screening protocols and clinical practice guidelines.	There are no tasks due for completion for this Milestone in DY2, Q3. Nonetheless, working towards establishing PPS-wide COPD screening protocols and clinical practice guidelines, the GOLD (Global Initiative for Chronic Obstructive Lung Disease) standards were approved as a clinical guideline by Care Compass Network's Clinical Governance Committee and Board of Directors (December 8, 2015). This standardization was a first step towards increasing access to quality preventative care. Late in 2016, these guidelines were updated and, therefore, require review again in order to pass these updates through Care Compass Network's Clinical Governance Committee. In the meantime, Care Compass Network is still looking to collect the information it can on the COPD population but anticipates updating GOLD standards to stratify patients and inform future interventions (Step 2a.). In DY2, Q2, a clinical guideline for COPD screening was endorsed by the Clinical Governance Committee in September and adopted by the Board of Directors on October 11, 2016. This guideline outlined the U.S. Preventative Services Task Force's recommendations for spirometry testing. It also included the validated screening tools for determining whether or not a patient is symptomatic and should continue to take a pulmonary function test. Partner organizations will be asked to report whether or not they determined a patient was symptomatic and proceeded to conduct a spirometry procedure. Additionally, we will be collecting the GOLD standards' categorizations in order to risk stratify and better understand the COPD population. This initial phase raises awareness of an underdiagnosed disease to better position the PPS to evaluate and select targeted interventions for the prevalent sub-populations of our COPD patients. As mentioned before, the changes to the GOLD standards may inform changes to this guideline as well. As a clinical guideline, the 5 A's of tobacco control were endorsed by the Clinical Governance Committee and approved by the Board of Directors on December 8th, 2015. Since then, Care Compass Network has connected with St. Joseph's Tobacco Cessation program to identify partner organizations that may need assistance implementing in their EHRs. Some of our partner organizations seeking to execute contracts for work under this project and 3.b.i have worked with St. Joseph's to meet the requirements of this Milestone while others will be outreached to for the remainder of DY2 in order to leverage the available resources in the community to promote this transformation (Step 2b.).
Milestone 3 - Increase pulmonary function testing (PFT)for COPD at risk adults.	There are no tasks due for completion for this Milestone in DY2, Q3. However, Compass Network currently offers to reimburse partner organizations for the use of screening (determination that a patient is symptomatic) paired with spirometry testing in an effort to increase use of pulmonary function testing and, consequently, appropriate diagnosis and treatment of COPD. In future quarters, the data collected from this phase can be used to inform future interventions and should help to stratify the patient population (using the GOLD standard guideline). In DY2, Q4, Care Compass Network anticipates continuing to contract with partner organizations for the initial phase.
Milestone 4 - Improve adherence to timely follow up of abnormal PFT screening results.	There are no tasks due for completion for this Milestone in DY2, Q3. As contracts are executed and work begins for this project, regular meetings with implementing providers will inform strategies in relation to the IT and workflow needs associated with improving adherence to timely follow-up of abnormal PFT results.
Mid-Point Assessment	

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

Instructions :

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

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Care Compass Network (PPS ID:44)

Attestation

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

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

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

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

☐ **I here by attest, as the Lead Representative of the 'Care Compass Network', that all information provided on this Quarterly report is true and accurate to the best of my knowledge, and that, following initial submission in the current quarterly reporting period as defined by NY DOH, changes made to this report were pursuant only to documented instructions or documented approval of changes from DOH or DSRIP Independent Assessor.**

Primary Lead PPS Provider:	UNITED HEALTH SERV HOSP INC
Secondary Lead PPS Provider:	
Lead Representative:	Mark Ropiecki
Submission Date:	03/17/2017 05:11 PM

Comments:	

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

Status Log				
Quarterly Report (DY,Q)	**Status**	**Lead Representative Name**	**User ID**	**Date Timestamp**
DY2, Q3	Adjudicated	Mark Ropiecki	mrurak	03/31/2017 12:38 PM

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Comments Log			
Status	**Comments**	**User ID**	**Date Timestamp**
Adjudicated	The DY2, Q3 Quarterly Reports have been adjudicated.	mrurak	03/31/2017 12:38 PM
Submitted	Updates in response to DY2, Q3 remediation requests for Care Compass Network.	ropiecki	03/17/2017 05:11 PM
Returned	The DY2, Q3 Quarterly Report is returned for remediation. Please see the remediation checklist highlighting all items requiring your attention in the MAPP portal. PPS remediation responses are due by March 17, 2017.	mrurak	03/03/2017 04:38 PM
Submitted	Submission of the Care Compass Network DY2,Q3 report. Of note, an updated PIT table has been provided to better detail PPS engagement.	ropiecki	01/30/2017 11:27 AM

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

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

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Section	Module Name / Milestone #	Review Status	
Section 01	Module 1.1 - PPS Budget - 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 & Ongoing	
	Milestone #7 Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	Pass & Ongoing	
	Milestone #8 Finalize workforce communication and engagement plan	Pass & 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	
	Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	Pass & Complete	

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Section	Module Name / Milestone #	Review Status	
	Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Pass & Complete	
	Milestone #4 Develop a Value Based Payments Needs Assessment ("VNA")	Pass & Ongoing	
	Milestone #5 Develop an implementation plan geared towards addressing the needs identified within your VNA	Pass & Ongoing	
	Milestone #6 Develop partner engagement schedule for partners for VBP education and training	Pass & Ongoing	
	Milestone #7 ≥50% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and ≥ 8%* (blended for 15% target for fully capitated plans (MLTC and SNPS) and 5% target for not fully capitated plans) of total MCO payments captured in VBPs has to be in Level 2 VBPs or higher	Pass & Ongoing	
	Milestone #8 ≥80% of total MCO payments (in terms of total dollars) captured in at least Level 1 VBPs, and ≥ 20%* (blended for 35% target for fully capitated plans (MLTC and SNPS) and 15% target for not fully capitated plans) of total MCO payments 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 & Ongoing	
	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 & Complete	
	Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	Pass & Ongoing	
	Milestone #5 Develop a data security and confidentiality plan.	Pass & 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 & Ongoing	
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 & Complete	
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 & Ongoing	
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 & Complete	
	Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	Pass & Complete	
	Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	Pass & Complete	
	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 & Complete	
	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 eligible participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	Pass & Ongoing	
	Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	Pass & Ongoing	
	Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	Pass & Ongoing	
	Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	Pass & Ongoing	
2.b.iv	Module 2.b.iv.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.b.iv.3 - Prescribed Milestones		
	Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	Pass & Ongoing	
	Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	Pass & Ongoing	
	Milestone #3 Ensure required social services participate in the project.	Pass & Complete	
	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	

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Pass & Complete	
	Milestone #6 Ensure that a 30-day transition of care period is established.	Pass & Complete	
	Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Complete	
2.b.vii	Module 2.b.vii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.b.vii.3 - Prescribed Milestones		
	Milestone #1 Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.	Pass & Ongoing	
	Milestone #2 Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	Pass & Complete	
	Milestone #3 Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	Pass & Ongoing	
	Milestone #4 Educate all staff on care pathways and INTERACT principles.	Pass & Ongoing	
	Milestone #5 Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	Pass & Ongoing	
	Milestone #6 Create coaching program to facilitate and support implementation.	Pass & Complete	
	Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	Pass & Ongoing	
	Milestone #8 Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	Pass & Ongoing	
	Milestone #9 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Pass & Ongoing	
	Milestone #10 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Complete	
2.c.i	Module 2.c.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.c.i.3 - Prescribed Milestones		
	Milestone #1 Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.	Pass & Ongoing	
	Milestone #2 Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.	Pass & Complete	
	Milestone #3 Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.	Pass & Ongoing	
	Milestone #4 Resource appropriately for the community navigators, evaluating placement and service type.	Pass & Complete	
	Milestone #5 Provide community navigators with access to non-clinical resources, such as transportation and housing services.	Pass & Complete	

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #6 Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.	Pass & Complete	
	Milestone #7 Market the availability of community-based navigation services.	Pass & Ongoing	
	Milestone #8 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Complete	
2.d.i	Module 2.d.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.d.i.3 - Prescribed Milestones		
	Milestone #1 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	Pass & Complete	
	Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	Pass & Complete	
	Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	Pass & Complete	
	Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.	Pass & Complete	
	Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	Pass & Complete	
	Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.	Pass & Ongoing	
	Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	Pass & Ongoing	
	Milestone #8 Include beneficiaries in development team to promote preventive care.	Pass & Complete	
	Milestone #9 Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to	Pass & Ongoing	

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	a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.		
	Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	Pass & Ongoing	
	Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	Pass & Complete	
	Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	Pass & Complete	
	Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	Pass & Complete	
	Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	Pass & Complete	
	Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	Pass & Complete	
	Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	Pass & Ongoing	
	Milestone #17 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	Pass & Complete	
3.a.i	Module 3.a.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.a.i.3 - Prescribed Milestones		
	Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating eligible 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 & Complete	
	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	

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	Milestone #7 Conduct preventive care screenings, including physical and behavioral health screenings.	Pass & Ongoing	
	Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Complete	
	Milestone #9 Implement IMPACT Model at Primary Care Sites.	Pass & Ongoing	
	Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Pass & Ongoing	
	Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Pass & Ongoing	
	Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	Pass & Ongoing	
	Milestone #13 Measure outcomes as required in the IMPACT Model.	Pass & Ongoing	
	Milestone #14 Provide "stepped care" as required by the IMPACT Model.	Pass & Ongoing	
	Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
3.a.ii	Module 3.a.ii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.a.ii.3 - Prescribed Milestones		
	Milestone #1 Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.	Pass & Complete	
	Milestone #2 Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.	Pass & Ongoing	
	Milestone #3 Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.	Pass & Ongoing	
	Milestone #4 Develop written treatment protocols with consensus from participating providers and facilities.	Pass & Complete	
	Milestone #5 Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.	Pass & Ongoing	
	Milestone #6 Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).	Pass & Ongoing	
	Milestone #7 Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.	Pass & Complete	
	Milestone #8 Ensure that all PPS safety net providers have actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.	Pass & Ongoing	
	Milestone #9 Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.	Pass & Ongoing	
	Milestone #10 Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.	Pass & Ongoing	
	Milestone #11 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Complete	

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Project ID	Module Name / Milestone #	Review Status	
3.b.i	Module 3.b.i.2 - Patient Engagement Speed	Pass & 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 & Complete	
	Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	Pass & Ongoing	
	Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	Pass & Ongoing	
	Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Pass & Ongoing	
	Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	Pass & Ongoing	
	Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	Pass & Ongoing	
	Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	Pass & Ongoing	
	Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	Pass & Ongoing	
	Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	Pass & Ongoing	
	Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	Pass & Ongoing	
	Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	Pass & Ongoing	
	Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	Pass & Ongoing	
	Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	Pass & Ongoing	
	Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	Pass & Ongoing	
	Milestone #18 Adopt strategies from the Million Hearts Campaign.	Pass & Ongoing	
	Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	Pass & Ongoing	
3.g.i	Module 3.g.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.g.i.3 - Prescribed Milestones		
	Milestone #1 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.	Pass & Ongoing	
	Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	Pass & Ongoing	
	Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	Pass & Ongoing	
	Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	Pass & Ongoing	
	Milestone #5 Engage with Medicaid Managed Care to address coverage of services.	Pass & Ongoing	
	Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.	Pass & Ongoing	
4.a.iii	Module 4.a.iii.2 - PPS Defined Milestones	Pass & Ongoing	
4.b.ii	Module 4.b.ii.2 - PPS Defined Milestones	Pass & Ongoing	

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Providers Participating in Projects

	Selected Projects										
	Project 2.a.i	**Project 2.b.iv**	**Project 2.b.vii**	**Project 2.c.i**	**Project 2.d.i**	**Project 3.a.i**	**Project 3.a.ii**	**Project 3.b.i**	**Project 3.g.i**	**Project 4.a.iii**	**Project 4.b.ii**
Provider Speed Commitments	DY3 Q4	DY2 Q4	DY3 Q4	DY2 Q4	DY3 Q4	DY3 Q4	DY3 Q4	DY3 Q4	DY2 Q4		

Provider Category		**Project 2.a.i**		**Project 2.b.iv**		**Project 2.b.vii**		**Project 2.c.i**		**Project 2.d.i**		**Project 3.a.i**		**Project 3.a.ii**		**Project 3.b.i**		**Project 3.g.i**		**Project 4.a.iii**		**Project 4.b.ii**	
		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	201	285	198	58	0	-	89	-	98	-	21	163	0	-	65	228	47	81	48	-	18	-
	Safety Net	39	48	37	48	0	-	22	0	27	48	9	48	0	0	7	64	3	21	4	-	4	-
Practitioner - Non-Primary Care Provider (PCP)	Total	310	479	310	66	0	-	120	-	142	-	2	0	0	-	0	22	0	0	58	-	11	-
	Safety Net	15	43	15	43	0	-	6	0	12	43	1	0	0	0	0	5	0	0	0	-	1	-
Hospital	Total	8	7	8	5	2	-	3	-	5	-	2	-	1	-	3	-	2	-	1	-	2	-
	Safety Net	8	7	8	7	2	7	3	-	5	7	2	-	1	2	3	-	2	-	1	-	2	-
Clinic	Total	12	23	8	-	2	-	5	-	8	-	3	0	1	-	3	10	2	0	1	-	2	-
	Safety Net	12	24	8	-	2	-	5	0	8	24	3	0	1	0	3	14	2	0	1	-	2	-
Case Management / Health Home	Total	8	12	2	7	0	-	6	-	6	-	1	-	2	-	0	12	1	-	1	-	0	-
	Safety Net	5	7	2	7	0	-	3	0	3	-	1	-	2	3	0	7	1	-	1	-	0	-
Mental Health	Total	23	63	15	-	1	-	11	-	14	-	6	37	3	-	1	0	1	-	1	-	1	-
	Safety Net	16	28	8	-	1	-	6	0	9	-	5	16	3	7	1	0	1	-	1	-	1	-
Substance Abuse	Total	9	14	2	-	0	-	3	-	7	-	5	0	1	-	1	0	1	-	0	-	0	-
	Safety Net	9	13	2	-	0	-	3	0	7	-	5	0	1	7	1	0	1	-	0	-	0	-
Nursing Home	Total	14	20	1	-	14	-	1	-	3	-	0	-	0	-	0	-	0	-	0	-	0	-
	Safety Net	14	18	1	-	14	19	1	-	3	-	0	-	0	-	0	-	0	-	0	-	0	-
Pharmacy	Total	6	0	5	-	0	-	4	-	5	-	0	-	0	-	4	0	0	-	0	-	4	-
	Safety Net	3	0	2	-	0	-	1	0	2	0	0	-	0	-	1	0	0	-	0	-	1	-
Hospice	Total	6	4	3	-	0	-	2	-	1	-	1	-	0	-	1	-	5	4	0	-	1	-

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Provider Category		Project 2.a.i		Project 2.b.iv		Project 2.b.vii		Project 2.c.i		Project 2.d.i		Project 3.a.i		Project 3.a.ii		Project 3.b.i		Project 3.g.i		Project 4.a.iii		Project 4.b.ii	
		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed	
	Safety Net	1	0	1	-	0	-	1	-	1	-	1	-	0	-	1	-	0	0	0	-	1	-
Community Based Organizations	Total	18	26	4	0	0	-	11	-	11	-	1	0	1	-	0	20	0	0	4	-	0	-
	Safety Net	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-
All Other	Total	460	375	426	95	17	-	183	-	213	-	28	0	3	-	75	31	53	0	98	-	26	-
	Safety Net	88	95	60	95	14	-	40	0	56	95	16	0	3	0	11	31	5	0	5	-	7	-
Uncategorized	Total	8	-	7	-	0	-	3	-	4	-	0	-	1	-	0	-	0	-	1	-	0	-
	Safety Net	1	-	1	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-
Additional Providers	Total	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-
	Safety Net	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-

Additional Project Scale Commitments

Instructions:

Please indicate the scale of the categories below that meet all of the project requirements committed to in the Project Plan Application. Documentation must be submitted in Excel format in the quarter when the PPS provider speed commitments for a particular project are due. This documentation should include the target category(e.g. Medical Villages, Emergency Departments with Care Triage, Community-based navigators, etc.), the project ID(e.g. 2.a.iv,2.a.v,3.a.ii, etc.), and the name of the providers/entities/individuals associated with this project, if applicable.

Project Scale Category	Project	Selected	Committed
Community-based navigators participating in project	2.c.i	0	14
PAM(R) Providers	2.d.i	0	378
Expected Number of Crisis Intervention Programs Established	3.a.ii	0	7

* Safety Net Providers in Green

Participating in Projects												
Provider Name	Provider Category	2.a.i	2.b.iv	2.b.vii	2.c.i	2.d.i	3.a.i	3.a.ii	3.b.i	3.g.i	4.a.iii	4.b.ii
Mcclintic William R Do	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Sharma Hari Har Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Eisman Michael H Md	Practitioner - Primary Care Provider (PCP)											
Breiman Robert J Md	Practitioner - Primary Care Provider (PCP)	✓	✓									

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Participating in Projects												
Provider Name	**Provider Category**	**2.a.i**	**2.b.iv**	**2.b.vii**	**2.c.i**	**2.d.i**	**3.a.i**	**3.a.ii**	**3.b.i**	**3.g.i**	**4.a.iii**	**4.b.ii**
Sheikh Mushtaq A Md	Practitioner - Primary Care Provider (PCP)											
Gill Roy Md	Practitioner - Primary Care Provider (PCP)											
Nirgudkar Sriram D Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Sutton Mala V	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Rao Rajaram N S Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Uphoff Marguerite H Mckay Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Kahn Ronald Lee Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Driscoll Daniel J Md	Practitioner - Primary Care Provider (PCP)											
Zander David Brooks Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓			✓			✓
Wasco Michael J Md	Practitioner - Primary Care Provider (PCP)											
Cardina Timothy M Md	Practitioner - Primary Care Provider (PCP)											
Klepack William Andrew Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Contini William Md	Practitioner - Primary Care Provider (PCP)											
Brereton John Md	Practitioner - Primary Care Provider (PCP)											
Patel Arjun J	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓			✓			✓
Rana Shamsuddin Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓			✓			✓
Kerr Cheryl Md	Practitioner - Primary Care Provider (PCP)											
Alt Allen David Md	Practitioner - Primary Care Provider (PCP)											
Leslie Joyce Ruth Md	Practitioner - Primary Care Provider (PCP)											
Qadir Abdul Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Terwilliger Jerry W Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Shallish Neil Frederick Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Costello Ann Racker Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Costello John E Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Susarla Ahalya Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Glosenger Mark E Md	Practitioner - Primary Care Provider (PCP)											
Enders Gary C Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Hawkins Charlotte Annette Md	Practitioner - Primary Care Provider (PCP)											
Jones Edward Leslie Md	Practitioner - Primary Care Provider (PCP)											
Miller Alan V Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Leonti Vincent Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓	✓					

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Participating in Projects												
Provider Name	**Provider Category**	**2.a.i**	**2.b.iv**	**2.b.vii**	**2.c.i**	**2.d.i**	**3.a.i**	**3.a.ii**	**3.b.i**	**3.g.i**	**4.a.iii**	**4.b.ii**
Winkler James Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Dean Gary D Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓			✓			✓
Seddon Lorraine Md	Practitioner - Primary Care Provider (PCP)											
Hurley Rosemarie Md	Practitioner - Primary Care Provider (PCP)											
Boyle Michele Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓	✓		✓			✓
Midura Alan T Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Anderson Suzanne Kochweser Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Giannone John J Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Masarech Martin Charles Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Ryan Debra A Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Lofaso Peter Joseph Md Jr	Practitioner - Primary Care Provider (PCP)											
Tarricone Nicholas Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Armstrong Robert W Jr Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Teris Wayne C Md	Practitioner - Primary Care Provider (PCP)											
Weitzel Martin Kress Do	Practitioner - Primary Care Provider (PCP)											
Modrak Mary Anne Md	Practitioner - Primary Care Provider (PCP)											
Jewell James R Md	Practitioner - Primary Care Provider (PCP)											
Woglom Russell C Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Floyd Frank Daniel Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Simcoe James Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Galatzan Russell E Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Skezas Jacob W Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Cruz John Norbert Md	Practitioner - Primary Care Provider (PCP)											
Stevanovic Radomir Md	Practitioner - Primary Care Provider (PCP)	✓					✓					
Lambert John Y Iii Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Margie Iii Walter E Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Crepet Ruth Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Mauer Mark William Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Rao Mukesh G Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓			✓			✓
Choi Susan Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Bailey-Kunte Jemma	Practitioner - Primary Care Provider (PCP)											

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* Safety Net Providers in Green

Participating in Projects												
Provider Name	**Provider Category**	**2.a.i**	**2.b.iv**	**2.b.vii**	**2.c.i**	**2.d.i**	**3.a.i**	**3.a.ii**	**3.b.i**	**3.g.i**	**4.a.iii**	**4.b.ii**
Mateya Louis P Jr Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Young Daniel M Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓	✓					
Ho Elizabeth T F Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Gustafson Thomas R Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Wilson Christine Behling Do	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Clark Peter David	Practitioner - Primary Care Provider (PCP)	✓	✓									
Law Adam Md	Practitioner - Primary Care Provider (PCP)	✓										
Crosby James Theo Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓	✓					
Skiff James M Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Spaulding Stephen Arthur Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Weinberg Janet L Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Murphy Michael F Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Singh Jagmohan Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Phillips Eric C Md	Practitioner - Primary Care Provider (PCP)											
Ziegler Sharon Lynn Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Yaeger Thomas A Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Ryan Christopher W Md	Practitioner - Primary Care Provider (PCP)											
Phykitt Donald Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Sendek Janusz Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Nayo Eunice Yaafio Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Powell Marita Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓	✓					
Shrivastava Amitabh	Practitioner - Primary Care Provider (PCP)	✓	✓									
Meneses Robert P Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Snedeker Jeffrey David Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Wacendak John W Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓	✓					
Malavet Angel L Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Serrano De Malavet Janette Md	Practitioner - Primary Care Provider (PCP)											
Eder Frank Steven Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Fathalla Mahmoud F Md	Practitioner - Primary Care Provider (PCP)											
Hinterberger Joseph W Md	Practitioner - Primary Care Provider (PCP)											
Zhang Michael Yu	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						

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Ward Anna Marie Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Jimenez Domingo D Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓	✓					
Konefal Tanya	Practitioner - Primary Care Provider (PCP)											
Estill Matthew Reilly Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Howson Mary Frances Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Javid Ahmad	Practitioner - Primary Care Provider (PCP)	✓	✓			✓	✓					
Harper Yusuf	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Loehr James Christopher Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
White Cherilyn Anne Md	Practitioner - Primary Care Provider (PCP)	✓	✓			✓	✓					
Kwiatkowski David E Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Lewis Paulette V Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Gordon Cindy Md	Practitioner - Primary Care Provider (PCP)											
Silcoff Howard W Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Talati Kiran A Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓			✓			✓
Gromniak Suzanne M	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Ali Nadifa Abdi Md	Practitioner - Primary Care Provider (PCP)											
Nulton Michelle Ann	Practitioner - Primary Care Provider (PCP)											
Abueg Renato A Md	Practitioner - Primary Care Provider (PCP)											
Sharma Ram Charitra Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Lord Amy Elizabeth	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Van Doren Clay J Do	Practitioner - Primary Care Provider (PCP)											
Freeman Michael Jay Do	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Fox Stanley	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Rule Jennifer	Practitioner - Primary Care Provider (PCP)											
Howard Jean Pierson	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓			✓			✓
Saber Kendall M	Practitioner - Primary Care Provider (PCP)											
Steinberg Joshua D Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓	✓					
Freeman Denise Ann Do	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Desilva Audrey H Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Alkhouri Hani Md	Practitioner - Primary Care Provider (PCP)											
Guizano Emmanuel M Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						

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Djafari Mohammad	Practitioner - Primary Care Provider (PCP)	✓			✓						✓	
Mccauley Maura C Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Pendell-Mckee Judy	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Harpst Lisa Lynnelle Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Corey Mark J Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Spaulding Theresa A Md	Practitioner - Primary Care Provider (PCP)											
Zarzecki Cathy	Practitioner - Primary Care Provider (PCP)	✓	✓			✓	✓					
Galyanova Valentina	Practitioner - Primary Care Provider (PCP)	✓	✓									
Whelan Karen A	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓			✓			✓
Hallinan Kathleen Ann Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Mohyuddin Aliasghar Md	Practitioner - Primary Care Provider (PCP)											
Guizano Melissa Tamondong Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Yu Hong Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓			✓			✓
Williams David Dea Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Steinberg Esther Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
La Face Karen Marie Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Jones Cynthia Blair Md	Practitioner - Primary Care Provider (PCP)											
Monaghan Viola Peachey Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Deguardi Mary C Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Speicher Mark P Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Scott Roger Edward Md	Practitioner - Primary Care Provider (PCP)	✓	✓			✓						
Darlow Lloyd Alan Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Doty John Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Aranda Arvin Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓			✓			✓
Florini Marita A	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓			✓			✓
Sandway David Charles	Practitioner - Primary Care Provider (PCP)											
Khan Rowshanul Islam Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Mead John-Paul D Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Blegen Michelle P Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Jayasena Rohan Senerat Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Alley John A Md	Practitioner - Primary Care Provider (PCP)	✓	✓									

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Davydov Valentina Do	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Kuntz Bruce L Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Bradshaw John A Md	Practitioner - Primary Care Provider (PCP)											
Bradshaw Suzanne M Md	Practitioner - Primary Care Provider (PCP)											
Stein Susan	Practitioner - Primary Care Provider (PCP)											
Torrado Andrea Gonzalez Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Casey Jessica L Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Galu Maria Gabriela Livia Md	Practitioner - Primary Care Provider (PCP)											
Bambara Julie Ann	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓	✓					
Barnes Julie A	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Brozovic Barbara	Practitioner - Primary Care Provider (PCP)											
Hadwin Jeannette	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓			✓			✓
Mcphee Maureen Np	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Spielman Connie L	Practitioner - Primary Care Provider (PCP)											
Stank Holli	Practitioner - Primary Care Provider (PCP)											
Elsisi Amr M Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Jander Lucia Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Butt Mahmood	Practitioner - Primary Care Provider (PCP)											
Weston John W Do	Practitioner - Primary Care Provider (PCP)											
Szabo Andras Md	Practitioner - Primary Care Provider (PCP)	✓	✓			✓						
Tao Sue Hong Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Solomon Sarra Gwyn Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Cooke John David Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Choi Mike Joon Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Stradley Shelly Lynn	Practitioner - Primary Care Provider (PCP)											
Wold Kathleen J	Practitioner - Primary Care Provider (PCP)											
Davydov Vadim Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Anis Uzma Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓			✓			✓
Gardner Donna L	Practitioner - Primary Care Provider (PCP)											
O'Shae Marne Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Klein Eleanor Christine	Practitioner - Primary Care Provider (PCP)	✓	✓			✓	✓					

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Stormann Nita J	Practitioner - Primary Care Provider (PCP)											
Fitzgerald Kathleen J	Practitioner - Primary Care Provider (PCP)											
Franzese-Lynch Vallerie	Practitioner - Primary Care Provider (PCP)	✓	✓									
Coleman James Patrick Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Prabhu Sheela Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Mcclelland Robert Thomas Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Ingerick Brent S Do	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Chapman Alla Grigorevna Md	Practitioner - Primary Care Provider (PCP)											
Samodal Rodrigo T Jr Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Mirza Victoria Miruna Md	Practitioner - Primary Care Provider (PCP)											
Gray Jeffrey R Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Moussallem Charbel Georges	Practitioner - Primary Care Provider (PCP)	✓	✓									
Weiner Jamie S Md	Practitioner - Primary Care Provider (PCP)											
Rahner Douglas A Md	Practitioner - Primary Care Provider (PCP)	✓	✓			✓	✓					
El Ghissassi Mostafa	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Shady Amr Ali Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Lawyer Dawn Catherine Np	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Williams Marie A Np	Practitioner - Primary Care Provider (PCP)											
Pichette Carey Marie Np	Practitioner - Primary Care Provider (PCP)											
Schlaen Brenda-Roxana Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Berg Richard E Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓			✓			✓
Naik Dhruti Md	Practitioner - Primary Care Provider (PCP)											
Moukala-Cadet Anne-Marie L Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Jayaraman Venkatesh B	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓			✓			✓
Meyers Lee C Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Little Ryan Daniel Np	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Malik Shahid Nasir Md	Practitioner - Primary Care Provider (PCP)											
Zarrini Hossein Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Gutman Alan J Rpa	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Kelly Ann Butler Family Nurse	Practitioner - Primary Care Provider (PCP)											
Scarseth Stephen Clive	Practitioner - Primary Care Provider (PCP)											

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Crispell Carolyn D.O.	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Fucito Christopher D Do	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Anderson Susan C Rpa	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Baker Wallace	Practitioner - Primary Care Provider (PCP)											
Sarmast Farzad Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Robert Lawrence Averbach	Practitioner - Primary Care Provider (PCP)											
Barreto Mark Anthony Md	Practitioner - Primary Care Provider (PCP)											
Stalter Stacey	Practitioner - Primary Care Provider (PCP)											
Mikloucich Cori L Do	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓			✓			✓
Bhandari Jacqueline	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Westervelt Megan Md	Practitioner - Primary Care Provider (PCP)											
Hodder Heidi Rose Do	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Desai Vikas	Practitioner - Primary Care Provider (PCP)											
Cummings Kristina Mae Md	Practitioner - Primary Care Provider (PCP)	✓	✓									
Perle Kristine Ellen Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Speicher Joanne Elizabeth	Practitioner - Primary Care Provider (PCP)	✓	✓			✓	✓					
Shawn Patrick Emmons	Practitioner - Primary Care Provider (PCP)											
Debra Lyn Paxton	Practitioner - Primary Care Provider (PCP)											
Chowdhury Nazif Ahmed	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Rajaram Aswini	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Silva Lourdes G	Practitioner - Primary Care Provider (PCP)											
Palakkumar K Patel Md	Practitioner - Primary Care Provider (PCP)											
Skiadas Melissa Erin	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Cotton Elisabeth	Practitioner - Primary Care Provider (PCP)	✓	✓									
Cregan Kathleen Ann	Practitioner - Primary Care Provider (PCP)											
Odife Amechi Valentine Jr Md	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Gasparis Demetrios Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Maklad Safa A	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓	✓					
Sean Patrick Holdridge	Practitioner - Primary Care Provider (PCP)											
Ponticiello Jacqueline Ann	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Kissi Harry	Practitioner - Primary Care Provider (PCP)											

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Mohammed Rashedul Mowla	Practitioner - Primary Care Provider (PCP)											
Daniel F Karn	Practitioner - Primary Care Provider (PCP)	✓	✓			✓	✓					
Maygoe Richard Sheehan	Practitioner - Primary Care Provider (PCP)											
Button Sue Ellen	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Tsay Theresia	Practitioner - Primary Care Provider (PCP)											
Converse Susan Marie	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Saks Benjamin Joseph	Practitioner - Primary Care Provider (PCP)	✓	✓									
Manek Megha Bharat	Practitioner - Primary Care Provider (PCP)											
Rosman Scott R	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓	✓					
Dzmitryieu Aliaksandr	Practitioner - Primary Care Provider (PCP)											
Asgher Shoaib	Practitioner - Primary Care Provider (PCP)											
Hassan Humaira	Practitioner - Primary Care Provider (PCP)	✓	✓									
Holmes Katherine M Md	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓	✓					
Drilon Michelle Ann	Practitioner - Primary Care Provider (PCP)											
Pero Amanda R	Practitioner - Primary Care Provider (PCP)											
Ashley Marie Havtur	Practitioner - Primary Care Provider (PCP)											
Chen Yong	Practitioner - Primary Care Provider (PCP)											
Mclaughlin Jennifer Theresa	Practitioner - Primary Care Provider (PCP)											
Welch John Jr Do	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓			✓			✓
Meikle Robert W	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Baba Michael John	Practitioner - Primary Care Provider (PCP)											
Bertini John Nicholas	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Hoag Andrea Denise	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Bista Sukirti	Practitioner - Primary Care Provider (PCP)											
Corpora Cara L	Practitioner - Primary Care Provider (PCP)											
Yia Mary	Practitioner - Primary Care Provider (PCP)											
Rosato Elizabeth Ann	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Grant Kate A	Practitioner - Primary Care Provider (PCP)											
Attia Maximos Nabil Youssef	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Bertini Maria T	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Rooth Kathryn Marie	Practitioner - Primary Care Provider (PCP)	✓	✓									

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Koicke Betsy C	Practitioner - Primary Care Provider (PCP)											
Santoro Katherine Elizabeth	Practitioner - Primary Care Provider (PCP)											
Zeykan Violeta	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Hoover Derrick J	Practitioner - Primary Care Provider (PCP)											
Hummer Kristina	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Kohn Daniel Michael	Practitioner - Primary Care Provider (PCP)											
Teng Ann Y	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Leeson Thomas A	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Laing Meghan Marie	Practitioner - Primary Care Provider (PCP)	✓	✓		✓	✓						
Resurreccion I Am Panlilio	Practitioner - Primary Care Provider (PCP)											
Harris Timothy Carr	Practitioner - Primary Care Provider (PCP)	✓	✓									
Mccaffrey Jennifer B	Practitioner - Primary Care Provider (PCP)											
Sopchak Mason Michael	Practitioner - Primary Care Provider (PCP)	✓	✓									
Das Sujata	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Peralta Edelweiss De Perio	Practitioner - Primary Care Provider (PCP)											
Ibrahim Mohammed U	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Grant Norie	Practitioner - Primary Care Provider (PCP)											
Gillan Michael Fredric	Practitioner - Primary Care Provider (PCP)	✓	✓						✓	✓	✓	
Rosato Susan	Practitioner - Primary Care Provider (PCP)											
Olarewaju Temitope O	Practitioner - Primary Care Provider (PCP)	✓	✓			✓	✓					
Devine Donna	Practitioner - Primary Care Provider (PCP)											
Saylor Karen E	Practitioner - Primary Care Provider (PCP)											
Hinkson Michael Colvin Md	Practitioner - Primary Care Provider (PCP)											
Dobrydney Rosemarie F Np	Practitioner - Primary Care Provider (PCP)											
Wu Richard Hk Md	Practitioner - Non-Primary Care Provider (PCP)											
Ahmed Syed Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Bishop Ralph M	Practitioner - Non-Primary Care Provider (PCP)											
Pareek Natwar K Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Good Vance Ariel	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Matta Isaac I Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Blood Joseph Belten Md Jr	Practitioner - Non-Primary Care Provider (PCP)											

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Hammoud Walid S Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Mc Nerney James Edward Dpm	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Kilgore Carl Judson Md Pc	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Kreps Edward Michael Md	Practitioner - Non-Primary Care Provider (PCP)											
Major Leslie F Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Lessinger Eric Md	Practitioner - Non-Primary Care Provider (PCP)											
Lempert Philip Pc Md	Practitioner - Non-Primary Care Provider (PCP)											
Ong Ling S Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Weis John Harold Do	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Rubinstein Elliot Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Fras Ivan Md	Practitioner - Non-Primary Care Provider (PCP)											
Bylebyl Joseph Karol Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Pejo Samuel P Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Dave Rajesh J Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Devine Terence M Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Diab Wadih Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Sienkiewicz Genadij Md Pc	Practitioner - Non-Primary Care Provider (PCP)											
Baron Richard John Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Nash Donald W Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Stackman Jody Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Dugan Dirk H Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Tolhurst Kirk Duncan Md	Practitioner - Non-Primary Care Provider (PCP)											
Kardon Fredric M Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Lax Theodore Dds	Practitioner - Non-Primary Care Provider (PCP)											
Della Valle James Md	Practitioner - Non-Primary Care Provider (PCP)											
Pacheco Jose M Md	Practitioner - Non-Primary Care Provider (PCP)											
Husseini Sami T Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Rouse Steven Bryan Md	Practitioner - Non-Primary Care Provider (PCP)											
Hussain Ahmed Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Ghassem Mangouri Md	Practitioner - Non-Primary Care Provider (PCP)											
Bluh Donald G Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									

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Kacyrat Jamal Md	Practitioner - Non-Primary Care Provider (PCP)											
Antos John Michael Md	Practitioner - Non-Primary Care Provider (PCP)											
Sweet John Paul Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Lee Ferrol Joseph Md	Practitioner - Non-Primary Care Provider (PCP)											
King Joseph Tak-Pun	Practitioner - Non-Primary Care Provider (PCP)											
Lee Rachel D Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Prasad Srinivasa Br Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Johnson Maryellen Rn	Practitioner - Non-Primary Care Provider (PCP)											
Schreck Michael J Md	Practitioner - Non-Primary Care Provider (PCP)											
Mitchell Robert Louis Mdpc	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Kassis Iskandar Ilvas Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Todd Jeffrey Andrew Dpm	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Warski Patricia Lynn Dpm	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Hesson Robert A Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Zakariyya Hasan Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓						
Ronan Peter Graham Md	Practitioner - Non-Primary Care Provider (PCP)											
Nancy B Stewart	Practitioner - Non-Primary Care Provider (PCP)											
Brennan Peter Terence Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Skeist Barry P Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Colas Craig Stanley Dds	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Hudock Michael J Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Howland Timothy C Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Fenlon Christine H Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						✓
Santa-Ines Carlos P Md	Practitioner - Non-Primary Care Provider (PCP)											
Yousuf Mohammad Bashar Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						✓
Lofaso Liliana Md	Practitioner - Non-Primary Care Provider (PCP)											
Webb Paul R 111 Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Endo Lawrence Paul Md	Practitioner - Non-Primary Care Provider (PCP)											
Naman Safa K Md	Practitioner - Non-Primary Care Provider (PCP)											
Jannetti Raymond A Md	Practitioner - Non-Primary Care Provider (PCP)											
Feldshuh David Mark Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									

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Shenker David Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Perenyi Dennis Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Hudock Stephen Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Gillott Anthony R Md	Practitioner - Non-Primary Care Provider (PCP)											
Appleton Abraham Theodore	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Johnson Glen C Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Meyer Stephen Jay Do	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Ferrer Guillermo	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Shumeyko Nancy Keller Md	Practitioner - Non-Primary Care Provider (PCP)											
Martines Richard Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Georgetson Michael J Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Stiles Stuart Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Werner Harry R Do	Practitioner - Non-Primary Care Provider (PCP)											
Bezirganian John B Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Spavento Perry J Md	Practitioner - Non-Primary Care Provider (PCP)											
Mcdonald Thomas John Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Brown Daniel J Md	Practitioner - Non-Primary Care Provider (PCP)											
Immerman Marc Md	Practitioner - Non-Primary Care Provider (PCP)											
Connor Barbara J Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Kim Jin Bai Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						✓
Mccann Joseph Thomas Phd	Practitioner - Non-Primary Care Provider (PCP)											
Kashou Hisham Emile Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Mcdonald Lester Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Reimann George J Md	Practitioner - Non-Primary Care Provider (PCP)											
Fedczuk Bohdan P Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Holland Sandra Joan Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓						
Gacioch Gerald Matthew Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
O Connor Thomas P Md Pc	Practitioner - Non-Primary Care Provider (PCP)											
Deshmukh Pramod Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Cole Frank C Iii Md	Practitioner - Non-Primary Care Provider (PCP)											
Homan Mal R Md	Practitioner - Non-Primary Care Provider (PCP)											

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Massi Anthony Frank Md	Practitioner - Non-Primary Care Provider (PCP)											
Wiseman Jeffrey Scott	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Wiseman Barbara L Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Stuver Thomas Paul Md	Practitioner - Non-Primary Care Provider (PCP)											
Marino Paul Lawrence Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Doroghazi Paul M Md	Practitioner - Non-Primary Care Provider (PCP)											
Sporn Daniel P Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Bleiler Brian Eugene Od	Practitioner - Non-Primary Care Provider (PCP)											
Wong Kenneth T Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						✓
Steckline Kevin	Practitioner - Non-Primary Care Provider (PCP)											
Downing Margaret Apellaniz	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓						
Dumont Karen M Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Jones Thomas Richard	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Giangrieco Maureen A	Practitioner - Non-Primary Care Provider (PCP)											
Murray Richard W Md	Practitioner - Non-Primary Care Provider (PCP)											
Stevens John B	Practitioner - Non-Primary Care Provider (PCP)											
Bradstreet Richard Perry Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Walsh James J Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Erney Stanley L Md	Practitioner - Non-Primary Care Provider (PCP)											
Gaffney James Shannon Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Schwed David A Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Fellows David G Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Walker Steven R	Practitioner - Non-Primary Care Provider (PCP)											
Lockard John W Jr Md	Practitioner - Non-Primary Care Provider (PCP)											
Muhich Janet E Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Garbo Charles L Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Jones Denis M A Md	Practitioner - Non-Primary Care Provider (PCP)											
Boudreau William J Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Ellis George L Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Naman Maysoon A Md	Practitioner - Non-Primary Care Provider (PCP)											
Talenti David A Md	Practitioner - Non-Primary Care Provider (PCP)											

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Anderson Leonard S Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Swisher Lynn Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Smoolca Mary Ellen Dpm	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Bellina Daniel P Md	Practitioner - Non-Primary Care Provider (PCP)											
Arleo Robert Joseph	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Snyder Christine Rpa	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						✓
Monacelli David M Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Allen Richard L Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Cator Polly Ann Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓						
Carroll William Joseph Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Obrien James K Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Mauser Jonathan Frank Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Sacks Ronald H Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Joy Christopher R Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Sampson Lawrence Nathan Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Gelber Steven Andrew Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Toal Thomas M Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Hwang Kim S Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Garg Vinod K Md	Practitioner - Non-Primary Care Provider (PCP)											
Amaye-Obu Fons Alex Md	Practitioner - Non-Primary Care Provider (PCP)											
Rigotti Richard M Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
West Carl G Md	Practitioner - Non-Primary Care Provider (PCP)											
Tashman John S Md	Practitioner - Non-Primary Care Provider (PCP)											
Sacco-Bedosky Teresa Ann	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Andres Christopher D Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Hennessey Michael Shannon Md	Practitioner - Non-Primary Care Provider (PCP)											
Martinez David Gregg Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Raftis James R Do	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Suarez Paul Adrien Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Yoon Serene Hanee Md	Practitioner - Non-Primary Care Provider (PCP)											
Pfisterer David Alan Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	

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Farrell Dina	Practitioner - Non-Primary Care Provider (PCP)											
Foster Cora Lee Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Farrell Michael Joseph Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						✓
Settineri Marc Henri Md	Practitioner - Non-Primary Care Provider (PCP)											
Rogers Steven Alan Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Morpurgo Andrew J Md Pc	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Corey Timothy James Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Peter Schwartz Md Pllc	Practitioner - Non-Primary Care Provider (PCP)											
Klufas Christina Irene Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Vohra Sanjeev Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Warner Deborah	Practitioner - Non-Primary Care Provider (PCP)											
Ruparella Ashutosh Harish Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Yee Medicine & Pediatric Asso	Practitioner - Non-Primary Care Provider (PCP)											
Gordon Peter Eliot Md	Practitioner - Non-Primary Care Provider (PCP)											
Hossain Azhar Md	Practitioner - Non-Primary Care Provider (PCP)											
Wilson Thomas William Md	Practitioner - Non-Primary Care Provider (PCP)											
Petkov Theodore Michael Md	Practitioner - Non-Primary Care Provider (PCP)											
Sanito Anthony Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Heidelberger Sara Marie	Practitioner - Non-Primary Care Provider (PCP)											
Smith Christopher Allan Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓						
Burt Mattison A Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Deutsch Frederick	Practitioner - Non-Primary Care Provider (PCP)											
Barrett Michael W Md	Practitioner - Non-Primary Care Provider (PCP)											
Zevan John Peter Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Gomez Stephen Dominic Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Adusei Kwame A Md	Practitioner - Non-Primary Care Provider (PCP)											
Weinraub Jennifer Freda Md	Practitioner - Non-Primary Care Provider (PCP)											
Mcginn Raymond Joseph	Practitioner - Non-Primary Care Provider (PCP)											
Brown Deryck W S Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Herbst Lee J Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Strominger Robert N Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									

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Domke Robert M Md	Practitioner - Non-Primary Care Provider (PCP)											
Moheimani Christopher H Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓						
Vandermeer Thomas J Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Gregorie Erik Martin Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Nichols Shari Lou Dpm	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Baldauf-Madero Sharon Diane	Practitioner - Non-Primary Care Provider (PCP)											
Martynik Michael J Md	Practitioner - Non-Primary Care Provider (PCP)											
Brightman Janice Ada Tormey	Practitioner - Non-Primary Care Provider (PCP)											
Ovedovitz Lon A Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Raman Sucharita Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Schotanus Peter	Practitioner - Non-Primary Care Provider (PCP)											
Wattoo Muhammad A Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Cannon Kathleen Ann	Practitioner - Non-Primary Care Provider (PCP)											
Porter Burdett Roy Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Singh Amit Kumar	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Roach Stephanie Susan Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Hodgeman Paul D	Practitioner - Non-Primary Care Provider (PCP)											
Aronis Michael Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Davidenko Jorge Mario Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓						
Onysko Melodye Elaine Cnm	Practitioner - Non-Primary Care Provider (PCP)											
Liauw Sun Hua Md P C	Practitioner - Non-Primary Care Provider (PCP)											
Ruchames Robert	Practitioner - Non-Primary Care Provider (PCP)											
Rozum Bozena Slota Md	Practitioner - Non-Primary Care Provider (PCP)											
Snyder Lisa Simonetta	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓						
Cowdery Susan Richardson Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Kantor Walter John Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Lodi Yahia M Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Cetton Gregory Md	Practitioner - Non-Primary Care Provider (PCP)											
Brennan Mark Joseph Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Monticello Vicki C	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Getzin Andrew	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									

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Newman James Paul Do	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓						
Grella Beth Ann	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓						
Mannino Joseph Andrew Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Brand Malcolm Douglas Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Rubin John Do	Practitioner - Non-Primary Care Provider (PCP)											
Milner Dvorah Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Cagir Burt Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Vertino Michael L Md	Practitioner - Non-Primary Care Provider (PCP)											
Larson Robert Md	Practitioner - Non-Primary Care Provider (PCP)											
Steinmetz James Robert Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Borra Mary Ann Cnm	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓						
Darling Michael James Ddm	Practitioner - Non-Primary Care Provider (PCP)											
Norton J Russell Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Waldron Jennifer Ann	Practitioner - Non-Primary Care Provider (PCP)											
Tillotson Rebecca Rpa	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Atkins Christine Np	Practitioner - Non-Primary Care Provider (PCP)											
Williams Stephanie	Practitioner - Non-Primary Care Provider (PCP)											
Chivate Vandanamd	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Longacre Helene C Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Stapleton Dwight D Md	Practitioner - Non-Primary Care Provider (PCP)											
Koh Han Suk Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Kadlecik Jeffrey Pinkney Dpm	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Harris Marc S Do	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Torrado Jose A Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
O'Neill Allison	Practitioner - Non-Primary Care Provider (PCP)											
Wolsh Loren	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Reynolds Robert Michael Rpac	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Barton Victoria	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Sands Melony S Rpa	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓						
Rosenstein Jerome H Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						✓
Srivatana Ukorn Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	

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Higgins Julie Janeen Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Darling James Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Wiesner Lawrence Martin Do	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Ronald Michael R	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Roche Timothy Scott Do	Practitioner - Non-Primary Care Provider (PCP)											
Mughal Shakid Ahmed Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Mecenas John A Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Morales Romeo E Md	Practitioner - Non-Primary Care Provider (PCP)											
Pollack Barry Jay Md	Practitioner - Non-Primary Care Provider (PCP)											
Schaff Justine Lara Md	Practitioner - Non-Primary Care Provider (PCP)											
Hatch Karen Marie	Practitioner - Non-Primary Care Provider (PCP)											
Goodwin Stephanie Luette Do	Practitioner - Non-Primary Care Provider (PCP)											
Schwartz Jerrold Paul Md	Practitioner - Non-Primary Care Provider (PCP)											
Komatinsky Paul J	Practitioner - Non-Primary Care Provider (PCP)											
Aleccia Dorene A	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Bidwell Frances C Np	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Naughton Connie A	Practitioner - Non-Primary Care Provider (PCP)											
Olbrys Kathleen M	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Sabahat Ashraf Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Shah Ashokkumar R Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Bretz Gregory J Rpa	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Landsberg David Mitchell Md	Practitioner - Non-Primary Care Provider (PCP)											
Medical Pain Consultant Osteopathy	Practitioner - Non-Primary Care Provider (PCP)											
Grausgruber Anne Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Devapatla Srisatich Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Venkatesh Govindarajan Md	Practitioner - Non-Primary Care Provider (PCP)											
Burger Tamara Cnm	Practitioner - Non-Primary Care Provider (PCP)											
Corrigan Devlyn Lee Md	Practitioner - Non-Primary Care Provider (PCP)											
Gonzalez Adrian Michael	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Lee Sally S Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Solis Rosa A Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						

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Marte Juan M Md	Practitioner - Non-Primary Care Provider (PCP)											
Potochniak Vickie L Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Abdo Moufid J H Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Consolazio Anthony Jr Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Chaudhary Sumblina Aslam	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Brunt Joseph	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Finkelstein Arthur J Pt	Practitioner - Non-Primary Care Provider (PCP)											
Lorman Kathryn A	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Jewett Susan E	Practitioner - Non-Primary Care Provider (PCP)											
Reynolds Dermot M Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Davuluri Chaudhury D K	Practitioner - Non-Primary Care Provider (PCP)											
Martin Tamara L Rpa	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Lowry Philip A Md	Practitioner - Non-Primary Care Provider (PCP)											
Thibault Melissa Wei Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Barton Michael	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Birman George Dds	Practitioner - Non-Primary Care Provider (PCP)											
Ward April E Cnm	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓						
Van Every Monica Md	Practitioner - Non-Primary Care Provider (PCP)											
Sudilovsky Daniel Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Duplan Auguste Lytton Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Downs Daniel M Md	Practitioner - Non-Primary Care Provider (PCP)											
Maghaydah Qutaybeh S Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Factourovich Alexander Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Patel Ketan Arvindbhai Md	Practitioner - Non-Primary Care Provider (PCP)											
Clark Jennifer R Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Factourovich Inna Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Alvi Nisar Ahmed Md	Practitioner - Non-Primary Care Provider (PCP)											
Rees Russell E Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Rao Rajesh S K Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
De Jong Alida A	Practitioner - Non-Primary Care Provider (PCP)											
Lubell Richard R Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	

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Lopiccolo Beth A Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Poole Kimberlie A	Practitioner - Non-Primary Care Provider (PCP)											
Al-Khalidi Omar Farouq Md	Practitioner - Non-Primary Care Provider (PCP)											
Santa Ines Carlos Jr Md	Practitioner - Non-Primary Care Provider (PCP)											
Mccarthy Beth Anne	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Quasem Mohammad Abul	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						✓
Stewart Michele L	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Humayun Naeem U	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓						
Bael Timothy E Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
D'Angelo Aspen Lee Rpa	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Cryer Jonathan Eric	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Khibkin Yuri Md	Practitioner - Non-Primary Care Provider (PCP)											
Silbert Walter Coleman	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Mcnairn Julie Dk Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Reilly Tracey H Md	Practitioner - Non-Primary Care Provider (PCP)											
Tan Beng Jit Md	Practitioner - Non-Primary Care Provider (PCP)											
Burkett Russell Ephraim Do	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Lakin Rose Rpa	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Gardner Kathleen Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Norville Kim J Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
David Henry Edward Do	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓						
Burpee Charles Alan Pt	Practitioner - Non-Primary Care Provider (PCP)											
Magai Colleen S Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Lemberg Brent Davis Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Khan Mahmud Md	Practitioner - Non-Primary Care Provider (PCP)											
Barbis Andrea Mari Lcsw	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓	✓					
Barnes Charles R Rpa	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Haq Rashid Ul Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Anne Nirupama Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Gerson Henry David	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Burkert Erica Zilles	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						

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Crispell Jane	Practitioner - Non-Primary Care Provider (PCP)											
Olmstead Sam	Practitioner - Non-Primary Care Provider (PCP)											
Bollinger Wade S Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Sheriff-White Phyllis Md	Practitioner - Non-Primary Care Provider (PCP)											
Magargee Mariah Md	Practitioner - Non-Primary Care Provider (PCP)											
Kumar Manoj Koyamparambath Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓						
Michalovic Doris	Practitioner - Non-Primary Care Provider (PCP)											
Kerner Cheryl R Np	Practitioner - Non-Primary Care Provider (PCP)											
El-Kassis Liliane Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Hohn Magdalena D Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Rendano Laura Joyce	Practitioner - Non-Primary Care Provider (PCP)											
Ogembo Jane A Dds	Practitioner - Non-Primary Care Provider (PCP)											
Cheema Taseer A Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓						
Walsh Sarah	Practitioner - Non-Primary Care Provider (PCP)											
Sainez Juana Arcelia Md	Practitioner - Non-Primary Care Provider (PCP)											
Andrews Judy A Rpa	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Lambert Robert Arthur Md	Practitioner - Non-Primary Care Provider (PCP)											
Makayan Michael Acesor Md	Practitioner - Non-Primary Care Provider (PCP)											
Wilhelm Olayinka Olawale Md	Practitioner - Non-Primary Care Provider (PCP)											
Castro Stella M Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Latorre Julius Gene Silva Md	Practitioner - Non-Primary Care Provider (PCP)											
Yue Gang Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Joseph Jason Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Wang Xiu-Jie Md	Practitioner - Non-Primary Care Provider (PCP)											
Hannon Peter Md	Practitioner - Non-Primary Care Provider (PCP)											
Flanagan Joseph William	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Mitchell Patricia Anne	Practitioner - Non-Primary Care Provider (PCP)											
Ziad Mk El Zammar Md	Practitioner - Non-Primary Care Provider (PCP)											
Cook Henry Neal	Practitioner - Non-Primary Care Provider (PCP)											
Koch Drew	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Keating Catherine I	Practitioner - Non-Primary Care Provider (PCP)											

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Pisani Carrie Anne Rpa	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Brightsen Anne	Practitioner - Non-Primary Care Provider (PCP)											
Chase Terri	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Paula Fitzsimmons Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Novak Matthew J	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Adnan Mirza	Practitioner - Non-Primary Care Provider (PCP)											
Hsu Antony Po-Yu Md	Practitioner - Non-Primary Care Provider (PCP)											
Shepherd William Charles Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Thomas Nelson Osborne	Practitioner - Non-Primary Care Provider (PCP)											
Loomis Lisa	Practitioner - Non-Primary Care Provider (PCP)											
Jones Kathleen	Practitioner - Non-Primary Care Provider (PCP)											
Smith Janelle	Practitioner - Non-Primary Care Provider (PCP)											
Yang Chunjie	Practitioner - Non-Primary Care Provider (PCP)											
Shapiro Oleg Md	Practitioner - Non-Primary Care Provider (PCP)											
Hussain Anwar Ahmed Md	Practitioner - Non-Primary Care Provider (PCP)											
Jones Kara E Np	Practitioner - Non-Primary Care Provider (PCP)											
Stepanyan Hasmik Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Rubin Hyman	Practitioner - Non-Primary Care Provider (PCP)											
Sana Wajeeh	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Smith Melissa Margaret	Practitioner - Non-Primary Care Provider (PCP)											
Wolslau Hans Johann Do	Practitioner - Non-Primary Care Provider (PCP)											
Vanburen Morgan Joy Md	Practitioner - Non-Primary Care Provider (PCP)											
Jennifer Y Sweet	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Oteng-Bediak0 Evelyn Md	Practitioner - Non-Primary Care Provider (PCP)											
Adam T Campbell	Practitioner - Non-Primary Care Provider (PCP)											
Courtney L Ross	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Gray Mindi Anne	Practitioner - Non-Primary Care Provider (PCP)											
Granet Paul Jason Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Nelson Patricia Joan Rpa	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Silviu Catalin Marica	Practitioner - Non-Primary Care Provider (PCP)											
Matibag Jose Antonio Md	Practitioner - Non-Primary Care Provider (PCP)											

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Terwilliger Susan Harford Np	Practitioner - Non-Primary Care Provider (PCP)											
Bradley Walter Lash	Practitioner - Non-Primary Care Provider (PCP)											
Boyle Michael F Md	Practitioner - Non-Primary Care Provider (PCP)											
Rahman Nataliya	Practitioner - Non-Primary Care Provider (PCP)											
Joseph Pisani	Practitioner - Non-Primary Care Provider (PCP)											
Stallone Martin	Practitioner - Non-Primary Care Provider (PCP)											
Kozarski Tzvetan	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Corrigan Frank John	Practitioner - Non-Primary Care Provider (PCP)											
Castetter Lisa	Practitioner - Non-Primary Care Provider (PCP)											
Mcdermott Brian	Practitioner - Non-Primary Care Provider (PCP)											
Sholar Lisa	Practitioner - Non-Primary Care Provider (PCP)											
Argiro Salvatore	Practitioner - Non-Primary Care Provider (PCP)											
Clune Jenniferleigh Vonderhorst	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓						
Joseph Mwesige Md	Practitioner - Non-Primary Care Provider (PCP)											
Brian Peter Bollo	Practitioner - Non-Primary Care Provider (PCP)											
Smith Stacy L	Practitioner - Non-Primary Care Provider (PCP)											
Page Cathy Marie	Practitioner - Non-Primary Care Provider (PCP)											
Albro Sheri	Practitioner - Non-Primary Care Provider (PCP)											
Brathwaite Jillene	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
John Vijaya Kumar Pamula	Practitioner - Non-Primary Care Provider (PCP)											
Chanko Eric H	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Mcallister Josephine Chu	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Dietzman Brett Andrew	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						✓
Steven Sattler	Practitioner - Non-Primary Care Provider (PCP)											
Joseph Young Choi	Practitioner - Non-Primary Care Provider (PCP)											
Gaonkar Nelima Wood	Practitioner - Non-Primary Care Provider (PCP)											
Hameed Noumana	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Tiffany J Gates-Maby	Practitioner - Non-Primary Care Provider (PCP)											
Adam J Ash Do	Practitioner - Non-Primary Care Provider (PCP)											
Mukundan Dds Madhav	Practitioner - Non-Primary Care Provider (PCP)											
Yanusas Christophe	Practitioner - Non-Primary Care Provider (PCP)											

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Andreia Pereira De Lima	Practitioner - Non-Primary Care Provider (PCP)											
Avery Jeffrey Louis	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Peltz Stephanie	Practitioner - Non-Primary Care Provider (PCP)											
D'Achille Laura	Practitioner - Non-Primary Care Provider (PCP)											
Mohrien Kari Lynn	Practitioner - Non-Primary Care Provider (PCP)											
Ahmed Fawzy Md	Practitioner - Non-Primary Care Provider (PCP)											
Brimberg Ronee	Practitioner - Non-Primary Care Provider (PCP)											
Rosenfeld Valerie	Practitioner - Non-Primary Care Provider (PCP)											
Vieux Judy	Practitioner - Non-Primary Care Provider (PCP)											
Argetsinger Dorothy	Practitioner - Non-Primary Care Provider (PCP)											
Sturtevant M	Practitioner - Non-Primary Care Provider (PCP)											
Almanzar Jenny	Practitioner - Non-Primary Care Provider (PCP)											
Vidal Carmen M Dds	Practitioner - Non-Primary Care Provider (PCP)											
Witt Sandra	Practitioner - Non-Primary Care Provider (PCP)											
Mcmahon Matthew John	Practitioner - Non-Primary Care Provider (PCP)											
Lawsing James Fuller Iii	Practitioner - Non-Primary Care Provider (PCP)											
Scianna Christopher Robert Do	Practitioner - Non-Primary Care Provider (PCP)											
Paudel Keshab	Practitioner - Non-Primary Care Provider (PCP)											
Devasenapathy Ashok	Practitioner - Non-Primary Care Provider (PCP)											
Baker Marc Louis	Practitioner - Non-Primary Care Provider (PCP)											
Hassan Joseph George	Practitioner - Non-Primary Care Provider (PCP)											
Clowes Jackie Anne	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Kenhart Nicholas J	Practitioner - Non-Primary Care Provider (PCP)											
Macapinlac Eric Victor Aguas Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Evertsen Nicholas James	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Channin David Samuel Md	Practitioner - Non-Primary Care Provider (PCP)											
Stefek Paul	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Stewart Jessica R	Practitioner - Non-Primary Care Provider (PCP)											
Edmundson Laurel Duphiney	Practitioner - Non-Primary Care Provider (PCP)											
Young Brett Hennerty	Practitioner - Non-Primary Care Provider (PCP)											
Kimberly Carney Young	Practitioner - Non-Primary Care Provider (PCP)											

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Ratnakishore Pallapothu	Practitioner - Non-Primary Care Provider (PCP)											
Tran Vinh Quang	Practitioner - Non-Primary Care Provider (PCP)											
David J Bertsch	Practitioner - Non-Primary Care Provider (PCP)											
Webster Robert Bendana	Practitioner - Non-Primary Care Provider (PCP)											
Ansi K Pillai	Practitioner - Non-Primary Care Provider (PCP)											
Lowrie Ryan Paul	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Verbitskiy Olga	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						✓
Schiavone Michael	Practitioner - Non-Primary Care Provider (PCP)											
Bryan Matthew Burke	Practitioner - Non-Primary Care Provider (PCP)											
Golden James	Practitioner - Non-Primary Care Provider (PCP)											
Devine Sean Thomas	Practitioner - Non-Primary Care Provider (PCP)											
Robinson David	Practitioner - Non-Primary Care Provider (PCP)											
Lynch Cynthia Anne	Practitioner - Non-Primary Care Provider (PCP)											
Mcnerney Catherine	Practitioner - Non-Primary Care Provider (PCP)											
Giordano Elyse Marie	Practitioner - Non-Primary Care Provider (PCP)											
Din Phillip	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓						
Vosseller James	Practitioner - Non-Primary Care Provider (PCP)											
Douglas Jay Taber	Practitioner - Non-Primary Care Provider (PCP)											
Hartman Ricky E	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Oliver Candice M	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Tiyyagura Satish	Practitioner - Non-Primary Care Provider (PCP)											
Chio Agnes Ye-May	Practitioner - Non-Primary Care Provider (PCP)											
Goodman Kevin D	Practitioner - Non-Primary Care Provider (PCP)											
Lawrence Camelia Arlene	Practitioner - Non-Primary Care Provider (PCP)											
Curran Amy	Practitioner - Non-Primary Care Provider (PCP)											
Hinkley Kirk Stephens Iv	Practitioner - Non-Primary Care Provider (PCP)											
Gallagher David Jason Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Kandanati Vivek Vardhan Reddy Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						✓
Bennett Christopher Joseph	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Chung-Hussain Helen K Do	Practitioner - Non-Primary Care Provider (PCP)											
Kim Ryan Maxwell	Practitioner - Non-Primary Care Provider (PCP)											

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Cai Dove	Practitioner - Non-Primary Care Provider (PCP)											
Sabatino Michael Md	Practitioner - Non-Primary Care Provider (PCP)											
Maguire Francis	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Decker Kevin	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Hatala Peter	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Campbell Julie	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Thapa Rupak	Practitioner - Non-Primary Care Provider (PCP)											
Mcfarlane Michelle Aldonsa	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Wilson Suzanne Valerie	Practitioner - Non-Primary Care Provider (PCP)											
Khan Rizwan H	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Wood Brian C Md	Practitioner - Non-Primary Care Provider (PCP)											
Sarker Ashit Baran	Practitioner - Non-Primary Care Provider (PCP)											
Stilwell Mason S	Practitioner - Non-Primary Care Provider (PCP)											
Noreen Ruff	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Bordenet Simone	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Katherine M Rivard	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Benz Mary Barbara	Practitioner - Non-Primary Care Provider (PCP)											
Elias Rony	Practitioner - Non-Primary Care Provider (PCP)											
Wilson Michael	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Moore Ashley N	Practitioner - Non-Primary Care Provider (PCP)											
Jonathan David Brooks	Practitioner - Non-Primary Care Provider (PCP)											
Ross Jenny Ellen	Practitioner - Non-Primary Care Provider (PCP)											
Session Donald	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Bridget Savory	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓	✓					
Page Jessica Lynne	Practitioner - Non-Primary Care Provider (PCP)											
Mandapalli Srinivasa Rao	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Greer Charlene	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Jeannine Dodds	Practitioner - Non-Primary Care Provider (PCP)											
Harrison Marzella J	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Dunn Junius Josephine Martina	Practitioner - Non-Primary Care Provider (PCP)											
Cron Amy Esther	Practitioner - Non-Primary Care Provider (PCP)											

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Giuliana Loo Gallagher	Practitioner - Non-Primary Care Provider (PCP)											
Pellitteri Phillip K	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Baxter Franklin	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Godoy Heidi Erika	Practitioner - Non-Primary Care Provider (PCP)											
Macqueen Douglas D	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Izadyar Shahram	Practitioner - Non-Primary Care Provider (PCP)											
Yang Ming	Practitioner - Non-Primary Care Provider (PCP)											
Argila Charles R	Practitioner - Non-Primary Care Provider (PCP)											
Hoy Erik A	Practitioner - Non-Primary Care Provider (PCP)											
Silva Phaelon Henry	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Zang Douglas Michael	Practitioner - Non-Primary Care Provider (PCP)											
Elliott Steven J	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Carr Brenda Lynn Fnp	Practitioner - Non-Primary Care Provider (PCP)											
Siciliano Michael A	Practitioner - Non-Primary Care Provider (PCP)											
Jayaraman Gayatri	Practitioner - Non-Primary Care Provider (PCP)											
Schamel Patrick B	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Kappel Danielle Tchir	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Belokur Matthew	Practitioner - Non-Primary Care Provider (PCP)											
Smith Jacob W	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Brady Cariann Susan	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Siddiqui Budder	Practitioner - Non-Primary Care Provider (PCP)											
Barvinchak Jamie Marie	Practitioner - Non-Primary Care Provider (PCP)											
Swift Robert D	Practitioner - Non-Primary Care Provider (PCP)											
Kaluski Edo	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Levy Ernesto N	Practitioner - Non-Primary Care Provider (PCP)											
Hajar Nasser	Practitioner - Non-Primary Care Provider (PCP)											
Frankenberg Fred Wayne Ii	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Tarnowski Nicholas J	Practitioner - Non-Primary Care Provider (PCP)											
Winterstein Christopher James	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Powell John William	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Land Ramona M	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						

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Dellavalle Andrea	Practitioner - Non-Primary Care Provider (PCP)											
Breslau Vladimir F	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Macqueen Amy	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Judith Ann Abrams	Practitioner - Non-Primary Care Provider (PCP)											
Lindemann Timothy Lynn	Practitioner - Non-Primary Care Provider (PCP)											
Shah Manish Vipinchadra	Practitioner - Non-Primary Care Provider (PCP)											
Reynolds Kelly M	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓					✓	
Burkert Thomas Edward	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Fedor Justin P	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Plocharczyk Elizabeth Frances	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Brown Debra	Practitioner - Non-Primary Care Provider (PCP)											
Glick Scott M	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Joshi Abhash	Practitioner - Non-Primary Care Provider (PCP)											
Zuwiyya Wendi T	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Carskadden Erba Elizabeth	Practitioner - Non-Primary Care Provider (PCP)											
Rudzinski Wojciech	Practitioner - Non-Primary Care Provider (PCP)											
Teves Michelle A	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Ballard Geneva R	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Metcalf James Crawford Jr	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Cyr Risa D	Practitioner - Non-Primary Care Provider (PCP)											
Ballard Luke Justin	Practitioner - Non-Primary Care Provider (PCP)	✓	✓								✓	
Blake Deidre M	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Hart Bradley	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Day Mary	Practitioner - Non-Primary Care Provider (PCP)											
Finney Amanda	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓						
Baclawski Lisa	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Chang Angela	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Prager Roman	Practitioner - Non-Primary Care Provider (PCP)											
Shirvani Alireza	Practitioner - Non-Primary Care Provider (PCP)											
Chikunguwo Silas	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Baldwin Jennifer Lynn Rushak	Practitioner - Non-Primary Care Provider (PCP)											

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Lockett Maegan M	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Siu Holing	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Kurtz Jennifer L	Practitioner - Non-Primary Care Provider (PCP)											
Daws Maureen	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Day Daniel David	Practitioner - Non-Primary Care Provider (PCP)											
Ritter Jade Annique	Practitioner - Non-Primary Care Provider (PCP)											
Serens Kelley A	Practitioner - Non-Primary Care Provider (PCP)											
Kliment Andrew T	Practitioner - Non-Primary Care Provider (PCP)											
Geller Alan M	Practitioner - Non-Primary Care Provider (PCP)											
Wright Caitlin Marie	Practitioner - Non-Primary Care Provider (PCP)											
Connor Laura R	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Stulb John Riordan	Practitioner - Non-Primary Care Provider (PCP)											
Purohit Shivani	Practitioner - Non-Primary Care Provider (PCP)											
Downton Paul W	Practitioner - Non-Primary Care Provider (PCP)	✓	✓		✓	✓						
Smith Hana	Practitioner - Non-Primary Care Provider (PCP)	✓	✓			✓						
Dauria Colin Kenneth	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Ross Valerie Howarth	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Suen John Shaw-Der	Practitioner - Non-Primary Care Provider (PCP)	✓	✓									
Rose Gabriel	Practitioner - Non-Primary Care Provider (PCP)											
Ehrets Vicki	Practitioner - Non-Primary Care Provider (PCP)											
Seedat Ghazala	Practitioner - Non-Primary Care Provider (PCP)											
Rimmer John Dr.	Practitioner - Non-Primary Care Provider (PCP)											
Bump Hans Mr.	Practitioner - Non-Primary Care Provider (PCP)											
Freyer Chariese Ann Rpt	Practitioner - Non-Primary Care Provider (PCP)											
Tableman Brian Frederick Pt	Practitioner - Non-Primary Care Provider (PCP)											
Horn Lucinda	Practitioner - Non-Primary Care Provider (PCP)											
Perezalonso Luis	Practitioner - Non-Primary Care Provider (PCP)											
Rybinski Jean	Practitioner - Non-Primary Care Provider (PCP)											
Chiu Alexander	Practitioner - Non-Primary Care Provider (PCP)											
United Health Serv Hosp Inc	Hospital	✓	✓		✓	✓	✓	✓		✓		
Schuyler Hospital	Hospital	✓	✓									

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Corning Hosp	Hospital	✓	✓						✓	✓	✓	✓
Delaware Valley Hospital Inc	Hospital	✓	✓			✓			✓			
Our Lady Of Lourdes Mem	Hospital	✓	✓		✓	✓	✓		✓			✓
Cayuga Medical Ctr/Ithaca	Hospital	✓	✓									
Chenango Memorial Hosp Inc	Hospital	✓	✓	✓	✓	✓						
Cortland Reg Med Ctr	Hospital	✓	✓	✓		✓						
Finger Lakes Migrant Hlth	Clinic											
Ucp Nys Reg 1 #05 Medina St	Clinic											
Chemung County Doh Lthhcp	Clinic											
United Health Serv Hosp Inc	Clinic	✓	✓		✓	✓	✓	✓		✓		
Chenango Cty Dept Of Pub Hlth	Clinic											
Broome Cnty Health Dept	Clinic											
Family Hlth Netwrk Central Ny	Clinic	✓			✓	✓	✓					
Delaware Cty Public Hlth Nurs	Clinic											
Greater Hudson Valley Fam Hlt, The	Clinic											
Planned Prthd So Central Ny	Clinic	✓				✓						
Cortland Cty Dept Of Health	Clinic											
Schuyler Hospital	Clinic	✓	✓									
Planned Parenthood So Finger Lakes	Clinic	✓				✓						
Corning Hosp	Clinic	✓	✓						✓	✓	✓	✓
Tioga County Family Planning	Clinic											
Tompkins Cnty Hlth Dept Clini	Clinic											
Franziska Racker Centers	Clinic											
Steuben Board Of Superviso Co	Clinic											
Schuyler County Legislature	Clinic											
Delaware Valley Hospital Inc	Clinic	✓	✓			✓			✓			
Our Lady Of Lourdes Mem	Clinic	✓	✓		✓	✓	✓		✓			✓
Cayuga Medical Ctr/Ithaca	Clinic	✓	✓									
Chenango Memorial Hosp Inc	Clinic	✓	✓	✓	✓	✓						
Cortland Reg Med Ctr	Clinic	✓	✓	✓		✓						
Association For Vision Rehabilitati	Clinic											

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Parsons Child And Family Ctr	Clinic											
Judith Ann Abrams	Clinic											
Milestones Pediatric Ot Pc	Clinic											
Springbrook Ny Inc	Clinic											
Handicapped Childrens Assn Smp	Clinic	✓			✓							
Liberty Resources Inc	Case Management / Health Home	✓	✓									
Omrdd/Challenge Industries	Case Management / Health Home											
Omrdd/Schuyler Co Msc Broome	Case Management / Health Home											
Onondaga Case Management Inc	Case Management / Health Home											
Jm Murray Center	Case Management / Health Home	✓			✓	✓						
Family Ser Of Chemung Cnty Mh	Case Management / Health Home	✓						✓				
Omrdd/Schuyler Co Chap Nysarc	Case Management / Health Home											
Omrdd/Unity/Cayuga-Br	Case Management / Health Home											
Omrdd/Onondaga Comm Living Hc	Case Management / Health Home											
Omrdd/Franziska Racker Ctr-Br	Case Management / Health Home											
Southern Tier Indep Ctr	Case Management / Health Home											
Madison-Cortland Nysarc	Case Management / Health Home											
Omrdd/Joshua House Inc	Case Management / Health Home											
Jm Murray Center Inc	Case Management / Health Home	✓			✓	✓						
Omrdd/Handicapped Child So Ny	Case Management / Health Home											
Omrdd/Delaware Opp Inc	Case Management / Health Home											
Omrdd/Delaware Co Nysarc-Br	Case Management / Health Home											
Omrdd/Chenango Arc	Case Management / Health Home											
Southern Tier Aids Program Ai	Case Management / Health Home											
Lakeview Mental Health Icm Mh	Case Management / Health Home											
Schuyler Co Mhc Mh	Case Management / Health Home											
Rehabilitation Supp Svcs C	Case Management / Health Home	✓			✓	✓					✓	
Catholic Charities Cortland	Case Management / Health Home	✓			✓	✓						
Catholic Charities Mh	Case Management / Health Home											
Tompkins County Mh Dept Mh	Case Management / Health Home											
United Health Serv Hosp Inc	Case Management / Health Home	✓	✓		✓	✓	✓	✓		✓		

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Broome County Dept Of Hlth	Case Management / Health Home											
Cortland County Doh Div Nrsng	Case Management / Health Home											
Tompkins County Hm Hlth Care	Case Management / Health Home											
Schuyler Home Hlth Agcy Co	Case Management / Health Home											
Parsons Child And Family Ctr	Case Management / Health Home											
Schuyler County Chapter Nysarc Inc	Case Management / Health Home											
Challenge Industries	Case Management / Health Home	✓			✓	✓						
Liberty Resources Inc	Mental Health	✓	✓									
Brightsen Anne	Mental Health											
Hillside Childrens Ctr	Mental Health											
Kerner Cheryl R Np	Mental Health											
Olmstead Sam	Mental Health											
Crispell Jane	Mental Health											
Gerson Henry David	Mental Health	✓	✓									
Barbis Andrea Mari Lcsw	Mental Health	✓	✓		✓	✓	✓					
Onondaga Case Management Inc	Mental Health											
Northeast Parent Child Societ	Mental Health											
Factourovich Inna Md	Mental Health	✓	✓		✓	✓						
Factourovich Alexander Md	Mental Health	✓	✓		✓	✓						
Duplan Auguste Lytton Md	Mental Health	✓	✓									
Komatinsky Paul J	Mental Health											
Family Ser Of Chemung Cnty Mh	Mental Health	✓						✓				
Ruchames Robert	Mental Health											
Rtf Hs Of The Good Shepherd	Mental Health											
Lakeview Mental Health Icm Mh	Mental Health											
Unity House Cayuga County Inc	Mental Health											
Schuyler Co Mhc Mh	Mental Health											
Rehabilitation Supp Svcs C	Mental Health	✓			✓	✓					✓	
Rtf Childrens Home Rtf Inc	Mental Health											
Catholic Charities Cortland	Mental Health	✓			✓	✓						
Cath Char Inc/So Tier Off	Mental Health											

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Catholic Charities Chenango	Mental Health	✓			✓	✓						
Mccann Joseph Thomas Phd	Mental Health											
Tompkins County Mh Dept Mh	Mental Health											
Cortland County Mh	Mental Health											
Bezirganian John B Md	Mental Health	✓	✓									
Family Counsel Svc Cortland	Mental Health	✓					✓					
Chemung Co Nys Arc Children'S	Mental Health	✓						✓				
Ronan Peter Graham Md	Mental Health											
Family & Child Srv Of Ithaca	Mental Health											
Binghamton Pc	Mental Health											
Tioga Cty Community Srv Board	Mental Health											
United Health Serv Hosp Inc	Mental Health	✓	✓		✓	✓	✓	✓		✓		
Fras Ivan Md	Mental Health											
Chenango Cty Community Sv Brd	Mental Health	✓				✓	✓					
Broome Cty Comm Mntl Hlth Svc	Mental Health											
Delaware Cnty Comm Svc Board	Mental Health	✓				✓	✓					
Binghamton Pc	Mental Health											
Major Leslie F Md	Mental Health	✓	✓		✓	✓						
Steuben Cnty Comm Svcs Brd	Mental Health											
Franziska Racker Centers	Mental Health											
Our Lady Of Lourdes Mem	Mental Health	✓	✓		✓	✓	✓		✓			✓
Cayuga Medical Ctr/Ithaca	Mental Health	✓	✓									
Cortland Reg Med Ctr	Mental Health	✓	✓	✓		✓						
Loomis Lisa	Mental Health											
Smith Janelle	Mental Health											
Rubin Hyman	Mental Health											
Castetter Lisa	Mental Health											
Sholar Lisa	Mental Health											
Argiro Salvatore	Mental Health											
Gaonkar Nelima Wood	Mental Health											
Hameed Noumana	Mental Health	✓	✓		✓	✓						

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Yanusas Christophe	Mental Health											
D'Achille Laura	Mental Health											
Brimberg Ronee	Mental Health											
Rosenfeld Valerie	Mental Health											
Vieux Judy	Mental Health											
Argetsinger Dorothy	Mental Health											
Sturtevant M	Mental Health											
Almanzar Jenny	Mental Health											
Witt Sandra	Mental Health											
Family And Childrens Society Inc	Mental Health	✓	✓		✓	✓						
Stewart Jessica R	Mental Health											
Webster Robert Bendana	Mental Health											
Golden James	Mental Health											
Sabatino Michael Md	Mental Health											
Cron Amy Esther	Mental Health											
Parsons Child And Family Ctr	Mental Health											
Brown Debra	Mental Health											
Dauria Colin Kenneth	Mental Health	✓	✓									
Catholic Charities Of The Diocese	Mental Health											
Phoenix Houses Of New York Inc	Substance Abuse											
Hillside Childrens Ctr	Substance Abuse											
Asi Of Cortland Llc	Substance Abuse											
Carnegie Hill Institute Inc	Substance Abuse											
George Junior Republic Assoc	Substance Abuse											
Dick Van Dyke A T C	Substance Abuse											
Conifer Park	Substance Abuse											
Ithaca Alpha House Ctr Inc	Substance Abuse	✓				✓						
Family Counsel Svc Cortland	Substance Abuse	✓					✓					
Tioga County Comm Ser Brd Daa	Substance Abuse											
Alcohol & Sub Abuse Tompkins	Substance Abuse	✓					✓					
Council Alcohol Sub Abuse Livingstn	Substance Abuse	✓			✓	✓						

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Addiction Ctr Of Broome Cnty	Substance Abuse											
United Health Serv Hosp Inc	Substance Abuse	✓	✓		✓	✓	✓	✓		✓		
F L A C R A	Substance Abuse	✓			✓	✓						
Chenango Cty Community Sv Brd	Substance Abuse	✓				✓	✓					
Delaware Cnty Comm Svc Board	Substance Abuse	✓				✓	✓					
Greater Hudson Valley Fam Hlt, The	Substance Abuse											
Delaware Valley Hospital Inc	Substance Abuse	✓	✓			✓			✓			
Recovery Counseling, Llc	Substance Abuse											
Cortland Regional Medical Center In	Nursing Home	✓	✓	✓		✓						
Ideal Senior Living Ctr Snf	Nursing Home	✓		✓								
Absolut Ct Nr & Reh At Endicott	Nursing Home	✓		✓								
James G Johnston Mem Snf	Nursing Home	✓		✓								
Susquehanna Nrs & Rehab Center Adhc	Nursing Home											
Absolut Ct Nr & Reh At Three Rivers	Nursing Home	✓		✓								
Groton Community Hcc Snf	Nursing Home	✓		✓								
Chase Memorial Nur Home In Co	Nursing Home	✓		✓		✓						
Good Shepherd-Fairview Hm Inc	Nursing Home	✓		✓								
Elizabeth Church Manor Nh Inc	Nursing Home	✓		✓								
Chemung County Health Ctr Nsg	Nursing Home											
Riverview Manor Health Care C	Nursing Home											
Schuyler Hosp Long Term Inc	Nursing Home											
Bridgewater Ctr Rehab & Nrs	Nursing Home	✓		✓	✓	✓						
Willow Point Nursing Home	Nursing Home	✓		✓								
Cayuga Ridge Extended Care	Nursing Home											
Norwich Rehabilitation & Nrs Ct	Nursing Home											
Crown Center Nursing & Rehab	Nursing Home	✓		✓								
Vestal Rehabilitation & Nursing Ctr	Nursing Home	✓		✓								
Cortland Care Center	Nursing Home	✓		✓								
Pavilion Operations , Llc	Nursing Home											
Btrnc, Llc	Nursing Home											
Geroulds Prof Pharamcy Inc	Pharmacy	✓	✓		✓	✓			✓			✓

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Professional Home Care Inc	Pharmacy											
Geroulds Prof Pharm Inc	Pharmacy	✓	✓		✓	✓			✓			✓
Geroulds Prof Pharm Inc	Pharmacy	✓	✓		✓	✓			✓			✓
Schuyler Hospital	Pharmacy	✓	✓									
Planned Parenthood So Finger Lakes	Pharmacy	✓				✓						
Gerould S Professional Phcy	Pharmacy	✓	✓		✓	✓			✓			✓
Town Total Health Llc	Pharmacy											
Town Total Health Llc	Pharmacy											
Hospice Of Chenango Cty Inc	Hospice	✓								✓		
Catskill Area Hospice/Pall Ca	Hospice	✓	✓							✓		
Southern Tier Hospice/Pall Ca	Hospice	✓	✓		✓					✓		
Hospicare Of Tompkins County	Hospice	✓								✓		
Hospice At Lourdes	Hospice	✓								✓		
Twin Tier Home Health Inc	Hospice											
Our Lady Of Lourdes Mem	Hospice	✓	✓		✓	✓	✓		✓			✓
L Woerner Inc	Hospice											
Access To Independence Of Cortland County, Inc.	Community Based Organizations	✓	✓		✓	✓						
Alcohol And Drug Abuse Council Of Delaware County	Community Based Organizations	✓			✓	✓						
Anchor House, Inc.	Community Based Organizations											
Avre	Community Based Organizations											
Catholic Charities Tompkins/Tioga	Community Based Organizations											
Catskill Area Hospice And Palliative Care	Community Based Organizations											
Cayuga Area Preferred	Community Based Organizations	✓			✓							
Cayuga Medical Associates, Inc	Community Based Organizations	✓			✓		✓				✓	
Chemung County Public Health	Community Based Organizations											
Chenango County Area Agency On Aging	Community Based Organizations											
Chenango County Department Of Social Services	Community Based Organizations											
Chenango Health Network, Inc.	Community Based Organizations	✓				✓						
Children'S Health Home Of Upstate New York	Community Based Organizations											
Children'S Home Inc. Dba/Stillwater Rtf	Community Based Organizations											
Comfort Keepers	Community Based Organizations											

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Community Care Network Of Nichols	Community Based Organizations	✓	✓									
Compeer Chemung	Community Based Organizations											
Compeer Of The Southern Tier	Community Based Organizations											
Compeer Steuben	Community Based Organizations											
Compeer, Inc.	Community Based Organizations											
Cornell University -- Gannett Health Services	Community Based Organizations											
Cornell University Cooperative Extension Of Delaware County	Community Based Organizations											
Cornerstone Family Healthcare	Community Based Organizations	✓	✓			✓						
Dr. Garabed A. Fattal Community Free Clinic	Community Based Organizations											
Dryden Family Medicine	Community Based Organizations	✓										
Fairview Recovery Services, Inc.	Community Based Organizations											
Family Enrichment Network	Community Based Organizations	✓			✓	✓						
Family Medicine Associates Of Ithaca	Community Based Organizations	✓			✓						✓	
Friends Of Recovery Delaware And Otsego	Community Based Organizations											
Golden Days	Community Based Organizations											
Hemung County Department Of Aging And Long Term Care	Community Based Organizations											
Hospicare & Palliative Care Services	Community Based Organizations											
Hospicare & Palliative Care Services Of Tompkins County	Community Based Organizations											
Ithaca Housing Authority	Community Based Organizations											
Ithaca Primary Care	Community Based Organizations											
Mental Health Association Of Tompkins County	Community Based Organizations											
Mothers And Babies Perinatal Network Of Scny, Inc.	Community Based Organizations	✓			✓	✓					✓	
Nys Office For People With Development Disabilities	Community Based Organizations											
Nysarc, Inc., Broome, Tioga County Chapter (Dba Achieve)	Community Based Organizations											
Rural Health Network Of South Central New York, Inc.	Community Based Organizations	✓			✓	✓						
S2ay Rural Health Network	Community Based Organizations	✓			✓	✓						
Seven Valleys Health Coalition	Community Based Organizations	✓				✓						
Southern Tier Healthlink	Community Based Organizations											
Steuben County Office For The Aging	Community Based Organizations											
Steuben County Public Health	Community Based Organizations											
Suicide Prevention And Crisis Service	Community Based Organizations	✓						✓				

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Tioga County Council On Alcoholism And Substance Abuse	Community Based Organizations											
Tioga County Department Of Social Services	Community Based Organizations											
Tioga County Health Department	Community Based Organizations											
Tompkins Community Action	Community Based Organizations											
Tompkins County Office For The Aging	Community Based Organizations											
Tompkins Health Network	Community Based Organizations											
Trumansburg Medicine, Pllc	Community Based Organizations	✓										
United Way Of Broome County, Inc.	Community Based Organizations	✓			✓	✓						
Ymca Of Broome County	Community Based Organizations											
Ywca Binghamton & Broome County	Community Based Organizations	✓	✓		✓	✓					✓	
Phoenix Houses Of New York Inc	All Other											
Ziad Mk El Zammar Md	All Other											
Mcdowell Meredith Borham	All Other											
Koch Drew	All Other	✓	✓									
Liberty Resources Inc	All Other	✓	✓									
Keating Catherine I	All Other											
Pisani Carrie Anne Rpa	All Other	✓	✓		✓	✓						
Baker Wallace	All Other											
Saylor Karen E	All Other											
Sarmast Farzad Md	All Other	✓	✓									
Hillside Childrens Ctr	All Other											
Paula Fitzsimmons Rpa	All Other											
Robert Lawrence Averbach	All Other											
Novak Matthew J	All Other	✓	✓								✓	
Hsu Antony Po-Yu Md	All Other											
Anderson Susan C Rpa	All Other	✓	✓		✓	✓						
Wang Xiu-Jie Md	All Other											
Joseph Jason Md	All Other	✓	✓		✓	✓						
Fucito Christopher D Do	All Other	✓	✓						✓	✓	✓	
Yue Gang Md	All Other	✓	✓		✓	✓						
Latorre Julius Gene Silva Md	All Other											

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Crispell Carolyn D.O.	All Other	✓	✓		✓	✓						
Castro Stella M Md	All Other	✓	✓									
Wilhelm Olayinka Olawale Md	All Other											
Lambert Robert Arthur Md	All Other											
Andrews Judy A Rpa	All Other	✓	✓		✓	✓						
Kelly Ann Butler Family Nurse	All Other											
Gutman Alan J Rpa	All Other	✓	✓		✓	✓						
Zarrini Hossein Md	All Other	✓	✓									
Malik Shahid Nasir Md	All Other											
Rendano Laura Joyce	All Other											
El-Kassis Liliane Md	All Other	✓	✓		✓	✓						
Michalovic Doris	All Other											
Kumar Manoj Koyamparambath Md	All Other	✓	✓			✓						
Little Ryan Daniel Np	All Other	✓	✓		✓	✓						
Meyers Lee C Md	All Other	✓	✓						✓	✓	✓	
Magargee Mariah Md	All Other											
Jayaraman Venkatesh B	All Other	✓	✓		✓	✓			✓			✓
Sheriff-White Phyllis Md	All Other											
Bollinger Wade S Md	All Other	✓	✓									
Moukala-Cadet Anne-Marie L Md	All Other	✓	✓									
Burkert Erica Zilles	All Other	✓	✓		✓	✓						
Anne Nirupama Md	All Other	✓	✓		✓	✓						
Haq Rashid Ul Md	All Other	✓	✓		✓	✓						
Barnes Charles R Rpa	All Other	✓	✓		✓	✓						
Naik Dhruti Md	All Other											
Khan Mahmud Md	All Other											
Lemberg Brent Davis Md	All Other	✓	✓									
Unity Huse Of Cayuga Co Nd 6	All Other											
Berg Richard E Md	All Other	✓	✓		✓	✓			✓			✓
Schlaen Brenda-Roxana Md	All Other	✓	✓		✓	✓						
David Henry Edward Do	All Other	✓	✓			✓						

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Pichette Carey Marie Np	All Other											
Onondaga Case Management Inc	All Other											
Chenango Co Chap Nysarc Day	All Other											
Unity Hs Cayuga Co Inc Day	All Other											
Gardner Kathleen Md	All Other	✓	✓									
Schuyler Co Chap Nysarc Day	All Other											
Lawyer Dawn Catherine Np	All Other	✓	✓		✓	✓						
Lakin Rose Rpa	All Other	✓	✓		✓	✓						
Franziska Racker Ctr Day	All Other											
Broome-Tioga Co Chap Nysarc Day	All Other											
Tan Beng Jit Md	All Other											
Shady Amr Ali Md	All Other	✓	✓		✓	✓						
Reilly Tracey H Md	All Other											
El Ghissassi Mostafa	All Other	✓	✓		✓	✓						
Mcnairn Julie Dk Md	All Other	✓	✓		✓	✓						
Rahner Douglas A Md	All Other	✓	✓			✓	✓					
Silbert Walter Coleman	All Other	✓	✓									
Khibkin Yuri Md	All Other											
Cryer Jonathan Eric	All Other	✓	✓									
Weiner Jamie S Md	All Other											
Quasem Mohammad Abul	All Other	✓	✓		✓	✓			✓			✓
Al-Khalidi Omar Farouq Md	All Other											
Moussallem Charbel Georges	All Other	✓	✓									
Poole Kimberlie A	All Other											
Lubell Richard R Md	All Other	✓	✓								✓	
De Jong Alida A	All Other											
Rao Rajesh S K Md	All Other	✓	✓									
Chenango Co Chap Nysarc Rsp	All Other											
Rees Russell E Md	All Other	✓	✓								✓	
Finger Lakes Migrant Hlth	All Other											
Gray Jeffrey R Md	All Other	✓	✓		✓	✓						

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Patel Ketan Arvindbhai Md	All Other											
Franziska Racker Ctr Rsp	All Other											
Schuyler County Nysarc Rsp	All Other											
Maghaydah Qutaybeh S Md	All Other	✓	✓									
Samodal Rodrigo T Jr Md	All Other	✓	✓						✓	✓	✓	
Chapman Alla Grigorevna Md	All Other											
Ingerick Brent S Do	All Other	✓	✓						✓	✓	✓	
Mcclelland Robert Thomas Md	All Other	✓	✓						✓	✓	✓	
Sudilovsky Daniel Md	All Other	✓	✓									
Prabhu Sheela Md	All Other	✓	✓						✓	✓	✓	
Coleman James Patrick Md	All Other	✓	✓									
Van Every Monica Md	All Other											
Ward April E Cnm	All Other	✓	✓			✓						
Barton Michael	All Other	✓	✓		✓	✓						
Thibault Melissa Wei Md	All Other	✓	✓									
Lowry Philip A Md	All Other											
Davuluri Chaudhury D K	All Other											
Asi Of Cortland Llc	All Other											
Reynolds Dermot M Md	All Other	✓	✓								✓	
Franzese-Lynch Vallerie	All Other	✓	✓									
Klein Eleanor Christine	All Other	✓	✓			✓	✓					
Lorman Kathryn A	All Other	✓	✓		✓	✓						
Finkelstein Arthur J Pt	All Other											
Brunt Joseph	All Other	✓	✓		✓	✓			✓			✓
Chaudhary Sumblina Aslam	All Other	✓	✓								✓	
Consolazio Anthony Jr Md	All Other	✓	✓		✓	✓						
O'Shae Marne Md	All Other	✓	✓									
Gardner Donna L	All Other											
Anis Uzma Md	All Other	✓	✓		✓	✓			✓			✓
Davydov Vadim Md	All Other	✓	✓		✓	✓						
Abdo Moufid J H Md	All Other	✓	✓		✓	✓						

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Potochniak Vickie L Rpa	All Other											
Stradley Shelly Lynn	All Other											
Choi Mike Joon Md	All Other	✓	✓						✓	✓	✓	
Solis Rosa A Md	All Other	✓	✓		✓	✓						
Cooke John David Md	All Other	✓	✓									
Lee Sally S Md	All Other	✓	✓								✓	
Solomon Sarra Gwyn Md	All Other	✓	✓									
Tao Sue Hong Md	All Other	✓	✓						✓	✓	✓	
Gonzalez Adrian Michael	All Other	✓	✓									
Szabo Andras Md	All Other	✓	✓			✓						
Corrigan Devlyn Lee Md	All Other											
Weston John W Do	All Other											
Burger Tamara Cnm	All Other											
Venkatesh Govindarajan Md	All Other											
Butt Mahmood	All Other											
Grausgruber Anne Rpa	All Other											
Jander Lucia Md	All Other	✓	✓									
Medical Pain Consultant Osteopathy	All Other											
Chenango Co Chap Nysarc Nd 2	All Other											
Chenango Co Chap Nysac Nd 1	All Other											
Bretz Gregory J Rpa	All Other	✓	✓		✓	✓						
Shah Ashokkumar R Md	All Other	✓	✓								✓	
Elsisi Amr M Md	All Other	✓	✓						✓	✓	✓	
Sabahat Ashraf Md	All Other	✓	✓									
Stank Holli	All Other											
Olbrys Kathleen M	All Other	✓	✓		✓	✓						
Naughton Connie A	All Other											
Mcphee Maureen Np	All Other	✓	✓		✓	✓						
Hadwin Jeannette	All Other	✓	✓		✓	✓			✓			✓
Bidwell Frances C Np	All Other	✓	✓		✓	✓						
Barnes Julie A	All Other	✓	✓		✓	✓						

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Bambara Julie Ann	All Other	✓	✓		✓	✓	✓					
Aleccia Dorene A	All Other	✓	✓		✓	✓						
Schwartz Jerrold Paul Md	All Other											
Hatch Karen Marie	All Other											
Schaff Justine Lara Md	All Other											
Ramanujapuram Ramanujan Md	All Other	✓			✓	✓						
Galu Maria Gabriela Livia Md	All Other											
Morales Romeo E Md	All Other											
Mecenas John A Md	All Other	✓	✓									
Mughal Shakid Ahmed Md	All Other	✓	✓		✓	✓						
Roche Timothy Scott Do	All Other											
Casey Jessica L Md	All Other	✓	✓									
Torrado Andrea Gonzalez Md	All Other	✓	✓									
Wiesner Lawrence Martin Do	All Other	✓	✓		✓	✓						
Stein Susan	All Other											
Higgins Julie Janeen Rpa	All Other											
Unity House Of Cayuga Co Spv	All Other											
Schuyler Co Chap Nysarc Spv	All Other											
Schuyler Co Chap Nysarc Spt	All Other											
Franziska Racker Centers Spv	All Other											
Bradshaw Suzanne M Md	All Other											
Srivatana Ukorn Md	All Other	✓	✓								✓	
Rosenstein Jerome H Md	All Other	✓	✓		✓	✓			✓			✓
Barton Victoria	All Other	✓	✓		✓	✓						
Bradshaw John A Md	All Other											
Kuntz Bruce L Md	All Other	✓	✓						✓	✓	✓	
Wolsh Loren	All Other	✓	✓		✓	✓						
Torrado Jose A Md	All Other	✓	✓									
Davydov Valentina Do	All Other	✓	✓		✓	✓						
Carnegie Hill Institute Inc	All Other											
Kadlecik Jeffrey Pinkney Dpm	All Other	✓	✓									

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Koh Han Suk Md	All Other	✓	✓								✓	
Stapleton Dwight D Md	All Other											
Longacre Helene C Md	All Other	✓	✓		✓	✓						
Chivate Vandanamd	All Other	✓	✓								✓	
Alley John A Md	All Other	✓	✓									
Atkins Christine Np	All Other											
Tillotson Rebecca Rpa	All Other	✓	✓		✓	✓						
Norton J Russell Md	All Other	✓	✓									
Jm Murray Center Inc Smp	All Other	✓			✓	✓						
Onondaga Community Living Smp	All Other											
Unity House Of Cayuga Cty Smp	All Other											
Delaware Co Chaptr Nysarc Smp	All Other											
Schuyler Co Chap Nysarc Smp	All Other											
Jayasena Rohan Senerat Md	All Other	✓	✓		✓	✓						
Blegen Michelle P Md	All Other	✓	✓									
Borra Mary Ann Cnm	All Other	✓	✓			✓						
Steinmetz James Robert Md	All Other	✓	✓		✓	✓						
Mead John-Paul D Md	All Other	✓	✓									
Khan Rowshanul Islam Md	All Other	✓	✓						✓	✓	✓	
Larson Robert Md	All Other											
Cagir Burt Md	All Other	✓	✓								✓	
Milner Dvorah Md	All Other	✓	✓									
Sandway David Charles	All Other											
Brand Malcolm Douglas Md	All Other	✓	✓									
Florini Marita A	All Other	✓	✓		✓	✓			✓			✓
Family Ser Of Chemung Cnty Mh	All Other	✓						✓				
Aranda Arvin Md	All Other	✓	✓		✓	✓			✓			✓
Mannino Joseph Andrew Md	All Other	✓	✓									
Getzin Andrew	All Other	✓	✓									
Monticello Vicki C	All Other	✓	✓		✓	✓						
Doty John Md	All Other	✓	✓						✓	✓	✓	

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Brennan Mark Joseph Md	All Other	✓	✓		✓	✓						
Cetton Gregory Md	All Other											
Lodi Yahia M Md	All Other	✓	✓		✓	✓						
Darlow Lloyd Alan Md	All Other	✓	✓									
Guthrie Clinic Ltd	All Other	✓	✓						✓		✓	
Kantor Walter John Md	All Other	✓	✓									
Scott Roger Edward Md	All Other	✓	✓			✓						
Chenango Co Chap Nys Arc Hcb2	All Other											
Franziska Racker Ctr Inc Hcb7	All Other											
Snyder Lisa Simonetta	All Other	✓	✓			✓						
Rozum Bozena Slota Md	All Other											
Deguardi Mary C Md	All Other	✓	✓		✓	✓						
Jones Cynthia Blair Md	All Other											
La Face Karen Marie Md	All Other	✓	✓									
Liauw Sun Hua Md P C	All Other											
Onysko Melodye Elaine Cnm	All Other											
Steinberg Esther Md	All Other	✓	✓									
Williams David Dea Md	All Other	✓	✓									
Yu Hong Md	All Other	✓	✓		✓	✓			✓			✓
Guizano Melissa Tamondong Md	All Other	✓	✓		✓	✓						
Mohyuddin Aliasghar Md	All Other											
Davidenko Jorge Mario Md	All Other	✓	✓			✓						
Hallinan Kathleen Ann Md	All Other	✓	✓						✓	✓	✓	
Aronis Michael Md	All Other	✓	✓		✓	✓						
Whelan Karen A	All Other	✓	✓		✓	✓			✓			✓
Hodgeman Paul D	All Other											
Galyanova Valentina	All Other	✓	✓									
Roach Stephanie Susan Md	All Other	✓	✓									
Singh Amit Kumar	All Other	✓	✓									
Porter Burdett Roy Md	All Other	✓	✓								✓	
Ideal Senior Livin Center Alp	All Other	✓		✓								

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Zarzecki Cathy	All Other	✓	✓			✓	✓					
Wattoo Muhammad A Md	All Other	✓	✓									
Schotanus Peter	All Other											
Raman Sucharita Md	All Other	✓	✓								✓	
Spaulding Theresa A Md	All Other											
Ovedovitz Lon A Md	All Other	✓	✓								✓	
Corey Mark J Md	All Other	✓	✓						✓	✓	✓	
Harpst Lisa Lynnelle Md	All Other	✓	✓						✓	✓	✓	
Baldauf-Madero Sharon Diane	All Other											
Pendell-Mckee Judy	All Other	✓	✓		✓	✓						
Nichols Shari Lou Dpm	All Other	✓	✓		✓	✓						
Mccauley Maura C Md	All Other	✓	✓									
Gregorie Erik Martin Md	All Other	✓	✓								✓	
Elderchoice Inc Tbi	All Other	✓	✓			✓						
Djafari Mohammad	All Other	✓			✓						✓	
Guizano Emmanuel M Md	All Other	✓	✓		✓	✓						
Alkhouri Hani Md	All Other											
Vandermeer Thomas J Md	All Other	✓	✓								✓	
Domke Robert M Md	All Other											
Strominger Robert N Md	All Other	✓	✓									
Desilva Audrey H Md	All Other	✓	✓									
Freeman Denise Ann Do	All Other	✓	✓		✓	✓						
Steinberg Joshua D Md	All Other	✓	✓		✓	✓	✓					
Herbst Lee J Md	All Other	✓	✓								✓	
Brown Deryck W S Md	All Other	✓	✓								✓	
Howard Jean Pierson	All Other	✓	✓		✓	✓			✓			✓
Rule Jennifer	All Other											
Fox Stanley	All Other	✓	✓		✓	✓						
Weinraub Jennifer Freda Md	All Other											
Freeman Michael Jay Do	All Other	✓	✓		✓	✓						
Van Doren Clay J Do	All Other											

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Adusei Kwame A Md	All Other											
Lord Amy Elizabeth	All Other	✓	✓		✓	✓						
Sharma Ram Charitra Md	All Other	✓	✓						✓	✓	✓	
Barrett Michael W Md	All Other											
Abueg Renato A Md	All Other											
Nulton Michelle Ann	All Other											
Ali Nadifa Abdi Md	All Other											
Gromniak Suzanne M	All Other	✓	✓		✓	✓						
Burt Mattison A Md	All Other	✓	✓									
Talati Kiran A Md	All Other	✓	✓		✓	✓			✓			✓
Silcoff Howard W Md	All Other	✓	✓									
Gordon Cindy Md	All Other											
Professional Home Care Inc	All Other											
Lewis Paulette V Md	All Other	✓	✓						✓	✓	✓	
Smith Christopher Allan Md	All Other	✓	✓			✓						
Kwiatkowski David E Md	All Other	✓	✓		✓	✓						
Heidelberger Sara Marie	All Other											
Sanito Anthony Md	All Other	✓	✓									
Southern Tier Indep Ctr	All Other											
White Cherilyn Anne Md	All Other	✓	✓			✓	✓					
Gordon Peter Eliot Md	All Other											
Ruparella Ashutosh Harish Md	All Other	✓	✓									
Loehr James Christopher Md	All Other	✓	✓									
Warner Deborah	All Other											
Vohra Sanjeev Md	All Other	✓	✓									
Klufas Christina Irene Md	All Other	✓	✓									
Peter Schwartz Md Pllc	All Other											
Corey Timothy James Md	All Other	✓	✓		✓	✓						
Harper Yusuf	All Other	✓	✓		✓	✓						
Rogers Steven Alan Md	All Other	✓	✓									
Settineri Marc Henri Md	All Other											

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Javid Ahmad	All Other	✓	✓			✓	✓					
Farrell Michael Joseph Md	All Other	✓	✓		✓	✓			✓			✓
Foster Cora Lee Md	All Other	✓	✓									
Farrell Dina	All Other											
Pfisterer David Alan Md	All Other	✓	✓								✓	
Yoon Serene Hanee Md	All Other											
Howson Mary Frances Md	All Other	✓	✓									
Raftis James R Do	All Other	✓	✓								✓	
Martinez David Gregg Md	All Other	✓	✓		✓	✓						
Hennessey Michael Shannon Md	All Other											
Andres Christopher D Md	All Other	✓	✓								✓	
Sacco-Bedosky Teresa Ann	All Other	✓	✓		✓	✓						
Estill Matthew Reilly Md	All Other	✓	✓						✓	✓	✓	
Tashman John S Md	All Other											
Konefal Tanya	All Other											
Jimenez Domingo D Md	All Other	✓	✓		✓	✓	✓					
Ward Anna Marie Md	All Other	✓	✓		✓	✓						
Zhang Michael Yu	All Other	✓	✓		✓	✓						
West Carl G Md	All Other											
Rigotti Richard M Md	All Other	✓	✓		✓	✓						
Amaye-Obu Fons Alex Md	All Other											
Hinterberger Joseph W Md	All Other											
Garg Vinod K Md	All Other											
Hwang Kim S Md	All Other	✓	✓									
Fathalla Mahmoud F Md	All Other											
Eder Frank Steven Md	All Other	✓	✓		✓	✓						
Lourdes Primary Care Associat	All Other											
Toal Thomas M Md	All Other	✓	✓									
Gelber Steven Andrew Md	All Other	✓	✓									
Sampson Lawrence Nathan Md	All Other	✓	✓								✓	
Serrano De Malavet Janette Md	All Other											

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Malavet Angel L Md	All Other	✓	✓						✓	✓	✓	
Joy Christopher R Md	All Other	✓	✓								✓	
Wacendak John W Md	All Other	✓	✓		✓	✓	✓					
Sacks Ronald H Md	All Other	✓	✓		✓	✓						
Snedeker Jeffrey David Md	All Other	✓	✓									
Meneses Robert P Md	All Other	✓	✓						✓	✓	✓	
Mauser Jonathan Frank Md	All Other	✓	✓									
Carroll William Joseph Md	All Other	✓	✓									
Shrivastava Amitabh	All Other	✓	✓									
Cator Polly Ann Md	All Other	✓	✓			✓						
Allen Richard L Md	All Other	✓	✓									
Powell Marita Md	All Other	✓	✓		✓	✓	✓					
Nayo Eunice Yaafio Md	All Other	✓	✓									
Challenge Industries Inc Hcbs	All Other	✓			✓	✓						
Sendek Janusz Md	All Other	✓	✓									
Phykitt Donald Md	All Other	✓	✓						✓	✓	✓	
Arleo Robert Joseph	All Other	✓	✓									
Ryan Christopher W Md	All Other											
Yaeger Thomas A Md	All Other	✓	✓						✓	✓	✓	
Madison Co Chap Nysarc Inc	All Other											
Swisher Lynn Md	All Other	✓	✓									
Ziegler Sharon Lynn Md	All Other	✓	✓									
Cortland Regional Medical Center	All Other	✓	✓	✓		✓						
Cortland Regional Medical Center In	All Other	✓	✓	✓		✓						
Phillips Eric C Md	All Other											
United Medical Associates Pc	All Other											
Conifer Park	All Other											
Anderson Leonard S Md	All Other	✓	✓		✓	✓						
Talenti David A Md	All Other											
Naman Maysoon A Md	All Other											
Singh Jagmohan Md	All Other	✓	✓									

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Murphy Michael F Md	All Other	✓	✓		✓	✓						
Jones Denis M A Md	All Other											
Schuyler Co Mhc Mh	All Other											
Muhich Janet E Md	All Other	✓	✓		✓	✓						
Lockard John W Jr Md	All Other											
Weinberg Janet L Md	All Other	✓	✓		✓	✓						
Walker Steven R	All Other											
Spaulding Stephen Arthur Md	All Other	✓	✓									
Skiff James M Md	All Other	✓	✓		✓	✓						
Schwed David A Md	All Other	✓	✓									
Gaffney James Shannon Md	All Other	✓	✓									
Crosby James Theo Md	All Other	✓	✓		✓	✓	✓					
Law Adam Md	All Other	✓										
Clark Peter David	All Other	✓	✓									
Bradstreet Richard Perry Md	All Other	✓	✓								✓	
Stevens John B	All Other											
Lifeline Systems, Inc	All Other											
Ithaca Alpha House Ctr Inc	All Other	✓				✓						
Wilson Christine Behling Do	All Other	✓	✓		✓	✓						
Murray Richard W Md	All Other											
Giangrieco Maureen A	All Other											
Jones Thomas Richard	All Other	✓	✓		✓	✓						
Bleiler Brian Eugene Od	All Other											
Sporn Daniel P Md	All Other	✓	✓								✓	
Gustafson Thomas R Md	All Other	✓	✓						✓	✓	✓	
Ho Elizabeth T F Md	All Other	✓	✓						✓	✓	✓	
Stuver Thomas Paul Md	All Other											
Wiseman Barbara L Md	All Other	✓	✓		✓	✓						
Massi Anthony Frank Md	All Other											
Homan Mal R Md	All Other											
Young Daniel M Md	All Other	✓	✓		✓	✓	✓					

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Mateya Louis P Jr Md	All Other	✓	✓		✓	✓						
Schuyler Cnty Nys Arc Canal	All Other											
Bailey-Kunte Jemma	All Other											
Choi Susan Md	All Other	✓	✓						✓	✓	✓	
Rao Mukesh G Md	All Other	✓	✓		✓	✓			✓			✓
Deshmukh Pramod Md	All Other	✓	✓								✓	
Mauer Mark William Md	All Other	✓	✓						✓	✓	✓	
O Connor Thomas P Md Pc	All Other											
Gacioch Gerald Matthew Md	All Other	✓	✓									
Ideal Senior Living Ctr Snf	All Other	✓		✓								
Holland Sandra Joan Md	All Other	✓	✓			✓						
Ideal Senior Living Ctr Ltc	All Other	✓		✓								
Fedczuk Bohdan P Md	All Other	✓	✓		✓	✓						
Crepet Ruth Md	All Other	✓	✓						✓	✓	✓	
Margie Iii Walter E Md	All Other	✓	✓									
Mcdonald Lester Md	All Other	✓	✓								✓	
Lambert John Y Iii Md	All Other	✓	✓									
Connor Barbara J Md	All Other	✓	✓									
Tompkins County Mh Dept Mh	All Other											
Cortland County Mh	All Other											
Mcdonald Thomas John Md	All Other	✓	✓								✓	
Stevanovic Radomir Md	All Other	✓					✓					
Werner Harry R Do	All Other											
Cruz John Norbert Md	All Other											
Georgetson Michael J Md	All Other	✓	✓								✓	
Skezas Jacob W Md	All Other	✓	✓						✓	✓	✓	
Martines Richard Md	All Other	✓	✓								✓	
Shumeyko Nancy Keller Md	All Other											
Family Counsel Svc Cortland	All Other	✓					✓					
Galatzan Russell E Md	All Other	✓	✓		✓	✓						
Ferrer Guillermo	All Other	✓	✓									

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Catskill Area Hospice/Pall Ca	All Other	✓	✓							✓		
Meyer Stephen Jay Do	All Other	✓	✓									
Floyd Frank Daniel Md	All Other	✓	✓		✓	✓						
Johnson Glen C Md	All Other	✓	✓								✓	
Appleton Abraham Theodore	All Other	✓	✓								✓	
Gillott Anthony R Md	All Other											
Hudock Stephen Md	All Other	✓	✓								✓	
Woglom Russell C Md	All Other	✓	✓						✓	✓	✓	
Jewell James R Md	All Other											
Perenyi Dennis Md	All Other	✓	✓		✓	✓						
Modrak Mary Anne Md	All Other											
Teris Wayne C Md	All Other											
Armstrong Robert W Jr Md	All Other	✓	✓						✓	✓	✓	
Tioga County Comm Ser Brd Daa	All Other											
Southern Tier Hospice/Pall Ca	All Other	✓	✓		✓					✓		
Endo Lawrence Paul Md	All Other											
Tarricone Nicholas Md	All Other	✓	✓		✓	✓						
Lofaso Peter Joseph Md Jr	All Other											
Webb Paul R 111 Md	All Other	✓	✓								✓	
Ryan Debra A Md	All Other	✓	✓						✓	✓	✓	
Lofaso Liliana Md	All Other											
Hospicare Of Tompkins County	All Other	✓								✓		
Hospice At Lourdes	All Other	✓								✓		
Masarech Martin Charles Md	All Other	✓	✓		✓	✓						
Giannone John J Md	All Other	✓	✓		✓	✓						
Vns Ithaca & Tompkins Co Inc	All Other	✓	✓		✓							
Chemung Co Nys Arc Children'S	All Other	✓						✓				
Anderson Suzanne Kochweser Md	All Other	✓	✓									
Howland Timothy C Md	All Other	✓	✓		✓	✓						
Hudock Michael J Md	All Other	✓	✓								✓	
Skeist Barry P Md	All Other	✓	✓								✓	

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Brennan Peter Terence Md	All Other	✓	✓									
Ronan Peter Graham Md	All Other											
Midura Alan T Md	All Other	✓	✓									
Zakariyya Hasan Md	All Other	✓	✓			✓						
Boyle Michele Md	All Other	✓	✓		✓	✓	✓		✓			✓
Hurley Rosemarie Md	All Other											
Seddon Lorraine Md	All Other											
James G Johnston Mem Snf	All Other	✓		✓								
Dean Gary D Md	All Other	✓	✓		✓	✓			✓			✓
Winkler James Md	All Other	✓	✓									
Todd Jeffrey Andrew Dpm	All Other	✓	✓		✓	✓						
Leonti Vincent Md	All Other	✓	✓		✓	✓	✓					
Family & Child Srv Of Ithaca	All Other											
Kassis Iskandar Ilvas Md	All Other	✓	✓		✓	✓						
Mitchell Robert Louis Mdpc	All Other	✓	✓									
Miller Alan V Md	All Other	✓	✓		✓	✓						
Johnson Maryellen Rn	All Other											
Prasad Srinivasa Br Md	All Other	✓	✓		✓	✓						
Susquehanna Nrs & Rehab Center Adhc	All Other											
Lee Rachel D Md	All Other	✓	✓								✓	
Schuyler Cnty Nys Arc Cedar I	All Other											
Alcohol & Sub Abuse Tompkins	All Other	✓					✓					
King Joseph Tak-Pun	All Other											
Jones Edward Leslie Md	All Other											
Lee Ferrol Joseph Md	All Other											
Sweet John Paul Md	All Other	✓	✓		✓	✓						
Antos John Michael Md	All Other											
Hawkins Charlotte Annette Md	All Other											
Kacyrat Jamal Md	All Other											
Bluh Donald G Md	All Other	✓	✓									
Ghassem Mangouri Md	All Other											

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Hussain Ahmed Md	All Other	✓	✓		✓	✓						
Enders Gary C Md	All Other	✓	✓						✓	✓	✓	
Ucp Nys Reg 1 #05 Medina St	All Other											
Binghamton Pc	All Other											
Rouse Steven Bryan Md	All Other											
Husseini Sami T Md	All Other	✓	✓									
Glosenger Mark E Md	All Other											
Della Valle James Md	All Other											
Kardon Fredric M Md	All Other	✓	✓									
Susarla Ahalya Md	All Other	✓	✓		✓	✓						
Tolhurst Kirk Duncan Md	All Other											
Dugan Dirk H Md	All Other	✓	✓									
Costello John E Md	All Other	✓	✓									
Costello Ann Racker Md	All Other	✓	✓									
Nash Donald W Md	All Other	✓	✓		✓	✓						
Shallish Neil Frederick Md	All Other	✓	✓									
Terwilliger Jerry W Md	All Other	✓	✓						✓	✓	✓	
Baron Richard John Md	All Other	✓	✓		✓	✓						
Council Alcohol Sub Abuse Livingstn	All Other	✓			✓	✓						
Qadir Abdul Md	All Other	✓	✓						✓	✓	✓	
Twin Tier Home Health Inc	All Other											
Chemung County Doh Lthhcp	All Other											
Leslie Joyce Ruth Md	All Other											
Addiction Ctr Of Broome Cnty	All Other											
Devine Terence M Md	All Other	✓	✓								✓	
Alt Allen David Md	All Other											
Kerr Cheryl Md	All Other											
Tioga Cty Community Srv Board	All Other											
United Health Serv Hosp Inc	All Other	✓	✓		✓	✓	✓	✓		✓		
Patel Arjun J	All Other	✓	✓		✓	✓			✓			✓
F L A C R A	All Other	✓			✓	✓						

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Family And Children Society	All Other	✓	✓		✓	✓						
Chenango Cty Community Sv Brd	All Other	✓				✓	✓					
Broome Cty Comm Mntl Hlth Svc	All Other											
Contini William Md	All Other											
Delaware Cnty Comm Svc Board	All Other	✓				✓	✓					
Klepack William Andrew Md	All Other	✓	✓									
Endwell Family Physicians	All Other											
Rubinstein Elliot Md	All Other	✓	✓									
Cardina Timothy M Md	All Other											
Wasco Michael J Md	All Other											
Zander David Brooks Md	All Other	✓	✓		✓	✓			✓			✓
Driscoll Daniel J Md	All Other											
Ong Ling S Md	All Other	✓	✓									
Chase Memorial Nur Home In Co	All Other	✓		✓		✓						
Good Shepherd-Fairview Hm Inc	All Other	✓		✓								
Chenango Cty Dept Of Pub Hlth	All Other											
Broome Cnty Health Dept	All Other											
Cortland County Doh Div Nrsng	All Other											
Family Hlth Netwrk Central Ny	All Other	✓			✓	✓	✓					
Delaware Cty Public Hlth Nurs	All Other											
Greater Hudson Valley Fam Hlt, The	All Other											
Planned Prthd So Central Ny	All Other	✓				✓						
Uphoff Marguerite H Mckay Md	All Other	✓	✓									
Rao Rajaram N S Md	All Other	✓	✓									
Sutton Mala V	All Other	✓	✓						✓	✓	✓	
Nirgudkar Sriram D Md	All Other	✓	✓		✓	✓						
Elizabeth Church Manor Nh Inc	All Other	✓		✓								
Kilgore Carl Judson Md Pc	All Other	✓	✓									
Mc Nerney James Edward Dpm	All Other	✓	✓		✓	✓						
Gill Roy Md	All Other											
Sheikh Mushtaq A Md	All Other											

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Breiman Robert J Md	All Other	✓	✓									
Eisman Michael H Md	All Other											
Sharma Hari Har Md	All Other	✓	✓						✓	✓	✓	
Hammoud Walid S Md	All Other	✓	✓		✓	✓						
Chemung County Health Ctr Nsg	All Other											
Cortland Cty Dept Of Health	All Other											
Mcclintic William R Do	All Other	✓	✓						✓	✓	✓	
Good Vance Ariel	All Other	✓	✓								✓	
Schuyler Hospital	All Other	✓	✓									
Planned Parenthood So Finger Lakes	All Other	✓				✓						
Corning Hosp	All Other	✓	✓						✓	✓	✓	✓
Pareek Natwar K Md	All Other	✓	✓		✓	✓						
Steuben Cnty Comm Svcs Brd	All Other											
Tioga County Family Planning	All Other											
Tompkins County Hm Hlth Care	All Other											
Tompkins Cnty Hlth Dept Clini	All Other											
Franziska Racker Centers	All Other											
Schuyler Home Hlth Agcy Co	All Other											
Steuben Board Of Superviso Co	All Other											
Riverview Manor Health Care C	All Other											
Schuyler Hosp Long Term Inc	All Other											
Delaware Valley Hospital Inc	All Other	✓	✓			✓			✓			
Our Lady Of Lourdes Mem	All Other	✓	✓		✓	✓	✓		✓			✓
Bishop Ralph M	All Other											
Cayuga Medical Ctr/Ithaca	All Other	✓	✓									
Chenango Memorial Hosp Inc	All Other	✓	✓	✓	✓	✓						
Bridgewater Ctr Rehab & Nrs	All Other	✓		✓	✓	✓						
Willow Point Nursing Home	All Other	✓		✓								
Ahmed Syed Md	All Other	✓	✓		✓	✓						
Cortland Reg Med Ctr	All Other	✓	✓	✓		✓						
Wu Richard Hk Md	All Other											

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Barreto Mark Anthony Md	All Other											
Thomas Nelson Osborne	All Other											
Jones Kathleen	All Other											
Stalter Stacey	All Other											
Smith Janelle	All Other											
Shapiro Oleg Md	All Other											
Mikloucich Cori L Do	All Other	✓	✓		✓	✓			✓			✓
Hussain Anwar Ahmed Md	All Other											
Bhandari Jacqueline	All Other	✓	✓		✓	✓						
Westervelt Megan Md	All Other											
Jones Kara E Np	All Other											
Stepanyan Hasmik Md	All Other	✓	✓		✓	✓						
Hodder Heidi Rose Do	All Other	✓	✓						✓	✓	✓	
Desai Vikas	All Other											
Good Shepherd Fairview Home Alp	All Other	✓		✓								
Smith Melissa Margaret	All Other											
Wolslau Hans Johann Do	All Other											
Jennifer Y Sweet	All Other	✓	✓		✓	✓						
Courtney L Ross	All Other											
Oteng-Bediak0 Evelyn Md	All Other											
Cummings Kristina Mae Md	All Other	✓	✓									
Nelson Patricia Joan Rpa	All Other	✓	✓									
Gray Mindi Anne	All Other											
Silviu Catalin Marica	All Other											
Matibag Jose Antonio Md	All Other											
Terwilliger Susan Harford Np	All Other											
Bradley Walter Lash	All Other											
Rahman Nataliya	All Other											
Perle Kristine Ellen Md	All Other	✓	✓						✓	✓	✓	
Speicher Joanne Elizabeth	All Other	✓	✓			✓	✓					
Shawn Patrick Emmons	All Other											

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Kozarski Tzvetan	All Other	✓	✓		✓	✓						
Corrigan Frank John	All Other											
Debra Lyn Paxton	All Other											
Mcdermott Brian	All Other											
Chowdhury Nazif Ahmed	All Other	✓	✓		✓	✓						
Rajaram Aswini	All Other	✓	✓		✓	✓						
Joseph Mwesige Md	All Other											
Silva Lourdes G	All Other											
Brian Peter Bollo	All Other											
Smith Stacy L	All Other											
Albro Sheri	All Other											
Brathwaite Jillene	All Other	✓	✓		✓	✓						
Mcallister Josephine Chu	All Other	✓	✓									
Palakkumar K Patel Md	All Other											
Dietzman Brett Andrew	All Other	✓	✓		✓	✓			✓			✓
Steven Sattler	All Other											
Skiadas Melissa Erin	All Other	✓	✓		✓	✓						
Cotton Elisabeth	All Other	✓	✓									
Joseph Young Choi	All Other											
Cregan Kathleen Ann	All Other											
Odife Amechi Valentine Jr Md	All Other	✓	✓						✓	✓	✓	
Gasparis Demetrios Md	All Other	✓	✓		✓	✓						
Tiffany J Gates-Maby	All Other											
Maklad Safa A	All Other	✓	✓		✓	✓	✓					
Adam J Ash Do	All Other											
Avery Jeffrey Louis	All Other	✓	✓		✓	✓						
Peltz Stephanie	All Other											
Ahmed Fawzy Md	All Other											
Sean Patrick Holdridge	All Other											
Scianna Christopher Robert Do	All Other											
Lawsing James Fuller Iii	All Other											

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Family And Childrens Society Inc	All Other	✓	✓		✓	✓						
Paudel Keshab	All Other											
Devasenapathy Ashok	All Other											
Clowes Jackie Anne	All Other	✓	✓								✓	
Baker Marc Louis	All Other											
Kenhart Nicholas J	All Other											
Ponticiello Jacqueline Ann	All Other	✓	✓		✓	✓						
Macapinlac Eric Victor Aguas Md	All Other	✓	✓								✓	
Channin David Samuel Md	All Other											
Stefek Paul	All Other	✓	✓									
Kissi Harry	All Other											
Edmundson Laurel Duphiney	All Other											
Young Brett Hennerty	All Other											
Ratnakishore Pallapothu	All Other											
Kimberly Carney Young	All Other											
Tran Vinh Quang	All Other											
Daniel F Karn	All Other	✓	✓			✓	✓					
Lowrie Ryan Paul	All Other	✓	✓		✓	✓						
Verbitskiy Olga	All Other	✓	✓		✓	✓			✓			✓
Maygoe Richard Sheehan	All Other											
Bryan Matthew Burke	All Other											
Button Sue Ellen	All Other	✓	✓		✓	✓						
Tsay Theresia	All Other											
Liberty Resources Inc Tbi	All Other	✓	✓									
Devine Sean Thomas	All Other											
Robinson David	All Other											
Lynch Cynthia Anne	All Other											
Mcnerney Catherine	All Other											
Converse Susan Marie	All Other	✓	✓		✓	✓						
Elder Choice Inc	All Other	✓	✓			✓						
Giordano Elyse Marie	All Other											

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Regional Medical Practice Pc	All Other											
Schuyler Hospital Inc	All Other	✓	✓									
Hartman Ricky E	All Other	✓	✓								✓	
Recovery Counseling, Llc	All Other											
Chio Agnes Ye-May	All Other											
Saks Benjamin Joseph	All Other	✓	✓									
Goodman Kevin D	All Other											
Lawrence Camelia Arlene	All Other											
Hinkley Kirk Stephens Iv	All Other											
Curran Amy	All Other											
Gallagher David Jason Md	All Other	✓	✓		✓	✓						
Kandanati Vivek Vardhan Reddy Md	All Other	✓	✓		✓	✓			✓			✓
Manek Megha Bharat	All Other											
Bennett Christopher Joseph	All Other	✓	✓								✓	
Chung-Hussain Helen K Do	All Other											
Rosman Scott R	All Other	✓	✓		✓	✓	✓					
Kim Ryan Maxwell	All Other											
Cai Dove	All Other											
Campbell Julie	All Other	✓	✓									
Asgher Shoaib	All Other											
Thapa Rupak	All Other											
Hassan Humaira	All Other	✓	✓									
Holmes Katherine M Md	All Other	✓	✓		✓	✓	✓					
Khan Rizwan H	All Other	✓	✓		✓	✓						
Sarker Ashit Baran	All Other											
Stilwell Mason S	All Other											
Drilon Michelle Ann	All Other											
Pero Amanda R	All Other											
Jonathan David Brooks	All Other											
Ashley Marie Havtur	All Other											
Bordenet Simone	All Other	✓	✓		✓	✓						

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Chen Yong	All Other											
Benz Mary Barbara	All Other											
Elias Rony	All Other											
Wilson Michael	All Other	✓	✓									
Ross Jenny Ellen	All Other											
Session Donald	All Other	✓	✓									
Page Jessica Lynne	All Other											
Vestal Rehabilitation & Nursing Ctr	All Other	✓		✓								
Greer Charlene	All Other	✓	✓		✓	✓						
Harrison Marzella J	All Other	✓	✓		✓	✓						
Dunn Junius Josephine Martina	All Other											
Robinson Terrace Senior Living	All Other	✓		✓								
Parsons Child And Family Ctr	All Other											
Mclaughlin Jennifer Theresa	All Other											
Giuliana Loo Gallagher	All Other											
Pellitteri Phillip K	All Other	✓	✓								✓	
Baxter Franklin	All Other	✓	✓		✓	✓						
Godoy Heidi Erika	All Other											
Welch John Jr Do	All Other	✓	✓		✓	✓			✓			✓
Macqueen Douglas D	All Other	✓	✓									
Meikle Robert W	All Other	✓	✓						✓	✓	✓	
Baba Michael John	All Other											
Yang Ming	All Other											
Bertini John Nicholas	All Other	✓	✓		✓	✓						
Hoag Andrea Denise	All Other	✓	✓		✓	✓						
Corpora Cara L	All Other											
Yia Mary	All Other											
Argila Charles R	All Other											
Rosato Elizabeth Ann	All Other	✓	✓		✓	✓						
Smith Jacob W	All Other	✓	✓									
Silva Phaelon Henry	All Other	✓	✓									

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Zang Douglas Michael	All Other											
Elliott Steven J	All Other	✓	✓									
Attia Maximos Nabil Youssef	All Other	✓	✓						✓	✓	✓	
L Woerner Inc	All Other											
Siciliano Michael A	All Other											
Bertini Maria T	All Other	✓	✓		✓	✓						
L Woerner Inc	All Other											
L Woerner Inc	All Other											
Jayaraman Gayatri	All Other											
Schamel Patrick B	All Other	✓	✓									
Santoro Katherine Elizabeth	All Other											
Koicke Betsy C	All Other											
Zeykan Violeta	All Other	✓	✓						✓	✓	✓	
Hoover Derrick J	All Other											
Hummer Kristina	All Other	✓	✓		✓	✓						
Swift Robert D	All Other											
Kaluski Edo	All Other	✓	✓								✓	
Tarnowski Nicholas J	All Other											
Winterstein Christopher James	All Other	✓	✓		✓	✓						
Powell John William	All Other											
Land Ramona M	All Other	✓	✓		✓	✓						
Sidhu Jagmohan S	All Other	✓	✓		✓	✓						
Kohn Daniel Michael	All Other											
Breslau Vladimir F	All Other	✓	✓		✓	✓						
Judith Ann Abrams	All Other											
Milestones Pediatric Ot Pc	All Other											
Lindemann Timothy Lynn	All Other											
Shah Manish Vipinchadra	All Other											
Reynolds Kelly M	All Other	✓	✓		✓	✓					✓	
Burkert Thomas Edward	All Other	✓	✓		✓	✓						
Plocharczyk Elizabeth Frances	All Other	✓	✓									

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Teng Ann Y	All Other	✓	✓		✓	✓						
Glick Scott M	All Other	✓	✓									
Leeson Thomas A	All Other	✓	✓						✓	✓	✓	
Laing Meghan Marie	All Other	✓	✓		✓	✓						
Joshi Abhash	All Other											
Resurreccion I Am Panlilio	All Other											
Carskadden Erba Elizabeth	All Other											
Rudzinski Wojciech	All Other											
Ballard Geneva R	All Other	✓	✓								✓	
Cyr Risa D	All Other											
Ballard Luke Justin	All Other	✓	✓								✓	
Harris Timothy Carr	All Other	✓	✓									
Blake Deidre M	All Other	✓	✓									
Hart Bradley	All Other	✓	✓		✓	✓						
Day Mary	All Other											
Finney Amanda	All Other	✓	✓			✓						
Baclawski Lisa	All Other	✓	✓									
Sopchak Mason Michael	All Other	✓	✓									
Das Sujata	All Other	✓	✓						✓	✓	✓	
Peralta Edelweiss De Perio	All Other											
Baldwin Jennifer Lynn Rushak	All Other											
Ibrahim Mohammed U	All Other	✓	✓						✓	✓	✓	
Lockett Maegan M	All Other	✓	✓		✓	✓						
Siu Holing	All Other	✓	✓		✓	✓						
Kurtz Jennifer L	All Other											
Grant Norie	All Other											
Day Daniel David	All Other											
Serens Kelley A	All Other											
Stulb John Riordan	All Other											
Purohit Shivani	All Other											
Handicapped Childrens Assn Smp	All Other	✓			✓							

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Smith Hana	All Other	✓	✓			✓						
Gillan Michael Fredric	All Other	✓	✓						✓	✓	✓	
Rosato Susan	All Other											
Olarewaju Temitope O	All Other	✓	✓			✓	✓					
Devine Donna	All Other											
Rose Gabriel	All Other											
37 North Chemung Street Operating C	All Other	✓		✓								
Schuyler County Chapter, Nysarc Inc.	Uncategorized											
Chenango Cnty Chapter Nys Arc	Uncategorized											
Liberty Resources, Inc.	Uncategorized	✓	✓									
Chenango C0 Chap Nys Arc Hcbs	Uncategorized											
Schuyler County Chapter, Nysarc Inc.	Uncategorized											
J M Murray Ctr Inc Hcbs 2	Uncategorized											
The House Of The Good Shepherd	Uncategorized											
Liberty Resources Inc	Uncategorized	✓	✓									
Chenango Co Nysarc Inc Smp	Uncategorized											
The Institute For Human Services, Inc.	Uncategorized											
Ruiter Todd Dr.	Uncategorized											
Broome County Health Department Licensed Home Care Service Agency	Uncategorized											
Center For Remote Medical Management Llc	Uncategorized											
United Jewish Council Home Attendant Program	Uncategorized											
Spencer Frederick	Uncategorized											
Geroulds Professional Pharmacy, Inc./Gerould'S Healthcare Center	Uncategorized											
Epilepsy-Pralid, Inc.	Uncategorized											
Mental Health Association Of The Southern Tier, Inc.	Uncategorized	✓						✓				
Guthrie Medical Group, P.C.	Uncategorized											
Asi Of Cortland, Llc	Uncategorized											
Broome County Health Department Licensed Home Care Service Agency	Uncategorized											
Delaware County Public Health Services	Uncategorized											

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Spencer Ryan	Uncategorized											
Arjun J. Patel, M.D.	Uncategorized											
Waters Victor Dr.	Uncategorized											
Incer Maria Dr.	Uncategorized											
Cmh Services Inc	Uncategorized	✓	✓		✓	✓						
West Donna	Uncategorized											
Burke Patricia	Uncategorized											
Bahr Jennifer	Uncategorized											
Turner Margaret	Uncategorized											
Lukose Joseph Dr.	Uncategorized											
Schuyler Co Home Hlth Psshsp	Uncategorized											
Companion Care Of Rochester	Uncategorized											
Madison Barbara	Uncategorized											
Lourdes Health Support, Llc	Uncategorized											
Charlotte Hawkins Md	Uncategorized											
Baynar Cathleen	Uncategorized											
Guter Marvin Dr.	Uncategorized											
Elderwood Health Care At Tioga	Uncategorized											
George Matthew	Uncategorized											
Dowd Sharon	Uncategorized											
Vallone Jennifer Ms.	Uncategorized											
Murphy Matthew	Uncategorized											
Karp Jeanne	Uncategorized											
Christophersen Rebecca	Uncategorized											
Northeast Parent And Child Society, Inc.	Uncategorized											
Reyes Rowena	Uncategorized											
Gottlieb Megan	Uncategorized											
Hospitality House Tc, Inc.	Uncategorized											
Barge Rosa	Uncategorized											
Kenny Joseph	Uncategorized											
Larson Henry C Md	Uncategorized											

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Providence Of Delaware	Uncategorized											
The Arc Of Delaware County	Uncategorized											
Harvey Darrel	Uncategorized											
Cahill William	Uncategorized											
Moore Paula	Uncategorized											
Ripley Kenneth Mr.	Uncategorized											
Krizan Bruce	Uncategorized											
Hayes James	Uncategorized	✓	✓								✓	
Coleman Janice	Uncategorized											
Shaller Marge	Uncategorized											
Haas Catherine Mrs.	Uncategorized											
Broome County Office For Aging	Uncategorized											
Zaleski Andrew	Uncategorized											
Delaware County Office For The Aging	Uncategorized											
Monroe Plan For Medical Care Inc	Uncategorized	✓	✓		✓	✓						
Olson Kimberly Mrs.	Uncategorized											
Mann Nathan Dr.	Uncategorized											
Catholic Charities Of Broome County	Uncategorized											
Jacobs Allan Md	Uncategorized											
Badger Charles Dr.	Uncategorized											
Elderchoice Inc.	Uncategorized	✓	✓			✓						
Cornwall Claude	Uncategorized	✓	✓		✓	✓						
Abran Margaret	Uncategorized											
Brunson John Dr.	Uncategorized											
The Family & Children'S Society, Inc.	Uncategorized											
Stamford Health Care Society	Uncategorized											
Access To Home Care Services Inc.	Uncategorized											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :