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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

TABLE OF CONTENTS

Care Compass Network (PPS ID:44)

Care Compass Network (PPS ID:44)

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Quarterly Report - Implementation Plan for Care Compass Network

Year and Quarter: DY2, Q4 **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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.

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	

New York State Department Of Health
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	24,544,375	199,078,479

Budget Items	DY2 Q4 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	**4,942,254**	**11,715,991**	**9,870,548**	**52.62%**	**86,024,608**	**88.01%**
Administration	1,418,908					
Implementation	3,523,346					
Revenue Loss	**0**	**0**	**6,143,640**	**100.00%**	**61,436,396**	**100.00%**
Hospitals	0					
Physicians	0					
Internal PPS Provider Bonus Payments	**1,038,225**	**2,256,319**	**1,702,865**	**43.01%**	**17,743,682**	**88.72%**
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	**5,980,479**	**14,540,065**				

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

DSRIP Implementation Plan Project

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.

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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	29,707,611.61	206,777,111.61

Funds Flow Items	DY2 Q4 Quarterly Amount - Update	Percentage of Safety Net Funds - DY2 Q4 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	0	0.00%	991,654.25	100.00%	991,654.25	0	0	0	0	0	0	0	0	0	0	0	6,984,074.75	86,272,912.75
Clinic	0	0.00%	91,155	100.00%	91,155	0	0	0	0	0	0	0	0	0	0	0	1,562,164	12,912,109
Case Management / Health Home	0	0.00%	37,778	100.00%	37,778	0	0	0	0	0	0	0	0	0	0	0	538,947	3,862,523
Mental Health	0	0.00%	86,585.50	100.00%	86,585.50	0	0	0	0	0	0	0	0	0	0	0	1,376,619.50	10,652,444.50
Substance Abuse	0	0.00%	52,720	100.00%	52,720	0	0	0	0	0	0	0	0	0	0	0	467,677	3,726,501
Nursing Home	0	0.00%	48,495	100.00%	48,495	0	0	0	0	0	0	0	0	0	0	0	202,669	2,206,569
Pharmacy	0	0.00%	33,537.50	100.00%	33,537.50	0	0	0	0	0	0	0	0	0	0	0	111,579.50	684,901.50
Hospice	0	0.00%	0	0.00%	22,052	0	0	0	0	0	0	0	0	0	0	0	795,637	7,128,511
Community Based Organizations	0	0.00%	0	0.00%	139,904	0	0	0	0	0	0	0	0	0	0	0	4,255,444	22,372,855
All Other	0	0.00%	23,154	36.54%	63,371	0	0	0	0	0	0	0	0	0	0	0	0	0
Uncategorized	0	0.00%	1,040	0.98%	105,769	0	0	0	0	0	0	0	0	0	0	0	0	0
Additional Providers	0	0.00%	0	0.00%	0													
PPS PMO	1,403,628.14	100.00%	4,668,048.14	100.00%	5,168,411.14												0	14,377,065.86
Total	**1,403,628.14**	**100.00%**	**6,034,167.39**	**95.16%**	**6,841,432.39**													

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 :

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

Please refer to uploaded PIT replacement file for additional spend by provider type.

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)

* Safety Net Providers in Green

Waiver Quarterly Update Amount By Provider		
Provider Name	**Provider Category**	**DY2Q4**
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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* Safety Net Providers in Green

Waiver Quarterly Update Amount By Provider			
Provider Name	**Provider Category**	**IA Provider Approval/Rejection Indicator**	**DY2Q4**
Additional Providers			**0**
	Additional Providers		0

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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 Q4 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 :

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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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 Q4 Quarterly Amount - Update	Percentage of Safety Net Funds - DY2 Q4 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		

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Funds Flow Items	DY2 Q4 Quarterly Amount - Update	Percentage of Safety Net Funds - DY2 Q4 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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* Safety Net Providers in Green

Non-Waiver Quarterly Update Amount By Provider		
Provider Name	**Provider Category**	**DY2Q4**
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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* Safety Net Providers in Green

Non-Waiver Quarterly Update Amount By Provider			
Provider Name	**Provider Category**	**IA Provider Approval/Rejection Indicator**	**DY2Q4**
Additional Providers			**0**
	Additional Providers		0

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 1.11 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Section 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	

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	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	09/30/2017	09/30/2017	DY3 Q2	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	

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	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	06/30/2017	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	

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	brosetti	Templates	44_DY2Q4_GOV_MDL21_PRES1_TEMPL_CCN_Meeting_Schedule_Templates_DY2Q4_14100.pdf	CCN Meeting Schedule Templates	04/28/2017 09:42 AM
	brosetti	Templates	44_DY2Q4_GOV_MDL21_PRES1_TEMPL_Governance_Committee_Template_DY2Q4_14098.xlsx	Governance Committee Template	04/28/2017 09:41 AM
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	brosetti	Templates	44_DY2Q4_GOV_MDL21_PRES2_TEMPL_DY2,Q4_Clinical_Governance_Template_14113.xlsx	DY2Q4 Clinical Governance Template	04/28/2017 09:51 AM
	brosetti	Other	44_DY2Q4_GOV_MDL21_PRES2_OTH_South_RPU_Behavioral_Health_Charter_14112.pdf	South RPU BH Charter	04/28/2017 09:50 AM
	brosetti	Other	44_DY2Q4_GOV_MDL21_PRES2_OTH_EastRPU_CharterDY2Q4_14109.pdf	East RPU Charter DY2Q4	04/28/2017 09:50 AM
	brosetti	Meeting Materials	44_DY2Q4_GOV_MDL21_PRES2_MM_CCN_DY2Q4_Clinical_Governance_Committee_Meeting_Schedule_14107.pdf	CCN DY2Q4 Clinical Governance Committee Meeting Schedule	04/28/2017 09:48 AM
Finalize bylaws and policies or Committee Guidelines where applicable	brosetti	Policies/Procedures	44_DY2Q4_GOV_MDL21_PRES3_P&P_CCN_FN4_-_RPU_Budget_Policy_14118.pdf	CCN_FN4 - RPU Budget Policy	04/28/2017 09:55 AM
	brosetti	Meeting Materials	44_DY2Q4_GOV_MDL21_PRES3_MM_Board_of_Directors_Minutes_March_14,_2017_14117.pdf	Board of Directors Minutes - March 14, 2017	04/28/2017 09:54 AM
Establish governance structure reporting and monitoring processes	brosetti	Other	44_DY2Q4_GOV_MDL21_PRES4_OTH_CCNproofof2wayReportingDY2Q4_14120.pdf	CCN Proof of 2 way Reporting DY2Q4	04/28/2017 09:57 AM
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	brosetti	Other	44_DY2Q4_GOV_MDL21_PRES5_OTH_April_Newsletter_14124.docx	CCN April Newsletter	04/28/2017 10:02 AM
	brosetti	Implementation Plan & Periodic Updates	44_DY2Q4_GOV_MDL21_PRES5_IMP_Combined_Communications_Plan_and_Timeline_04-13-17_14122.pdf	CCN Combined Communication Plan and Timeline	04/28/2017 10:00 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize governance structure and sub-committee structure	This milestone was complete and passed in the DY1, Q2 report however, as part of the ongoing quarterly reporting, we have updates to provide. In DY2Q4, there

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	were no changes to the CCN organization charts however there were subcommittee roster changes to report. On the Nominating Committee there was one change, Greg Rittenhouse replaced Jackie Leaf- Carlton from Seven Valleys. On the IT Governance Committee Don Waddell has stepped down, due to workload conflicts. His replacement has not yet been determined. On the Compliance & Audit Committee, Jan Miller retired and hence resigned from the Compliance and Audit Committee in February. We have not yet replaced her or the vacancy left by Anne Wolanski. An updated contact info for Governance the subcommittees has been uploaded along with the meeting schedule for DY2Q4. Additionally, the vacancy on the Board of Directors was filled in March 2017. The Nominating Committee met on February 22, 2017 and reviewed several candidates for the open Care Compass Network Board of Directors position. Dr. Jason A. Andrews was felt to be able to provide the workforce representation that is currently not represented on the board. The continued focus on Workforce will help sustain DSRIP efforts. The Board of Directors accepted the motion from the Nominating Committee and approved Jason Andrews to fill the Board of Directors vacancy.
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 DY2Q4, however there have been changes in membership on some of the quality committees. On the South Regional Performing Unit (RPU) Behavioral Health Sub Committee Sarah Harding stepped down on January 1st, 2017. Cheryl Minnier replaced Sarah Harding on the South RPU Behavioral Health Sub Committee January 6, 2017. For the North RPU, the Disease Management and Onboarding Committees have merged. Membership from both committees were combined and Jackie Leaf-Carlton from Seven Valleys was replaced on this committee with Kimberly Corbett from JM Murray. For the North RPU Behavioral Health Quality Committee there were also membership changes. Elizabeth Davis from SUNY Cortland and Shawn Rosno from Schyuler County Mental Health were no longer able to participate in the committee meetings due to workload challenges. Dr. James Loehr from Cayuga Family Medicine and Tamara Bame Hawley from Cayuga Medical Associates were added to the North RPU Behavioral Health Quality Committee. For the East RPU, there were changes to the Charter. Jan Miller retired in January 2017 and was replaced with Tina Snyder from Catskill Area Hospice and Palliative Care. Patricia Outhouse retired March 31, 2017, and was replaced with Kendall Drexler from Hospice and Palliative Care of Chenango County. The updated charters for all three committees, the Clinical Governance Committees template and meeting schedule for DY2Q4 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 complete and passed in the DY1, Q2 report. There have been no changes to the bylaws this last quarter. For the Finance committee, there was a change in CCN_FN4, the RPU Budget Policy. The Finance Committee desired to remove the specific reference to a dollar amount for the RPU budgets as it will be necessary to flex those in the near future based on operationalizing the RPUs to create the Integrated Delivery System and in completing the Corrective Action Plans being filed with DOH for the Mid-Point Assessment. The specific references to the RPU Leads was also removed. The updated CCN_FN4 policy and Board of Directors meeting minutes from when the Board approved the changes to the policy have been uploaded as supporting documentation.
Establish governance structure reporting and monitoring processes	This milestone was complete and passed 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. 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. Additionally, in DY2Q4, changes have been implemented in the RPUs for performance monitoring as part of the CCN response to the Mid-Point Assessment. The focus of each RPU has shifted to data driven discussion, performance assessment, network development and rapid cycle performance improvement. CCN is providing a standardized performance dashboard that includes: contracted patient engagement performance, and quality measure set performance. Each RPU will be accountable for monitoring and reporting RPU performance to the CCN Executive Director, PAC Executive Committee and the CCN Board of Directors. Contracted performance by partner will be tracked and reviewed in weekly RPU Meetings, bi-monthly at PAC Executive Committee and monthly at the CCN Board. PPS Population Health Quality Measure Sets will also be reviewed weekly. Follow up analytics to gain deeper insight into below target performance will

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	be commissioned and reviewed in each RPU with their dedicated analyst. The RPU will develop action plans for interventions through projects and/or care coordination with contracted partners. If the RPU cannot achieve the needed improvement in performance levels working directly with the partner, the issue will be promoted to the CCN Board for resolution. In addition to speed and scale, project performance, and project quality performance will also be tracked and monitored. As part of the Performance Management Agenda for the RPU, each project will be evaluated based on the quality measure set. Discussion will focus on understanding the care delivery process currently in place in the RPU network and potential interventions that could be adopted by the RPU network to change performance. RPUs will maintain an active issue log to assure that identified and approved interventions have an implementation plan that is actively managed. RPU leads will provide monthly reporting and tracking related to contracted partner performance, population quality metrics, Project Quality Metrics, and the RPU Network Action Plan to CCN. CCN will prepare and provide the RPU reports as well as PPS wide performance reports to PAC Executive Council and the CCN Board. CCN will provide feedback, direction and approval for the RPU plans. In the event that performance is off track, this system of reporting and monitoring should signal course correction in the earliest possible time frame to the CCN Board level. Lastly, 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 completed and passed in DY1Q3. During DY2Q4, Care Compass Network committed to maintaining a consistent presence in Social Media platforms including relevant posts on Twitter as well as Linked In. Post topics ranged from updates on Project progress, notifying interested participants of upcoming events, sharing job opportunities and promoting related communications from and about partner organizations. An effort to increase the frequency of activity on Twitter was successful and the follower audience has seen a slight increase. Similarly, enhanced attention to "tagging" and "retweeting" has resulted in an improvement in social media analytics. These analytics are monitored and reported on a regular basis to help gauge the topics getting the most user engagement. Now that DSRIP is entering its third year, it's clear that some of the communication tools can stand to be reevaluated. One such tool was the website. When first designed, the website served the purpose of educating a broad audience about the definition of DSRIP and who is part of the Southern Tier Performance Provider System. On the heels of launching CCN's Social Media presence and updating content pertaining to articles and news updates, it seemed prudent to canvas the CCN leadership team regarding goals and objectives for the website. Three specific "phase one" initiatives came out of that meeting: 1) The home page of the site would change to a sliding banner design, featuring information that would be accompanied by an engaging image and a link to more information on the site. 2) the Project pages would be redesigned to offer more in-depth information about each project's focus, progress and team members and 3) the events section would be heavily populated with information useful to the partners. Items 1 and 3 have been completed and item 2 is in the active design phase. Phase 2 of the Website Redesign will include the addition of training videos, webinars, resource guides and interactive models. To see the updated website, please navigate to www.carecompassnetwork.org. Care Compass Network has created a Twitter account (Twitter Handle: @CareCNdsrip) to engage and interact with Medicaid members, regional media outlets and the local communities within the nine-county region that CCN supports. Twitter posts and retweets are used to increase awareness about changes in healthcare as well as local community events provided by CCN's partners. The content of the Community Engagement Plan did not change however, the deliverables for DY2Q4 were updated in the plan to reflect status of the deliverable and the updated document has been uploaded as supporting documentation.
Finalize partnership agreements or contracts with CBOs	This milestone is due for completion in DY2Q4 however CCN is deferring completion to a future quarter as per previous IA guidance requiring all CBO Tier 1 Organizations to have executed contracts with CCN. Of the 29 CBO Tier 1 organizations, CCN has executed Partner Agreements and BAAs with 13 of them, with 12 of the 13 also executing at least 1 Appendix C to implement projects. Of the remaining 16 CBO Tier 1 organizations in the 9-county PPS, 15 of them previously provided attestations to CCN to become Partners but have yet to execute Partner Agreements with CCN. With the funds flow revisions in the CCN Phase II contracts and changes in reporting requirements along with rolling out support to Partners for IT needs, CCN is seeing more interest from the CBOs in contracting. As we identified in the Mid-Point Action Plans, CCN will leverage the RPUs to assess regional capacity for project implementation and identify gaps in functionality (e.g. care coordination) and partners that might fill those gaps. The RPUs are positioned to link CBOs who possess needed skills/competencies

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	with health care systems that need assistance with additional capacity to meet targeted goals. CCN expects to engage the remaining CBO Organizations by DY3Q2 after completion of the RPU analysis and ramp up of Phase II contracting.
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.)	
Finalize workforce communication and engagement plan	Milestone 8 was completed and passed in DY2Q2, however there are no changes.
Inclusion of CBOs in PPS Implementation.	Milestone 9 was completed and passed in DY2Q1, there are no changes to report. CCN continues to include CBOs in implementation of the DSRIP projects. As per the Mid-Point Action Plans submitted by CCN, CCN will use the RPUs link CBOs who possess needed skills/competencies with health care systems that need assistance with additional capacity to meet targeted goals. The CBOs will be critical in the continued development of the regional networks as part of the Integrated Delivery System.

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 & Complete	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.)

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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 :

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	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")	Completed	Administer VBP activity survey to network	04/01/2015	03/31/2020	04/01/2015	03/31/2017	03/31/2017	DY2 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	

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	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	03/31/2020	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	03/31/2020	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	03/31/2020	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	03/31/2020	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	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	

Care Compass Network (PPS ID:44)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	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	03/31/2020	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	03/31/2020	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	03/31/2020	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	03/31/2020	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	03/31/2020	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	03/31/2020	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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop a Value Based Payments Needs Assessment ("VNA")	mrbobc	Templates	44_DY2Q4_FS_MDL31_PRES4_TEMPL_VNA_13743.pdf	This is the Value-Based Payment Needs Assessment as issued by the PPS in 2017.	04/27/2017 11:26 AM
	mrbobc	Rosters	44_DY2Q4_FS_MDL31_PRES4_ROST_2017_VBP_Survey_Response_List_12755.pdf	List of organizations within CCN participating in the 2017 VNA.	04/26/2017 11:28 AM
	mrbobc	Baseline or Performance Documentation	44_DY2Q4_FS_MDL31_PRES4_BASE_Milestone_04_-_VBP_Baseline_2017_Complete_12742.pdf	A presentation given to the VBP Sub-Committee regarding the early 2017 Value-Based Needs Assessment done using the template provided by DoH.	04/26/2017 11:22 AM
	mrbobc	Baseline or Performance Documentation	44_DY2Q4_FS_MDL31_PRES4_BASE_Milestone_04_-_VBP_Baseline_2016_Complete_12741.pdf	A summary given to the VBP Sub-Committee about the initial VBP survey done by the PPS in late 2015.	04/26/2017 11:21 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize PPS finance structure, including reporting structure	No Changes.
Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	There are no updates for the DY2, Q4 submission for this milestone as it was completed and passed in DY1, Q4 and has no changes. The PPS sent out the most recent assessment on January 13th, 2017 and had no fragile providers identified.
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	No Changes.
Develop a Value Based Payments Needs Assessment ("VNA")	Milestone 4 is due for completion in DY2Q4 and is being reported as complete. All steps for this Milestone have been completed as previously scheduled prior to the announcement of the new VBP milestones in Financial Stability. When DOH released the new template for the Value Based Payment Needs Assessment (VNA), it had been slightly over one year since the PPS had surveyed its partners with regards to Value-Based Payment Status and Readiness. Therefore, the PPS re-surveyed its partners using the new template provided by DOH. In January 2017, the PPS sent the VNA to 61 Partner Organizations, compared to 40 in 2016. A total of 26 Organizations responded to the 2017 VNA, representing 155,495 duplicated Medicaid Lives in the PPS. Of the Organizations that responded, 16 of the 26 Organizations have onsite Care Coordination or Care Management Services, and 18 of them actively refer to the Medicaid Health Home. Several areas of education were identified in the VNA as well which will be incorporated into the Education Plan for Milestone 6 of Financial Stability. In the uploaded document, Milestone 04 - VBP Baseline 2017 Complete.pdf, a summary of the current state of VBP contracting by network partners is found on slide 2 and 3. Details on service line offerings (including availability of care coordination or care management services) is found on slide 4. Assessment of technology and analytic resources of the PPS network partners is found on slide 5. Identification of knowledge areas where additional education is needed is found on slide 6. Additionally, the PPS VNA has been uploaded for the IA to review.
Develop an implementation plan geared towards addressing the needs identified within your VNA	
Develop partner engagement schedule for partners for VBP education and training	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
≥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	

Milestone Review Status

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 3.2 - 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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 3.3 - 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:

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

• 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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 3.5 - 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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 3.6 - 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 Stephanie Woolever, Project Manager - East RPU Rachael Haller, Project Manager - West RPU Emily Balmer, Project Manager Bouakham Rosetti, Project Manager Nancy Frank, Project Manager - South RPU	PPS Project Managers	Collaboration with finance re: PPS Project Implementation, status of projects, reporting required to meet DOH requirements.
Joe Sexton	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, Care Compass Network Compliance & Audit Commitee Chair	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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
PPS Finance Committee	Dave MacDougall, Care Compass Network Finance Committee Chair	Board level oversight and responsibility for the PPS Finance function; Review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; collaboration with the Compliance Committee for audit and compliance related processes.
PPS Human Resources	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
Greg Rittenhouse	South RPU Lead	Alignment of RPU needs at the Governance Level, Coordination of Common Projects where PPS overlap occurs, general oversight of project implementation efforts at the local level.
External Stakeholders		
New York State Department of Health	NY DOH defines the DSRIP requirements	The PPS Lead and PPS finance function has responsibility for the overall administration of DSRIP reporting to DOH and the funds flow process.
PPS Stakeholders	Community Representatives	Community needs and interests are significant influencers of DSRIP projects and will contribute to the adoption and buy-in across the network. Communication regarding DSRIP status, results, and future strategies will be important to maintain their contribution and influence.
Government Agencies / Regulators	Government Agencies / Regulators	County and State agencies and regulatory bodies will have oversight and influence in a number of DSRIP related areas - including the importance of waivers or regulatory relief, construction / renovation projects, and other items related to DSRIP. Communication with them regarding DSRIP status, results, future strategies and their role in DSRIP success will be

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	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
Finalize cultural competency / health literacy strategy.	brosetti	Report(s)	44_DY2Q4_CCHL_MDL41_PRES1_RPT_Nathan_Klein_Assessment_12552.pdf	Nathan Klein Assessment	04/26/2017 09:00 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. In DY2Q4, CCN has made progress in distributing the Nathan Klein assessment to PPS partner Workforce Leads. The survey was live until April 14th. As of April 11th, there are 45 responses from partners. These responses will ultimately determine the engagement level of CCHL and what type of CCHL training our partners currently use. However, the CCHL Committee has identified a concern that this survey may not formulate a definitive answer of existing CCHL strategies since many partners have different comprehension levels of CCHL within their respective organizations. The results so far have varied among partners. As more responses are returned, the CCHL will formulate a strategy on how to fill the gaps in the trainings our partners are currently using.
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. In the upcoming quarter, CCN will draft and finalize the training module from CCSI, the selected vendor to have it launched in HWApps this summer. Following the MidPoint assessment recommendation to form an engagement metrics sub-team, CCN has continued to build the team to address partner engagement and in turn to execute a survey regarding this to partner organizations.

New York State Department Of Health
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 #1	Pass & Complete	
Milestone #2	Pass & Complete	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 4.2 - 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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 4.3 - 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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 4.4 - 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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 4.5 - 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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 4.6 - 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 :

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Section 05 – IT Systems and Processes

IPQR Module 5.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	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	Completed	PPS plan for engaging attributed members in Qualifying Entities, signed off by PPS Board. The plan should include your approach to outreach into culturally and linguistically isolated communities.	04/01/2015	03/31/2017	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

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	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).	rachaelm	Meeting Materials	44_DY2Q4_IT_MDL51_PRES1_MM_IT_M1_DY2Q4_Required_Attachments_14282.pdf	Meeting Schedule	04/28/2017 01:25 PM
Develop an IT Change Management Strategy.	rachaelm	Meeting Materials	44_DY2Q4_IT_MDL51_PRES2_MM_IT_M2_DY2_Q4_Required_Attachments_14285.pdf	Meeting Schedule and Training Schedule	04/28/2017 01:28 PM
Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	rachaelm	Other	44_DY2Q4_IT_MDL51_PRES3_OTH_IT_M3_DY2_Q4_Required_Attachments_14286.pdf	Training Schedule, Meeting Schedule, Updated Contract Listing	04/28/2017 01:30 PM
Develop a specific plan for engaging attributed members in Qualifying Entities	sculley	Meeting Materials	44_DY2Q4_IT_MDL51_PRES4_MM_IT_Systems_and_Processes_Milestone_4_Remediation_15575.pdf	Remediation documentation - proof of PPS board approval.	06/19/2017 10:13 PM
	rachaelm	Other	44_DY2Q4_IT_MDL51_PRES4_OTH_IT_M4_DY2_Q3_Required_Attachments_14288.pdf	i. QE Engagement Plan ii. Needs Assessment iii. Gap Analysis iv. Partner Agreement v. Cultural Competency & Health Literacy Strategy vi. RHIO Engagement Growth	04/28/2017 01:35 PM

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop a data security and confidentiality plan.	rachaelm	Other	44_DY2Q4_IT_MDL51_PRES5_OTH_IT_M5_DY2Q3_Required_Attachments_14289.pdf	Training policy and guidance	04/28/2017 01:37 PM

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 completed and passed in DY1Q4. There have not been any changes to the IT Roadmap. The IT staff continues to meet with all partners to assess their continued needs for IT support. The contracts for EMR implementation and Connectivity have been approved by the IT, Informatics and Data Governance Committee. Several contracts have been executed to provide funding to assist with RHIO connection, report generation, EMR modification, and IT infrastructure. Continued focus for DY3 will be the Safety Net partners. The meeting schedules of the IT governance body for DY2Q4 have been uploaded.
Develop an IT Change Management Strategy.	The IT Systems & Processes Milestone 2 was completed and passed in DY2Q3. A review of the Change Management Strategy was done with the PAC Executive Council on April 21, 2017 and PAC Stakeholders group on April 28, 2017.
Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	The IT Systems & Processes Milestone 3 was completed and passed in DY1Q4. There were no changes to the clinical data sharing and interoperable systems roadmap in DY2, Q4. 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. 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 and Partner Agreement with Care Compass Network.
Develop a specific plan for engaging attributed members in Qualifying Entities	The IT Systems & Processes Milestone 4 is due in DY2Q4 and is being reported as complete. 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 and one-on-one meetings between CCN's IT staff and partner organization IT staff. 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. CCN and the RHIOs do not have a direct engagement or contact with the Medicaid members. In order to gauge the level of engagement a member has, a dashboard has been developed to report partner organization progress collecting consents from the members/beneficiaries (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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	present CCN has 77% 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 a 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. The formal plan for engaging attributed members in Qualifying Entities was approved by the IT, Informatics and Data Governance Committee on April 20, 2017. It will be taken to the CCN Board of Directors meeting on May 9, 2017 for final approval. The plan was developed by the IT Department, with input from the Cultural Competency and Health Literacy Committee and the IT, Informatics and Data Governance Committee. The plan is monitored by IT Project Manager, Jennifer Parks who can be reached at jparks@carecompassnetwork.org.
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. CCN received the first Medicaid Confidential Data (MCD) files in February 2017. Documentation for RAM Validation was completed in March and April 2017 and submitted on April 17, 2017 to the DOH. Recently, DOH announced that an additional set of SSP workbooks are required prior to MCD being incorporated into a production environment. The new set of 18 workbooks include the original 359 controls plus 65 additional control requirements. CCN estimates the new set of workbooks will be completed during DY3 Q1. This is a top priority for the CCN IT Department and will utilize the IT & Data Security Subcommittee to ensure the new security controls are consistent with CCN's commitment to data privacy and security. There have been no changes to the 18 SSP workbooks previously submitted by CCN.

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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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 Sally Colletti / 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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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 :

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	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_DY2Q4_PR_MDL61_PRES2_TEMPL_PerformanceReporting_DY2Q4_Template_12720.xlsx	Copies of Training Schedule (using training schedule template)	04/26/2017 11:10 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish reporting structure for PPS-wide performance reporting and communication.	This Milestone was completed and passed 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.	This Milestone was completed and passed in DY2Q1. There have been no changes to the training program. Efforts to train and educate partner organizations continue as outlined in the training schedule attached.

Milestone Review Status

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	Greg Rittenhouse, Retired from UHS Home Care (Interim)	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	Joe Sexton (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.
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

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.

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 :

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
integration, and clinical improvement									
Task 2c. Financial risk seminars for concerned practitioners (involving MCOs), and PPS-wide plans for mitigating the impacts of revenue loss	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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.	brosetti	Meeting Materials	44_DY2Q4_PRCENG_MDL71_PRES1_MM_DY2,_Q4_Practitioner_Engagement_Meeting_Schedule_Template_12623.xlsx	DY2, Q4 Practitioner Engagement Meeting Schedule Template	04/26/2017 09:59 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.	brosetti	Training Documentation	44_DY2Q4_PRCENG_MDL71_PRES2_TRAIN_CCN_Training_Schedules_DY2Q4_Template_12624.pdf	Training schedules: CCN Training Schedules_DY2Q4 template	04/26/2017 10:02 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.	This Milestone was completed and passed in DY1Q4. Care Compass Networks efforts to train and educate practitioners continues as it has in previous quarters. In DY2Q4, a 2 day INTERACT training was provided by Pathway Health's Jeanne Carlson. This is the required Champion training for all INTERACT partners. It encompasses all aspects of the INTERACT project including the tools available, implementation and troubleshooting. Those who attend will be able to complete a certified INTERACT Champion training test to become a certified training champion. In the past quarter CCN hosted another 2-hour Leadership Program Overviewing INTERACT QIP at Cortland Regional Medical Center on March 1st (previously CCN held a 2-hour INTERACT overview in September 2016). This training session was aimed at educating hospital staff, Primary Care Physicians as well as Medical Directors working with Skilled Nursing Facilities. Education on Care Paths is included as part of the of the training. There have been no changes to the training and education plan.

Milestone Review Status

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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 :

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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 three key developments related to the population health strategy; first, initiating work on the Integrated Delivery System; second, continuing development on the CCN Data Warehouse, and, third, building the Population Health Team. 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. To date, 12 practice have achieved this certification; the remaining are on track to achieve certification by March 31, 2018. 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. Aggregate data from patient registries from partners can be used to determine the level of patient interaction and engagement between project efforts, which informs and measures the level of efficacy of interventions. Aggregation can help to identify opportunities for improvement in workflows or identify hot spot patient populations. The next phase, which includes the table structure for the Medicaid claims data and a data mart, is underway and will include project and performance metric dashboards. Future state will include additional sources of data, including clinical data for real-time decision support, PAM activation, and social determinants data. CCN is building operational support for the Regional Performance Units (RPU), including population health analysts assigned to the RPUs. The Population Health Team will provide the informational support for a continual process improvement model of engagement with partners for each RPU so that each can set local goals for outcomes improvement and have individualized monitoring. In addition, this team will disseminate performance results to various CCN forums, including the RPUs, Clinical Governance Committees, the Project Advisory Council, and the Board of Directors. Development of the Population Health Team is nascent; the team is being populated in DY3 Q1 with a Director and Senior Analyst.
Finalize PPS-wide bed reduction plan.	Care Compass Network completed the Bed Reduction Plan Milestone in DY2Q2. There are no updates to report.

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	This is being marked Pass & Ongoing because there are a number of PCMH providers that are still in progress or pending NCQA review for PCMH certification.

New York State Department Of Health
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 #2	Pass & Complete	

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

DSRIP Implementation Plan Project

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Instructions :

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	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	06/30/2017	06/30/2017	DY3 Q1	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.	Completed	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	Completed	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	

Care Compass Network (PPS ID:44)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	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.	Completed	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.	Completed	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.	Completed	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).	Completed	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	06/30/2017	06/30/2017	DY3 Q1	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	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	06/30/2017	06/30/2017	DY3 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 a clinical integration 'needs assessment'.	sculley	Other	44_DY2Q4_CI_MDL91_PRES1_OTH_IT_Partner_Landscape_14327.pdf	IT Partner landscape.	04/28/2017 03:35 PM
	sculley	Other	44_DY2Q4_CI_MDL91_PRES1_OTH_Submissions_Tracking_List_CCN_042017_14326.xlsx	Status of PCMH certification for providers in PPS network.	04/28/2017 03:35 PM
	sculley	Other	44_DY2Q4_CI_MDL91_PRES1_OTH_Clinical_Integration_Needs_Assessment_DY2Q4_Update_14324.docx	Update to CCN's Clinical Integration Needs Assessment.	04/28/2017 03:34 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform a clinical integration 'needs assessment'.	Milestone 1 was completed and passed in DY1Q4. In the DY2Q4 timeframe the clinical integration needs assessment has been updated and uploaded with applicable supporting documents.
Develop a Clinical Integration strategy.	Milestone 2 and all associated steps are due for completion in DY2Q4 however CCN is deferring the completion of the milestone and a few of the steps to DY3Q1 as CCN will be taking the Clinical Integration Strategy draft to the RPU Operations meetings to confirm the details of the strategy represent the regional needs. CCN has created a Clinical Integration Strategy leveraging information, existing technology information and needs from each of the RPUs (Step 1 – Complete). Aware of where gaps exist relative to the target state, CCN has already begun working on high priority areas such as assisting safety net providers in EHR

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	implementation and RHIO connectivity for partners that are common across the RPUs (Step 2 and Step 3 – Complete). In March 2017 at the CCN Coordinating Council, the key clinical and other data needed to support effective information exchange was discussed with practitioners and other key stakeholders (Step 4 – Complete). CCN has created incentive dollars and resource support to assist partners in clinical integration improvements (Step 5 – Complete). Examples of the IT incentive support is creating agreements for partners to purchase EHR systems with funding support from CCN, particularly incentivizing them to have the systems in place by December 31, 2017. Another example is supporting Primary Care Practices in achievement of PCMH 2014 Level 3 certification as this is a key element to improving efficiency and care coordination capacity of the Primary Care Practices supporting the PPS network (Step 5 – Complete). In DY3Q1 the Clinical Integration Strategy will be brought to each of the RPU Operational groups to ensure the strategy incorporates the needs of each RPU appropriately regarding clinical integration (Step 6 – Complete).

Milestone Review Status

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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 Sally Colletti, Provider Relations / Care Compass Network	Responsible for managing physician relations, performing education, training, and coordinating agreements.
South RPU Lead	Greg Rittenhouse (CCN)	Alignment of RPU needs at the Governance Level, including clinical integration.
North RPU Lead	Interim - Joe Sexton	Alignment of RPU needs at the Governance Level, including clinical integration.
East RPU Lead	Greg Rittenhouse (CCN)	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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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:

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Instructions :

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

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 (* Joe Sexton - Interim for North RPU * Greg Rittenhouse (CCN) - East RPU * Greg Rittenhouse (CCN) - Interim 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

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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 :

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	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_DY2Q4_WF_MDL112_PRES1_MM_Agenda1_31_13780.pdf	Agenda material from Workforce Development Workshop held January 31, 2017.	04/27/2017 12:17 PM
	sculley	Meeting Materials	44_DY2Q4_WF_MDL112_PRES1_MM_DY2Q4_Workforce_Meeting_Schedule_13778.xlsx	Workforce meeting schedule in DY2Q4	04/27/2017 12:16 PM
Create a workforce transition roadmap for achieving defined target workforce state.	sculley	Meeting Materials	44_DY2Q4_WF_MDL112_PRES2_MM_DY2Q4_Workforce_Meeting_Schedule_13785.xlsx	Workforce meeting schedule for DY2Q4	04/27/2017 12:19 PM
Develop training strategy.	sculley	Training Documentation	44_DY2Q4_WF_MDL112_PRES5_TRAIN_DY2Q4_Training_Schedule_13794.xlsx	Training schedule to document trainings delivered during the quarter.	04/27/2017 12:22 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Define target workforce state (in line with DSRIP program's goals).	This milestone was completed and passed in DY2Q2 however, over the course of DY2Q4, Care Compass Network has implemented areas of the transition roadmap. On January 31, 2017, Care Compass Network held a day long Workforce Summit. Its sole focus was identifying training needs from across the PPS by listening to the PPS' partner organizations. Partner organizations were organized by project participation for the sake of communication across the provider type spectrum as well as any identification of best practices and/or similar needs. The identified trainings were catalogued and prioritized by frequency across all projects. Care Compass Network has been in the process of selecting content and vendors for these prioritized trainings. One of the main trainings identified by CCN has been Cultural Competency and Health Literacy. During DY2Q4, CCN deployed a survey utilizing the Nathan Kline Institute's CCAS tool to its partner organizations. Furthermore, CCN has contracted with Coordinated Care Services, Inc. (CCSI) to create four CCHL modules for training purposes. The four modules will focus on CCHL in general, Aging population, lower socio-economic population, and the rural population. These will be completed by CCSI in early DY3. Care Compass Network has been in the process of selecting a learning management system over the course of DY2Q4. CCN has begun the process of vetting vendors and seeing how capabilities meet CCN's needs. Occupational training has begun via partnerships with institutions of higher education. CCN has been in

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	discussion with Binghamton University regarding the development of curriculum, programs, and internships/preceptorships from an interdisciplinary perspective since February 22, 2017. With an eye towards the School of Social Work, CCN has been working towards the placement of social workers in the offices of primary care providers, among other healthcare provider settings. Care Compass Network has been developing recruiting methods for the future workforce state. Through the Gap Analysis and Future Workforce State, CCN has identified its priority/high needs positions. The PPS is moving towards a recruitment firm to assist the PPS partner organizations in their recruitment needs. A set of criteria for both the recruitment vendor and PPS partner organizations looking to participate in this program have been developed. Budgetary monies are in the process of being reallocated to meet the needs and goals of this recruitment effort.
Create a workforce transition roadmap for achieving defined target workforce state.	This milestone was completed and passed in DY2Q2 however, over the course of DY2Q4, Care Compass Network has implemented areas of the transition roadmap. On January 31, 2017, Care Compass Network held a day long Workforce Summit. Its sole focus was identifying training needs from across the PPS by listening to the PPS' partner organizations. Partner organizations were organized by project participation for the sake of communication across the provider type spectrum as well as any identification of best practices and/or similar needs. The identified trainings were catalogued and prioritized by frequency across all projects. Care Compass Network has been in the process of selecting content and vendors for these prioritized trainings. One of the main trainings identified by CCN has been Cultural Competency and Health Literacy. During DY2Q4, CCN deployed a survey utilizing the Nathan Kline Institute's CCAS tool to its partner organizations. Furthermore, CCN has contracted with Coordinated Care Services, Inc. (CCSI) to create four CCHL modules for training purposes. The four modules will focus on CCHL in general, Aging population, lower socio-economic population, and the rural population. These will be completed by CCSI in early DY3. Care Compass Network has been in the process of selecting a learning management system over the course of DY2Q4. CCN has begun the process of vetting vendors and seeing how capabilities meet CCN's needs. Occupational training has begun via partnerships with institutions of higher education. CCN has been in discussion with Binghamton University regarding the development of curriculum, programs, and internships/preceptorships from an interdisciplinary perspective since February 22, 2017. With an eye towards the School of Social Work, CCN has been working towards the placement of social workers in the offices of primary care providers, among other healthcare provider settings. Care Compass Network has been developing recruiting methods for the future workforce state. Through the Gap Analysis and Future Workforce State, CCN has identified its priority/high needs positions. The PPS is moving towards a recruitment firm to assist the PPS partner organizations in their recruitment needs. A set of criteria for both the recruitment vendor and PPS partner organizations looking to participate in this program have been developed. Budgetary monies are in the process of being reallocated to meet the needs and goals of this recruitment effort.
Perform detailed gap analysis between current state assessment of workforce and projected future state.	This milestone was completed and passed in DY2Q2 however, over the course of DY2Q4, Care Compass Network has implemented areas of the transition roadmap. On January 31, 2017, Care Compass Network held a day long Workforce Summit. Its sole focus was identifying training needs from across the PPS by listening to the PPS' partner organizations. Partner organizations were organized by project participation for the sake of communication across the provider type spectrum as well as any identification of best practices and/or similar needs. The identified trainings were catalogued and prioritized by frequency across all projects. Care Compass Network has been in the process of selecting content and vendors for these prioritized trainings. One of the main trainings identified by CCN has been Cultural Competency and Health Literacy. During DY2Q4, CCN deployed a survey utilizing the Nathan Kline Institute's CCAS tool to its partner organizations. Furthermore, CCN has contracted with Coordinated Care Services, Inc. (CCSI) to create four CCHL modules for training purposes. The four modules will focus on CCHL in general, Aging population, lower socio-economic population, and the rural population. These will be completed by CCSI in early DY3. Care Compass Network has been in the process of selecting a learning management system over the course of DY2Q4. CCN has begun the process of vetting vendors and seeing how capabilities meet CCN's needs. Occupational training has begun via partnerships with institutions of higher education. CCN has been in discussion with Binghamton University regarding the development of curriculum, programs, and internships/preceptorships from an interdisciplinary perspective since February 22, 2017. With an eye towards the School of Social Work, CCN has been working towards the placement of social workers in the offices of

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	primary care providers, among other healthcare provider settings. Care Compass Network has been developing recruiting methods for the future workforce state. Through the Gap Analysis and Future Workforce State, CCN has identified its priority/high needs positions. The PPS is moving towards a recruitment firm to assist the PPS partner organizations in their recruitment needs. A set of criteria for both the recruitment vendor and PPS partner organizations looking to participate in this program have been developed. Budgetary monies are in the process of being reallocated to meet the needs and goals of this recruitment effort.
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 completed and passed in DY2Q2 however, over the course of DY2Q4, Care Compass Network has implemented areas of the transition roadmap. On January 31, 2017, Care Compass Network held a day long Workforce Summit. Its sole focus was identifying training needs from across the PPS by listening to the PPS' partner organizations. Partner organizations were organized by project participation for the sake of communication across the provider type spectrum as well as any identification of best practices and/or similar needs. The identified trainings were catalogued and prioritized by frequency across all projects. Care Compass Network has been in the process of selecting content and vendors for these prioritized trainings. One of the main trainings identified by CCN has been Cultural Competency and Health Literacy. During DY2Q4, CCN deployed a survey utilizing the Nathan Kline Institute's CCAS tool to its partner organizations. Furthermore, CCN has contracted with Coordinated Care Services, Inc. (CCSI) to create four CCHL modules for training purposes. The four modules will focus on CCHL in general, Aging population, lower socio-economic population, and the rural population. These will be completed by CCSI in early DY3. Care Compass Network has been in the process of selecting a learning management system over the course of DY2Q4. CCN has begun the process of vetting vendors and seeing how capabilities meet CCN's needs. Occupational training has begun via partnerships with institutions of higher education. CCN has been in discussion with Binghamton University regarding the development of curriculum, programs, and internships/preceptorships from an interdisciplinary perspective since February 22, 2017. With an eye towards the School of Social Work, CCN has been working towards the placement of social workers in the offices of primary care providers, among other healthcare provider settings. Care Compass Network has been developing recruiting methods for the future workforce state. Through the Gap Analysis and Future Workforce State, CCN has identified its priority/high needs positions. The PPS is moving towards a recruitment firm to assist the PPS partner organizations in their recruitment needs. A set of criteria for both the recruitment vendor and PPS partner organizations looking to participate in this program have been developed. Budgetary monies are in the process of being reallocated to meet the needs and goals of this recruitment effort.
Develop training strategy.	This milestone was completed and passed in DY2Q2 however, over the course of DY2Q4, Care Compass Network has implemented areas of the transition roadmap. On January 31, 2017, Care Compass Network held a day long Workforce Summit. Its sole focus was identifying training needs from across the PPS by listening to the PPS' partner organizations. Partner organizations were organized by project participation for the sake of communication across the provider type spectrum as well as any identification of best practices and/or similar needs. The identified trainings were catalogued and prioritized by frequency across all projects. Care Compass Network has been in the process of selecting content and vendors for these prioritized trainings. One of the main trainings identified by CCN has been Cultural Competency and Health Literacy. During DY2Q4, CCN deployed a survey utilizing the Nathan Kline Institute's CCAS tool to its partner organizations. Furthermore, CCN has contracted with Coordinated Care Services, Inc. (CCSI) to create four CCHL modules for training purposes. The four modules will focus on CCHL in general, Aging population, lower socio-economic population, and the rural population. These will be completed by CCSI in early DY3. Care Compass Network has been in the process of selecting a learning management system over the course of DY2Q4. CCN has begun the process of vetting vendors and seeing how capabilities meet CCN's needs. Occupational training has begun via partnerships with institutions of higher education. CCN has been in discussion with Binghamton University regarding the development of curriculum, programs, and internships/preceptorships from an interdisciplinary perspective since February 22, 2017. With an eye towards the School of Social Work, CCN has been working towards the placement of social workers in the offices of primary care providers, among other healthcare provider settings. Care Compass Network has been developing recruiting methods for the future workforce state. Through the Gap Analysis and Future Workforce State, CCN has

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	identified its priority/high needs positions. The PPS is moving towards a recruitment firm to assist the PPS partner organizations in their recruitment needs. A set of criteria for both the recruitment vendor and PPS partner organizations looking to participate in this program have been developed. Budgetary monies are in the process of being reallocated to meet the needs and goals of this recruitment effort.

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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.)

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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)	Interim - Scott Emery. M.S. Hall & Associates	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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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, Dr. Michael Lavin, 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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	Report(s)	44_DY2Q4_WF_MDL1110_RPT_Workforce_Staffing_Impact_(Actuals)_-_DY2Q3Q4_15665.xlsx	Remediation file - updated workforce staffing impact for DY2 Q3/Q4.	06/20/2017 08:28 AM
sculley	Report(s)	44_DY2Q4_WF_MDL1110_RPT_Workforce_Staffing_Impact_(Actuals)_-_DY1_15664.xlsx	Remediation file - workforce staffing impact for DY1.	06/20/2017 08:27 AM
sculley	Report(s)	44_DY2Q4_WF_MDL1110_RPT_Workforce_Module_11.10_Remediation_15663.docx	Remediation narrative addressing IA's comments.	06/20/2017 08:26 AM
sculley	Baseline or Performance Documentation	44_DY2Q4_WF_MDL1110_BASE_CCN_Workforce_Staffing_Impact_(Actuals)_DY2Q4_14296.xlsx	Workforce staffing impact analysis for DY2Q4.	04/28/2017 02:11 PM

Narrative Text :

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 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	68,165.40	116,795.40	42.40%
Redeployment	0.00	0.00	0.00	0.00%
New Hires	9,544.00	23,860.00	71,580.00	118.14%
Other	216,162.00	131,312.64	665,474.64	113.35%
Total Expenditures	**262,336.00**	**223,338.04**	**853,850.04**	**90.76%**

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.

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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 11.12 - IA Monitoring:

Instructions :

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project 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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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 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	Completed	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		Completed	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		Completed	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		Completed	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		Completed	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		On Hold	04/01/2015	03/31/2017	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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		Completed	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	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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 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	12/31/2016	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	12/31/2016	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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
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		Completed	04/01/2015	06/30/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
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		Completed	04/01/2015	06/30/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
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		Completed	04/01/2015	06/30/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
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		Completed	04/01/2015	03/31/2018	04/01/2015	03/31/2017	03/31/2017	DY2 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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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	12/31/2017	12/31/2017	DY3 Q3
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	12/31/2017	12/31/2017	DY3 Q3
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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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		Completed	04/01/2015	06/30/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
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		Completed	04/01/2015	06/30/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
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		Completed	04/01/2015	06/30/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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	Completed	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		Completed	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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
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		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

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
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	03/31/2018	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	03/31/2018	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	03/31/2018	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	03/31/2018	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		Completed	04/01/2015	03/31/2018	04/01/2015	03/31/2017	03/31/2017	DY2 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	03/31/2018	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		On Hold	04/01/2015	03/31/2018	04/01/2015	03/31/2020	03/31/2020	DY5 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	03/31/2018	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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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	12/31/2017	12/31/2017	DY3 Q3
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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	sculley	Other	44_DY2Q4_PROJ2ai_MDL2ai2_PRES3_OTH_2ai_M3_Remediation_documentation_15766.pdf	Remediation file - 2ai milestone 3 narrative and supporting documentation.	06/20/2017 10:59 AM
	swooleve	Other	44_DY2Q4_PROJ2ai_MDL2ai2_PRES3_OTH_CGC-CG-36_&_37_14328.pdf	CGC-CG-36 & 37 outlining process workflows for 3.a.i and 4.a.iii	04/28/2017 03:37 PM
	swooleve	Other	44_DY2Q4_PROJ2ai_MDL2ai2_PRES3_OTH_Training_materials_14325.pdf	Inventory of all IDS training available for the PPS with DY2Q4 performance reporting	04/28/2017 03:34 PM
	swooleve	Other	44_DY2Q4_PROJ2ai_MDL2ai2_PRES3_OTH_example_flow_charts_14242.pdf	CGC approved flow charts showing implementation of an IDS across the PPS	04/28/2017 12:08 PM
	swooleve	Other	44_DY2Q4_PROJ2ai_MDL2ai2_PRES3_OTH_CTI_workflow_for_identifying_patients_and_communication_with_PCP._14239.xlsx	Care Transitions Implementation workflow	04/28/2017 12:06 PM
	swooleve	Other	44_DY2Q4_PROJ2ai_MDL2ai2_PRES3_OTH_COPE_IDS_09122016_14237.pdf	COPE IDS diagram	04/28/2017 12:05 PM
	swooleve	Other	44_DY2Q4_PROJ2ai_MDL2ai2_PRES3_OTH_CCN_Partner_IT_Assessment_14232.pdf	CN updated analysis on partner organizations IT infrastructure	04/28/2017 12:02 PM
	swooleve	Other	44_DY2Q4_PROJ2ai_MDL2ai2_PRES3_OTH_HealthLinkNY_-_Participating_Providers_14229.pdf	Partners current RHIO use as supplied by HealthLinkNY RHIO	04/28/2017 12:02 PM
	swooleve	Other	44_DY2Q4_PROJ2ai_MDL2ai2_PRES3_OTH_Pop_Health_Roadmap_Draft_09072016_14225.pptx	Population health roadmap approved by board of directors Sept 2016	04/28/2017 12:00 PM
	swooleve	Other	44_DY2Q4_PROJ2ai_MDL2ai2_PRES3_OTH_Discharge_Plan_in_EHR_with_transmition_to_Health_Coach_14224.pdf	Validation of a discharge plan uploaded into the EHR with transmission to community organization	04/28/2017 11:59 AM
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.	swooleve	Other	44_DY2Q4_PROJ2ai_MDL2ai2_PRES5_OTH_2.a.i_Milestone_5_Narrative_14205.docx	In Process Narrative for Milestone 5	04/28/2017 11:44 AM
Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	swooleve	Meeting Materials	44_DY2Q4_PROJ2ai_MDL2ai2_PRES9_MM_Inventory_of_Meetings_with_MCOs_DY2_14213.xlsx	Inventory of Meetings with Managed care Organizations	04/28/2017 11:49 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	Milestone and steps completed and passed in DY1Q2. No updates to report.
Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	Please see uploaded document 2.a.i Milestone 3 Narrative.doc
Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Please see uploaded file entitled 2.a.i Milestone 5 Narrative.doc
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 steps 6h and 6i due for completion in DY2Q4 but the PPS is deferring these to DY3Q3, 12/31/2017, in order to refine development work taking place in the data warehouse around these elements.
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.	The milestone and associated steps are not due for completion until a future quarter, however, the PPS is submitting steps 7d, 7e and 7f as completed. Research and Marketing Strategies, Inc. (RMS) was hired as a PCMH consulting agency for the North RPU partners. On June 28th, 2016, the North held a kick off meeting bringing the independent physicians together with RMS to discuss PCMH Certification along with what the practice can expect during this transformation. RMS continues to hold monthly PCMH calls that are open to the independent physicians in the North RPU as well as all physician practice sites across the PPS. RMS offers personalized, one on one consulting to the FQHC and Independent Physicians in the North RPU as well (Step 7e – Complete). Between the PMO's efforts and RMS in the North, a clear action plan was created identifying practices within the PPS migrating from no certification level or a 2011 certification level, their needs as far as EHR readiness, and the ability to achieve PCMH 2014 Level 3 certification. In all 90 practice sites identified across the PPS, 5 have already achieved PCMH 2014 Level 3 certification. These 90 practice sites all have EHRs which are Meaningful Use (MU) Stage 2 certified within the primary care physician practice sites. One of the sites was granted a waiver as the hospital-based pharmacy EHR, which cannot be changed at this time, prevented the full MU Stage 2 certifications but the site will still be granted full certification. Through the use of RMS and CCN, an incentive guideline of Milestones was set forth to help sites achieve their transformation to becoming PCMH 2014 Level 3 certified (Step 7f – Complete). In addition, the IT group for the PPS has focused on RHIO connectivity across the PPS. The IT partner tracker is a dynamic tracker updated for each change in circumstance regarding MU, EHR status, which EHR system is in place, and the appropriate RHIO for a partnering agency to connect to as well as their current connection to the RHIOs. This has allowed IT to focus on the Article 28 sites in meeting their deadline to connect to the RHIOs by March 9th of 2017 as well as informing the full landscape of remaining partners and their needs for RHIO connectivity. Currently, all safety-net primary care physician practice sites have a current EHR and connection to the RHIO for their region. Out of all non-safety net primary care physician groups participating with the PPS, each has an EHR in place which meets the criteria and are connected to the RHIO for their region (Step 7d- Complete).
Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	Milestone 9 and two remaining steps are due for completion in DY2Q4 and are being reported as complete. With respect to VBP and MCO partnerships, the VBP subcommittee, formed in August of 2015, has been meeting monthly and is scheduled to continue meeting monthly throughout DY3. The PPS sent out a new VBP assessment on January 13, 2017 to gain further understanding of the VBP adoption needs across the PPS (Step 9n – Complete). 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 or less timeframes to allow PPS contracting efforts to migrate to VBP relationships and payment mechanisms over time. Year 1 & 2 contracts included development of fee for service standards PPS-wide, especially to engage community-based organizations (CBOs) that otherwise might have

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	operated on a grant funding basis alone, level-setting our CBOs that might have otherwise been even a step further behind traditional healthcare settings in the journey to VBP with those organizations already receiving FFS Medicaid funding. While this strategy has presented the PPS with its own unique set of challenges, CCN attributes some of its success in engaging a broad spectrum of CBOs with its inclusive contracting strategy. Year 3 contracts will include the upside risk contracting for metric and speed and scale performance 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 Excellus, UHC and Molina. Regular meetings are established with Excellus which operates in Broome County, and United HealthCare which operates across the PPS. Direct discussions with Total Care (now Molena), which operates in three of the nine PPS counties, are on hiatus, but continue on through the Cayuga Area Plan/Preferred in Tompkins County as they continue their work in a CCN-sponsored Value-Based Payment Model with Total Care (Milestone 9 and Step 9a – Complete). During these meetings with the MCOs, continuing discussion is held specifically around payment reform and the ongoing efforts of the MCOs in payment reform. As CCN will not be contracting directly with the MCOs on behalf of our network, CCN continues to gather information and share it across the PPS to assist our partners in shifting from Fee-for-Service to Value-Based Payments. Data sharing between CCN and the MCOs has been difficult thus far due to the nature of data sharing requirements of the MCO and CCN's role in VBP as a facilitator/coordinator, however, CCN has noted movement into VBP based on the results of the VNA from 2017 and 2016, submitted under Financial Stability Milestone 4. From the results of the VNA assessment, 16 of the 26 organizations that responded have Medicaid VBP arrangements. Of those, 4 of them are Level 1 shared savings, 3 of them are Level 2 shared risk and 8 of them are bonus/withhold arrangements. As part of these arrangements discussions on utilization and performance are occurring. CCN is incorporating feedback received in the value based needs assessment survey conducted in January of 2017 to create a VBP education plan focusing on primary care, mental health and community based organizations as required in financial stability milestone 6.
Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	The milestone and associated steps are not due for completion; however, the PPS is moving Step 10f to On Hold and has completed Step 10d. In March 2016, the Board of Directors the CCN VBP Strategy Resolution where recommended a shared savings, upside risk only contracting option whereby the managed care organizations would contract directly with providers. The PPS would not be involved in negotiating risks or terms. Rather, CCN would conduct education forums with payers. Therefore, the PPS is moving Step 10f to be On Hold as it is no longer a relevant step given VBP Strategy chosen by CCN (Step 10f – On Hold). Through reporting of the PIT, the PPS identified all primary care practice sites associated with a large medical group as "large" partner organizations as well as the medical group they are associated with. This left Independent physician practices to be classified as "independent providers" as they are smaller in size, staffing, and footprint than the region's large medical practices (Step 10d – Complete).
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.	Step 11b is due for completion in DY2Q4, however the PPS is deferring this step to be completed in a future quarter as CCN is modifying the strategy for CBO Engagement through the Patient Activation and Community Navigation projects. Through target contracting efforts centered around project 2.c.i and 2.d.i, the PPS has contracted with network partners who are safety net providers as well as known community based organizations that perform outreach and assistance in addressing the social determinates of health including Insurance navigation and recertification services. These contracting partners include the large safety net health care systems, Cayuga Area Preferred (CAP- an ACO in the northern region of the PPS representing the affiliated primary care sites under their ACO agreements), Cornerstone Family Health Care and Family Health Network of Central NY (the two FQHCs within the PPS), UHS, Our Lady of Lourdes Memorial Hospitals Inc, and CBOs such as Rural Health Network of South Central NY and S2AY Rural Health Network. CCN has contracted with CBOs working specifically within rural areas where burdens of social determinates and engagement with primary care is more difficult due to lack of services, lack of providers, and other barriers. Agencies have internal work flow processes to engage the member through their 2.d.i training for coaching for activation. The members who presented uninsured were then navigated through the health commerce marketplace and, once Medicaid eligibility was determined, the member was tracked by the CCN partner organization for the navigation project requirements and submitted to CCN for population health analysis. For current and recertifying members, the partnering organizations still enlist the coaching for activation training to help determine barriers and obstacles the member is having preventing their engagement with primary care. This has further been expanded through the Care Transition and Community Navigation projects to start educating and referring members into Medicaid Health Homes if they are deemed eligible or linking members back to health home case managers if already assigned. Currently, the PPS is in the next phase of contracting with each partnering agency. Through this year's contracting, all elements of this associated step are now incorporated as requirements for fulfillment by the partnering agencies.

New York State Department Of Health
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 #1	Pass & Ongoing	
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 #9	Pass & Complete	
Milestone #10	Pass & Ongoing	
Milestone #11	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 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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

Instructions :

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project 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).

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "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	13,168
	Percent(%) of Commitment	5.83%	10.31%	52.43%	234.77%
IA Approved	Quarterly Update	0	263	0	13,168
	Percent(%) of Commitment	0.00%	10.31%	0.00%	234.77%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
sculley	Rosters	44_DY2Q4_PROJ2biv_MDL2biv2_PES_ROST_AllPartners_CareTran_Hospital_DY2_Q4_14071.xlsx	Patient Registry for care transition project	04/28/2017 09:11 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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	Completed	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		Completed	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		Completed	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	Completed	04/01/2015	06/30/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

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
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.		Project		Completed	04/01/2015	06/30/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.		Project		Completed	04/01/2015	06/30/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.		Project		Completed	04/01/2015	06/30/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2d. The 2biv Project Team and PMO will collaborate with the Medicaid Managed Care organizations and Health Homes, with focus on strategy development with MCOs and Health Homes to: i) improve care coordination, access, and delivery, ii) strengthen the community and safety-net infrastructure, and iii) prevent illness and reduce disparities. Risk assessment will begin at admission. Within 24 hours of admission, the Care Transition RN will identify what each beneficiary requires for a smooth and safe transition from the acute care hospital. As part of this assessment, the team will leverage tools (e.g., screening tool) to identify whether the patient is i) Not Eligible for Health Home (HH) Services, ii) Eligible for HH and connected to a HH, or iii) Eligible for HH and not connected to a HH. The use of a standardized Care Transition Protocol (CTP) will identify the root cause for admission, assess/address clinical, functional, behavioral, available/lack of available resources and social determinants for each beneficiary. Data analytic and population health technologies will provide a foundation for quality improvement and enable beneficiaries to be effectively risk stratified. A longitudinal plan of care will be developed in concert with appropriate service and community based organizations including Health Homes. In an attempt to break down the barriers between systems (e.g., with MCOs) of mental health and long term care, and in recognition of the complex psycho-social needs of Medicaid beneficiaries as identified in the Care Compass Network		Project		Completed	04/01/2015	06/30/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

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
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		Completed	04/01/2015	06/30/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
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		On Hold	04/01/2015	06/30/2017	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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	Completed	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)	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Providers Associated with Completion:										

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
Armstrong Robert W Jr Md										
Task Policies and procedures are in place for early notification of planned discharges.		Provider	Practitioner - Non-Primary Care Provider (PCP)	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Providers Associated with Completion: Ballard Geneva R										
Task Policies and procedures are in place for early notification of planned discharges.		Provider	Hospital	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Providers Associated with Completion: United Health Serv Hosp Inc										
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		Completed	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		Completed	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		Completed	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		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
from hospitals, discharge planning staff, ED staff, behavioral health staff, home care services, and medical directors and administrators from skilled nursing facilities. Members of the Cross Continuum Team can be selected to engage 2-3 beneficiaries in meetings to solicit feedback. Physician recommendation is key to patients' acceptance as well as the initial presentation of the programs to beneficiaries and caregivers.										
Task 5c. Establish protocols for care record transition with Cross Continuum Team (CCT). Using the Eric Coleman model as a platform (an evidence based nationally recognized) protocol will be implemented inclusive of but not limited to the following four core pillars: 1. Medication reconciliation and teaching - using Medication tools from VNAA, 2. Ensuring follow up appointment with PCP after hospital discharge, 3. Disease/condition-specific teaching as well as recognition of signs and symptoms of worsening disease and how to appropriately respond, and 4. Personal Health Record is created with the patient to improve communication with providers-using document from VNAA.		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.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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 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 reviewed by the cross continuum team would include PPS use claims and lab reporting and related data fields and be reported to the associated RPU Quality Committee as required.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6f. Adjust procedures and protocols accordingly, informed by provider performance.		Project		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	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 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	03/31/2020	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		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
coordination. Utilization of care coordination software and an integrated electronic health record with connectivity to the RHIO are essential to creating capacity within the provider network. Utilization of Office Based Case Managers, RNs and Allied Health Professionals will also be an important factor. Technology such as Telehealth and telemedicine will connect patients to providers and allow for intervention and efficient access to patient information which will simplify providers work and simplifying processes will create capacity. To move toward a high reliability PPS, creating and imbedding disease management protocols in EHRs is a building block toward standardization and process optimization. CTI RN and PCP providers will be engaged to encourage beneficiaries to consent to the RHIOS's where providers can gain access to historical medical data; current treatments and medications, medical and surgical history, and community based organization involvement.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	rachaelm	Other	44_DY2Q4_PROJ2biv_MDL2biv3_PRES1_OTH_Medicaid_Health_Home_Referrals_upon_Hospital_Discharge_Final_for_approval_13679.pdf	Documentation of processes and workflows	04/27/2017 10:45 AM
	rachaelm	Other	44_DY2Q4_PROJ2biv_MDL2biv3_PRES1_OTH_Care_Transitions_Post-Acute_Care_Flowchart_13676.pdf	Documentation of processes and workflows	04/27/2017 10:44 AM
	rachaelm	Contracts and Agreements	44_DY2Q4_PROJ2biv_MDL2biv3_PRES1_CONTR_Appendix_C_Project_2biv_IP_Facilities_-_Phase_II_FINAL_13675.pdf	DY3 Contracting Terms	04/27/2017 10:42 AM
	rachaelm	Other	44_DY2Q4_PROJ2biv_MDL2biv3_PRES1_OTH_Care_Transition_Flowchart_for_UHS_13671.pdf	Documentation of processes and workflows	04/27/2017 10:41 AM
	rachaelm	Policies/Procedures	44_DY2Q4_PROJ2biv_MDL2biv3_PRES1_P&P_Phone_Call_Guidelines_12022016_13668.docx	Phone Call Guidelines	04/27/2017 10:39 AM
	rachaelm	Policies/Procedures	44_DY2Q4_PROJ2biv_MDL2biv3_PRES1_P&P_CGC-CG-33_Home_Visit_Checklist_13661.pdf	Home Visit Checklist	04/27/2017 10:33 AM
	rachaelm	Quarterly Report (no attachment necessary)	44_DY2Q4_PROJ2biv_MDL2biv3_PRES1_QR_DY2Q4_2biv_Milestone_1_Narrative_13660.docx	DY2Q4 2biv Milestone1 Narrative	04/27/2017 10:32 AM
Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure	sculley	Other	44_DY2Q4_PROJ2biv_MDL2biv3_PRES2_OTH_DY2Q4_2biv_Milestone_2_remediation_15757.docx	Remediation file - narrative for 2biv milestone 2	06/20/2017 10:45 AM

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
appropriate post-discharge protocols are followed.	rachaelm	Other	44_DY2Q4_PROJ2biv_MDL2biv3_PRES2_OTH_UHS_TCM_discharge_follow_up_13705.pdf	Discharge Follow up	04/27/2017 11:01 AM
	rachaelm	Other	44_DY2Q4_PROJ2biv_MDL2biv3_PRES2_OTH_Milestone_2_Steps_2c_and_2d_13700.pdf	Metric 3 - Substantiation for completion; Supporting Document for Step 2d.	04/27/2017 11:00 AM
	rachaelm	Other	44_DY2Q4_PROJ2biv_MDL2biv3_PRES2_OTH_Milestone_2_step_2i_MCO_Agreements_with_Partners_13699.xlsx	MCO Agreements	04/27/2017 10:59 AM
	rachaelm	Other	44_DY2Q4_PROJ2biv_MDL2biv3_PRES2_OTH_Milestone_2_step_2c_2biv_Care_Transitions_Champion_and_Health_Coach_Training_participants_as_of_4.12.17_13694.xlsx	Metric 3 - Substantiation for completion	04/27/2017 10:58 AM
	rachaelm	Other	44_DY2Q4_PROJ2biv_MDL2biv3_PRES2_OTH_Milestone_2_Step_2a_and_2b_13691.pdf	Metrics 1 and 2 - Substantiation for completion	04/27/2017 10:57 AM
	rachaelm	Quarterly Report (no attachment necessary)	44_DY2Q4_PROJ2biv_MDL2biv3_PRES2_QR_DY2Q4_2biv_Milestone_2_Narrative_13685.docx	DY2Q4 2biv Milestone 2 Narrative	04/27/2017 10:55 AM
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.	sculley	Other	44_DY2Q4_PROJ2biv_MDL2biv3_PRES4_OTH_DY2Q4_2biv_Milestone_4_remediation_15774.docx	Remediation file - narrative for 2biv milestone 4.	06/20/2017 11:21 AM
	sculley	Other	44_DY2Q4_PROJ2biv_MDL2biv3_PRES4_OTH_CCN_2biv_Partner_Engagement_15763.xlsx	Remediation file - updated provider engagement numbers for 2biv.	06/20/2017 10:48 AM
	rachaelm	Other	44_DY2Q4_PROJ2biv_MDL2biv3_PRES4_OTH_CCN_2biv_M4_PCP_Providers_13723.xlsx	Metric 1 - PCP Provider List	04/27/2017 11:11 AM
	rachaelm	Other	44_DY2Q4_PROJ2biv_MDL2biv3_PRES4_OTH_CCN_2biv_M4_non-PCP_Providers_13721.xlsx	Metric 1 - Non-PCP Provider List	04/27/2017 11:11 AM
	rachaelm	Other	44_DY2Q4_PROJ2biv_MDL2biv3_PRES4_OTH_CCN_2biv_M4_Hospital_Providers_13720.xlsx	Metric 1 - Hospital Provider List	04/27/2017 11:10 AM
	rachaelm	Other	44_DY2Q4_PROJ2biv_MDL2biv3_PRES4_OTH_Milestone_4_Step_4d_Documentation_13719.pdf	Metric 2 - Substantiation for Completion	04/27/2017 11:09 AM
	rachaelm	Other	44_DY2Q4_PROJ2biv_MDL2biv3_PRES4_OTH_Milestone_4_Step_4a_Documentation_13718.pdf	Metric 1 - Substantiation for Completion	04/27/2017 11:08 AM
	rachaelm	Other	44_DY2Q4_PROJ2biv_MDL2biv3_PRES4_OTH_Milestone_4_Step_4d_2biv_Care_Transitions_Champion_and_Health_Coach_Training_Roster_13717.xlsx	Roster of Care Transitions Training for Champions and Health Coaches	04/27/2017 11:07 AM
	rachaelm	Other	44_DY2Q4_PROJ2biv_MDL2biv3_PRES4_OTH_Milestone_4_Step_4a_,_4b,_4c,_4f_Care_Transitions_Post-Acute_Care_Flowchart_13715.pdf	Workflow	04/27/2017 11:05 AM
	rachaelm	Quarterly Report (no attachment necessary)	44_DY2Q4_PROJ2biv_MDL2biv3_PRES4_QR_DY2Q4_2biv_Milestone_4_Narrative_13713.docx	DY2Q4 2biv Milestone 4 Narrative	04/27/2017 11:05 AM

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.	Please refer to the uploaded document labeled DY2Q4 2biv Milestone1 Narrative.doc since the narrative exceeded the character limit.
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.	Please refer to the uploaded document labeled DY2Q4 2biv Milestone 2 Narrative.doc since the narrative exceeded the character limit.
Ensure required social services participate in the project.	Completed and passed in DY1Q3, no changes.
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.	Please refer to the uploaded document labeled DY2Q4 2biv Milestone 4 Narrative.doc since the narrative exceeded the character limit.
Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Completed and passed in DY2Q3, no changes.
Ensure that a 30-day transition of care period is established.	Completed and passed in DY2Q1, no changes.
Use EHRs and other technical platforms to track all patients engaged in the project.	Completed and passed in DY2Q3, no changes.

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 & Complete	
Milestone #7	Pass & Complete	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

Instructions :

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project 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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	1,677
	Percent(%) of Commitment	210.95%	297.08%	338.32%	612.04%
IA Approved	Quarterly Update	0	406	0	1,675
	Percent(%) of Commitment	0.00%	296.35%	0.00%	611.31%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
brosetti	Rosters	44_DY2Q4_PROJ2bvii_MDL2bvii2_PES_ROST_CCN_2bvii_DY2Q4_-_Actively_Engaged_12966.xlsx	Actively engaged roster	04/26/2017 02:04 PM

Narrative Text :

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

Care Compass Network is reporting 1,677 unique Medicaid members from April 1, 2016 through March 31, 2017.

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 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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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	Completed	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		Completed	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

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
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		Completed	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		Completed	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		Completed	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	Completed	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	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Providers Associated with Completion: Cortland Regional Medical Center In; Elizabeth Church Manor Nh Inc; Good Shepherd-Fairview Hm Inc; Ideal Senior Living Ctr Snf; James G Johnston Mem Snf; Willow Point Nursing Home										
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		Completed	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		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

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
Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.										
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).		Project		Completed	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		Completed	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		Completed	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		Completed	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		Completed	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		Completed	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	DY2 Q4	Project	N/A	Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
implementation.										
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
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	Completed	04/01/2015	03/31/2017	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		Completed	04/01/2015	03/31/2017	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		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
further outlined in the steps outlined in this plan.										
Task 7c. The PPS will collaborate and/or engage with local governing units (e.g., Social Service agencies) to facilitate patient and family/caretaker discussions with each participating facility.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 7d. The PPS will facilitate the achievement of interdisciplinary meetings focused on advanced care planning for the PPS community of related providers.		Project		Completed	04/01/2015	03/31/2017	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		Completed	04/01/2015	03/31/2017	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		Completed	04/01/2015	03/31/2017	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		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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

DSRIP Implementation Plan Project

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
allows increased accessibility, sharing of data and analysis of data. Proof of education from each participating facility shall be reported to the PMO.										
Task 8f. Each participating SNF to create and communicate a Nursing Home Capabilities List to local hospital emergency room staff, local hospital discharge planners and local hospital physicians at a minimum.		Project		In Progress	04/02/2015	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		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2

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

DSRIP Implementation Plan Project

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
9g. The project team and PMO to identify metrics to be used (such as Attachment J metrics) through the Clinical Governance Committee. Additionally, alternative or substitutive interventions as identified during the root cause analysis process will be validated by the Clinical Governance Committee and Board of Directors prior to adoption by the 2bvii Project Team.										
Milestone #10 Use EHRs and other technical platforms to track all patients engaged in the project.	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
Educate all staff on care pathways and INTERACT principles.	brosetti	Report(s)	44_DY2Q4_PROJ2bvii_MDL2bvii3_PRES4_RPT_CCN_2bvii_Milestone_4_-Step_4a_Provider_Engagement_13028.xlsx	Milestone 4 - Provider Engagement	04/26/2017 02:36 PM

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	brosetti	Training Documentation	44_DY2Q4_PROJ2bvii_MDL2bvii3_PRES4_TRAIN_CCN_2bvii_Milestone_4_-_INTERACT_Champion_Packet_13010.pdf	Milestone 4 - INTERACT Campion Training Packet	04/26/2017 02:30 PM
	brosetti	Training Documentation	44_DY2Q4_PROJ2bvii_MDL2bvii3_PRES4_TRAIN_CCN_2bvii_Milestone_4_-_Training_13008.xlsx	Milestone 4 - Training	04/26/2017 02:28 PM
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.	brosetti	Other	44_DY2Q4_PROJ2bvii_MDL2bvii3_PRES5_OTH_CCN_2bvii_Milestone_5_-_Attestation_Letter_13070.docx	Milestone 5 - Attestation Letter	04/26/2017 02:53 PM
	brosetti	Other	44_DY2Q4_PROJ2bvii_MDL2bvii3_PRES5_OTH_CCN_2bvii_Milestone_5_-_ACP_Toolkit_13063.pdf	Milestone 5 - ACP Toolkit	04/26/2017 02:52 PM
Create coaching program to facilitate and support implementation.	brosetti	Training Documentation	44_DY2Q4_PROJ2bvii_MDL2bvii3_PRES6_TRAIN_CCN_2bvii_Milestone_6-_Cortland_Park_Training_Materials_13080.pdf	Milestone 6 - Cortland Park Training Materials	04/26/2017 02:59 PM
	brosetti	Training Documentation	44_DY2Q4_PROJ2bvii_MDL2bvii3_PRES6_TRAIN_CCN_2bvii_Milestone_6_-_Training_13076.xlsx	Milestone 6 - Training	04/26/2017 02:58 PM
Educate patient and family/caretakers, to facilitate participation in planning of care.	brosetti	Training Documentation	44_DY2Q4_PROJ2bvii_MDL2bvii3_PRES7_TRAIN_CCN_2bvii_Milestone_7_-_JGJ_Education_Materials_13091.pdf	Milestone 7 - JGJ Education Materials	04/26/2017 03:06 PM
	brosetti	Training Documentation	44_DY2Q4_PROJ2bvii_MDL2bvii3_PRES7_TRAIN_CCN_2bvii_Milestone_7_-_Good_Shepherd_13089.pdf	Milestone 7 - Good Shepherd	04/26/2017 03:05 PM
	brosetti	Training Documentation	44_DY2Q4_PROJ2bvii_MDL2bvii3_PRES7_TRAIN_CCN_2bvii_Milestone_7_-_CRMC_-_Family_Teaching_13087.pdf	Milestone 7 - CRMC - Family Teaching	04/26/2017 03:04 PM
	brosetti	Policies/Procedures	44_DY2Q4_PROJ2bvii_MDL2bvii3_PRES7_P&P_CCN_2bvii_Milestone_7-_Staff_Advance_Care_Planning_Guide_13086.pdf	Milestone 7 - Staff Advance Care Planning Guide	04/26/2017 03:03 PM
	brosetti	Policies/Procedures	44_DY2Q4_PROJ2bvii_MDL2bvii3_PRES7_P&P_CCN_2bvii_Milestone_7_-_Family_Advance_Care_Planning_Guide_13083.pdf	Milestone 7 - Family Advance Care Planning Guide	04/26/2017 03:02 PM
Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	brosetti	Training Documentation	44_DY2Q4_PROJ2bvii_MDL2bvii3_PRES2_TRAIN_CCN_2bvii_Milestone_2_-_Champion_Training_12989.pdf	CCN Milestone 2 - Champion Training	04/26/2017 02:15 PM
	brosetti	Training Documentation	44_DY2Q4_PROJ2bvii_MDL2bvii3_PRES2_TRAIN_CCN_2bvii_Milestone_2_-_Champion_List_12987.xlsx	CCN Milestone 2 - Champion List	04/26/2017 02:15 PM
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.	brosetti	Training Documentation	44_DY2Q4_PROJ2bvii_MDL2bvii3_PRES3_TRAIN_CCN_2bvii_Milestone_3_-_Training_13001.xlsx	Milestone - Training	04/26/2017 02:23 PM
	brosetti	Implementation Plan & Periodic Updates	44_DY2Q4_PROJ2bvii_MDL2bvii3_PRES3_IMP_CCN_2bvii_Milestone_3_-_2bvii_Implementation_Plan_Checklist_12998.xlsx	Implementation Plan Checklist	04/26/2017 02:22 PM
	brosetti	Training Documentation	44_DY2Q4_PROJ2bvii_MDL2bvii3_PRES3_TRAIN_CCN_2bvii_Milestone_3_-	Cortland Park Training Materials	04/26/2017 02:21 PM

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
			_Cortland_Park_Training_Materials_12997.pdf		
	brosetti	Training Documentation	44_DY2Q4_PROJ2bvii_MDL2bvii3_PRES3_TRAIN_CCN_2bvii_Milestone_3_-_INTERACT_Champion_Packet_12995.pdf	INTERACT Champion Packet	04/26/2017 02:20 PM
	brosetti	Other	44_DY2Q4_PROJ2bvii_MDL2bvii3_PRES3_OTH_CCN_2bvii_Milestone_3_-_Care_Paths_and_Change_in_Condition_File_Cards_12994.pdf	Milestone 3 - Care paths and Change in Condition File Cards	04/26/2017 02:19 PM

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.	
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 17 Skilled Nursing Facilities to participate in INTERACT, with 15 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 15 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 DY2Q4, 15 SNFs total are reported as meeting this milestone. 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. In previous quarterly reports CCN has reported 14 Skilled Nursing Facilities meeting this milestone. In DY2Q4, Absolut Care of Three Rivers (NPI # 1619004439) is also now meeting this milestone.
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.	Milestone 3 and the remaining four steps are due for completion in DY2Q4 and are being reported as complete. After a contract is executed with Care Compass Network to participate in the INTERACT project the Skilled Nursing Facility (SNF) is given a binder containing the 10 INTERACT Care Paths approved by the Clinical Governance Committee (CGC) (Step 3a, 3c, & 3d – Complete). As part of the INTERACT Champion training, the attendees are educated on all INTERACT principles, including the Care Paths. Attendees are made aware the Care Paths and all other INTERACT tools and documents are made available free of charge 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 staff in the SNFs on the INTERACT principles and Care Paths. Since the majority of our SNFs have identified a Champion and Co-Champion and have received Certified INTERACT Champion training, internal training on the INTERACT Care Paths and other INTERACT principles continues to be executed (Step 3b – Complete). Facilities have executed in-house training sessions, some with their own educational materials, for their staff as well as incorporating INTERACT into their new employee orientation. They have also incorporated Care Paths into their respective workflows (Step 3f – Complete). CCN has uploaded the training material provided to the Champion and Co-Champions that has been used by many SNFs to train remaining clinical staff at each facility. 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 continuing to address this barrier. In the past quarter CCN hosted another 2-hour Leadership Program Overviewing INTERACT QIP at Cortland Regional Medical Center on March 1st (previously CCN held a 2-hour INTERACT overview in September 2016). This training session was aimed at educating hospital staff, Primary Care Physicians as well as Medical Directors working with Skilled Nursing Facilities. Education on Care Paths is included as part of the of the training (Step 3e – Complete).

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	As part of monthly reporting, SNF Partners submit all Care Path usage, even those that are not one of the 10 INTERACT Care Paths. CCN reimburses SNF partners for use of the CGC approved Care Paths and requests information on other Care Paths the SNFs use so CCN can continue to build the list of CGC approved Care Paths. A contracted partner provided CCN a "Symptoms of Sepsis and Septic Shock" Care Path created by IPRO (Island Peer Review Organization) who has contracted with CMS. This Care Path was brought to the CCN Clinical Governance Committee for endorsement. The CGC endorsed the Care Path and it will be eligible for reimbursement for SNF partners beginning April 1, 2017. Since then, CCN was notified from Pathway Health that an INTERACT Sepsis Care Path is currently being develop by Dr. Ouslander, creator of INTERACT, and his team. Once this Care Path is created and rolled out on the INTERACT website, Care Compass Network plans to replace the IPRO Care Path with the INTERACT Care Path to ensure consistency and continuity among the tools in this project (Step 3g – Complete). In the implementation of this project, CCN chose to reimburse SNFs for use of the Care Paths with the goal of early identification and intervention to avoid hospital readmission (Milestone 3 – Complete).
Educate all staff on care pathways and INTERACT principles.	Milestone 4 and the remaining three steps are due for completion in DY2Q4 and are being reported as complete. After a contract is executed with Care Compass Network to participate in the INTERACT project the Skilled Nursing Facility (SNF) is given a binder containing the 10 INTERACT Care Paths approved by the Clinical Governance Committee (CGC). As part of the INTERACT Champion training, the attendees are educated on all INTERACT principles, including the Care Paths. Attendees are made aware the Care Paths and all other INTERACT tools and documents are made available free of charge 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 staff in the SNFs on the INTERACT principles and Care Paths. Since the majority of our SNFs have identified a Champion and Co-Champion and have received Certified INTERACT Champion training, internal training on the INTERACT Care Paths and other INTERACT principles continues to be executed (Step 4a and 4b – Complete). Facilities have executed in-house training sessions, some with their own educational materials, for their staff as well as incorporating INTERACT into their new employee orientation (Step 4c – Complete). They have also incorporated Care Paths into their respective workflows. CCN has uploaded the training material provided to the Champion and Co-Champions that has been used by many SNFs to train remaining clinical staff at each facility. 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 continuing to address this barrier. In the past quarter CCN hosted another 2-hour Leadership Program Overviewing INTERACT QIP at Cortland Regional Medical Center on March 1st (previously CCN held a 2-hour INTERACT overview in September 2016). This training session was aimed at educating hospital staff, Primary Care Physicians as well as Medical Directors working with Skilled Nursing Facilities. Education on Care Paths is included as part of the of the training. For Step 4a, an Excel spreadsheet is provided containing the list of Providers and NPI numbers for the Providers meeting the metric.
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 due for completion in DY2Q4 and are being reported as complete. In New York State, there currently exists Advance Directives/Advance Care Planning Regulatory and Statutory Requirements for Skilled Nursing Facilities. To augment the current tools being used by our SNF partners, our SNF partners have also adopted the INTERACT Advance Care Planning guide and have been conducting 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 included in the SNF admissions packet, while the staff packet is a compilation of suggestions on how to successfully conduct the conversations involved with Advance Care Planning (Step 5a – Complete). With the creation of these packets, each partner evaluated their own Advance Care Planning tools to see how they aligned with the CCN INTERACT packets. Within the past year, many facilities identified the gaps within their own tools and have integrated the packets into their workflows. Additionally, tools that were created via CCN's Palliative Care project were sent to partners as additional tools regarding Advance Care Planning (Step 5b, 5c and 5f – Complete). Since our SNF partners have existing Advance Care Planning tools in place, and are required to offer these to residents and families, there was not a need to develop additional Advance Care Planning tools with our partners. In addition, our SNF partners are reporting the use of these tools through the attestation and contracting process in which the CCN PMO audits each partner's use of these tools on a regular basis. This same process is used to ensure our partners are conducting meetings with residents and families using the aforementioned Advance Care Planning tools (Step 5d – Complete).

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	As part of project implementation, CCN reimburses SNF partners for having an initial Advance Care Planning discussion when a resident is enrolled at the Skilled Nursing Facility or for an annual review of Advance Care Planning for existing SNF residents. To date, there have been 124 Advance Care Planning sessions reported by 2.b.vii partners (Step 5d and 5e – Complete). The PPS will be providing an educational training within each Regional Performance Unit (RPU) on Advance Care Planning vs. Palliative Care for all organizations in DY3. The family education packet and staff education material packet CCN created have been uploaded to substantiate completion of this milestone.
Create coaching program to facilitate and support implementation.	Milestone 6 was completed and passed in DY2Q3, however there are updates to report. There are 16 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 RPUs. In addition to the three Champion Trainings held in DY2Q1 and DY2Q2, a fourth training was held in the West RPU at Guthrie Corning Hospital on February 27th and February 28th. Absolut Care Three Rivers has been a contracted partner for several months and their Champion and Co-Champion attended this training. 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.
Educate patient and family/caretakers, to facilitate participation in planning of care.	Milestone 7 and the remaining steps are due for completion in DY2Q4 and are being reported as complete. Through interdisciplinary meetings among the SNFs there was a recognized 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 incorporating Advance Care Planning, Stop & Watch materials, and other family educational resources that was distributed to contracted partners (Step 7d – Complete). The Family Educational Packet can be included in the SNF admissions packet, while the staff packet is a compilation of suggestions on how to conduct those often-difficult conversations. Additionally, tools that were created via CCN's Palliative Care project were sent to partners as additional tools regarding Advance Care Planning (Step 7b – Complete). Included in the Family Educational Packet is a Stop & Watch in both English and Spanish (Step 7e – Complete). Six facilities have reported using the resource packets created by CCN. The admissions packets have educated family members on the principles of INTERACT as well as including family members in the planning of care. Additionally, one of the contracted partners, UHS Ideal, has held family educational training sessions with great success. They have reported an increase in family engagement with use of Stop & Watch and eMOLST registration (Step 7a – Complete). Care Compass Network previously placed Step 7c permanently on hold since family/caretaker discussions held in the SNFs will not likely involve local governing units. The 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 Advance Care Planning vs. Palliative Care for all organizations in DY3. Strategies, tools, and materials for Advance Care Planning will continue to be distributed to partners as they evolve (Step 7f – Complete). The family education packet CCN created as well as examples of SNF patient/family education methodology have been uploaded to substantiate completion of this milestone.
Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	
Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	
Use EHRs and other technical platforms to track all patients engaged in the project.	Milestone 10 was completed and passed in DY2Q3 and there are no changes.

Milestone Review Status

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

New York State Department Of Health
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 #2	Pass & Complete	
Milestone #3	Pass & Complete	
Milestone #4	Pass & Complete	
Milestone #5	Pass & Complete	
Milestone #6	Pass & Complete	
Milestone #7	Pass & Complete	
Milestone #8	Pass & Ongoing	
Milestone #9	Pass & Ongoing	
Milestone #10	Pass & Complete	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

Instructions :

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project 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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	22,262
	Percent(%) of Commitment	3.98%	6.16%	17.42%	117.17%
IA Approved	Quarterly Update	0	393	0	22,209
	Percent(%) of Commitment	0.00%	6.13%	0.00%	116.89%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
espape	Rosters	44_DY2Q4_PROJ2ci_MDL2ci2_PES_ROST_DY2Q4_Actively_Engaged_13548.csv	Attached, please find Care Compass Network's actively engaged report, totaling 22,262 unique navigation services.	04/27/2017 09:09 AM

Narrative Text :

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

Care Compass Network is reporting 22,262 unique Medicaid members were navigated from April 1st through March 31st of 2017.

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 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	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Community-based health navigation services established.		Project		Completed	04/01/2015	03/31/2017	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		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

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
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		Completed	04/01/2015	03/31/2017	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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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

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
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	Completed	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		Completed	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		Completed	04/01/2015	03/31/2017	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		Completed	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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Health navigator personnel and services marketed within designated communities.		Project		Completed	04/01/2015	03/31/2017	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	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 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	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.	espape	Quarterly Report (no attachment necessary)	44_DY2Q4_PROJ2ci_MDL2ci3_PRES1_QR_DY2Q4_2ci_Milestone1_Narrative_13553.docx	DY2 Q4 2ci Milestone 1 Narrative	04/27/2017 09:13 AM
Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.	espape	Other	44_DY2Q4_PROJ2ci_MDL2ci3_PRES3_OTH_CCN_Executed_contracts_2ci_DY2Q4_13560.pdf	CCN 2ci Executed Contracts	04/27/2017 09:24 AM
	espape	Training Documentation	44_DY2Q4_PROJ2ci_MDL2ci3_PRES3_TRAIN_Navigator_Training_Roster_+_Credentials_13559.xlsx	Navigator Training Roster	04/27/2017 09:23 AM
Market the availability of community-based navigation services.	sculley	Other	44_DY2Q4_PROJ2ci_MDL2ci3_PRES7_OTH_Community_Based_Navigation_Services-Advertisment_15670.pdf	Remediation file - Addition detail regarding distribution areas for media marketing of Community Based navigation services	06/20/2017 08:36 AM
	sculley	Other	44_DY2Q4_PROJ2ci_MDL2ci3_PRES7_OTH_Community_Resource_Guide_Postcard_15669.pdf	Remediation file - Community Resource Guide Postcard distributed to clinicians.	06/20/2017 08:34 AM
	sculley	Report(s)	44_DY2Q4_PROJ2ci_MDL2ci3_PRES7_RPT_2ci_M7_Remediation_15668.docx	Remediation file - narrative for 2ci Milestone 7	06/20/2017 08:33 AM
	espape	Other	44_DY2Q4_PROJ2ci_MDL2ci3_PRES7_OTH_Community_Navigation_Marketing_Plan_13571.pdf	CCN Navigation Marketing plan	04/27/2017 09:36 AM
	espape	Other	44_DY2Q4_PROJ2ci_MDL2ci3_PRES7_OTH_Communication_Preferences_Survey_Report.10.22.2015_13568.pdf	CCN Communications Survey	04/27/2017 09:34 AM
	espape	Communication Documentation	44_DY2Q4_PROJ2ci_MDL2ci3_PRES7_COMM_Combined_Communication_Plan_and_Timeline_13564.pdf	CCN Communication Plan and Timeline	04/27/2017 09:33 AM
	espape	Quarterly Report (no attachment necessary)	44_DY2Q4_PROJ2ci_MDL2ci3_PRES7_QR_DY2Q4_2ci_Milestone7_Narrative_13563.docx	CCN Narrative for Milestone 7.	04/27/2017 09:33 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.	Please refer to the uploaded document labeled DY2Q4 2ci Milestone1 Narrative.doc since the narrative exceeded the character limit.
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.	Milestone 2 was completed and passed in DY2Q3 and there are no changes to report.
Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.	Milestone 3 and the remaining three steps are due for completion in DY2Q4, and all are being reported as complete. In April 2015, the Care Compass Network (CCN) Project 2ci Team developed an assessment to gauge the existing services, programs, and general level of readiness for CCN partner participation within the 2ci project. Among other questions, community-based organizations were asked to indicate their technical capabilities, locations of service, and how many community navigators (or roles capable of transforming into community navigators) they currently employed (Step 3b - Complete). During DY2, as the community navigation project was being implemented throughout the PPS, CCN found there is a large talent pool of community navigators, specifically Care Manager/Coordinators, Care or Patient Navigator, Community Health Worker, and Peer Support Workers. The talent pool of community navigators in our PPS are many who grew up and lived in the community,

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	understanding the needs of the community and help patients access healthcare services and social needs efficiently and effectively. These community navigators are placed in hot spots throughout the PPS such as free clinics, department of social services, WIC clinics, and insurance enrollment locations, many who have a long-lasting employment history community based organizations. Therefore, there was not a need to recruit, but to build upon, engage, and educate existing community navigators located in the PPS (Step 3c-Complete). On 1/31/2017, CCN along with the Workforce Development Team hosted a summit centered on the current and future training needs across all the projects and all Workforce positions. The participants' input helped inform and create and overall training strategy and plan for the Workforce component. Based on what CCN learned from the workforce summit, the Project Team discussed and decided to continue to have each organization on-board and train their new navigator based on the criteria and standards the organization has to meet. However, the Project Team will specifically target our navigators in the PPS to be trained on the Community Resource Guide, intake process and follow-thru with patients, as well as the Clinical Guidelines related to navigation such as warm hand-offs to PCPs and the graduation from navigation process (Step 3d- Complete). As of 3/31/2017, we have successfully executed contracts and implemented Navigator placement for thirty-five organizations with a total of 67 employed Community Health Advocates (reference document Navigator Training Roster and Credentials.xls). CCN will continue to analyze workforce development needs with where new navigation services are developed and continue to support organizations in region specific areas with recruiting navigators in DY3 and beyond (Milestone 3 and Step 3a-Complete). The list of trained community navigators and a sample of contract agreements from partners have been uploaded to substantiate completion of the milestone.
Resource appropriately for the community navigators, evaluating placement and service type.	Milestone 4 was completed and passed in DY2Q2 and there are no changes to report.
Provide community navigators with access to non-clinical resources, such as transportation and housing services.	Milestone 5 was completed and passed in DY2Q3 and there are no changes to report.
Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.	Milestone 6 was completed and passed in DY2Q3 with no changes to report.
Market the availability of community-based navigation services.	Please refer to the uploaded document labeled DY2Q4 2ci Milestone7 Narrative.doc since the narrative exceeded the character limit.
Use EHRs and other technical platforms to track all patients engaged in the project.	Milestone 8 was completed and passed in DY2Q3 with no changes to report.

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 & Complete	
Milestone #7	Pass & Complete	

New York State Department Of Health
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 #8	Pass & Complete	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	

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

DSRIP Implementation Plan Project

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	2,325
	Percent(%) of Commitment	3.04%	7.24%	13.00%	10.25%
IA Approved	Quarterly Update	0	534	0	2,300
	Percent(%) of Commitment	0.00%	7.06%	0.00%	10.14%

Warning: PPS Reported - Please note that your patients engaged to date (2,325) does not meet your committed amount (22,680) for 'DY2,Q4'

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
sculley	Rosters	44_DY2Q4_PROJ2di_MDL2di2_PES_ROST_DY2Q4_Actively_Engaged_13647.xlsx	CCN DY2Q4 Patient Activation roster	04/27/2017 10:26 AM

Narrative Text :

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

Of the 2,325 PAM Surveys administered, 123 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
Fail	The PPS failed to meet at least 80% of its Actively Engaged commitments for DY2,Q4

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
organizations 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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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 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	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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
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		Completed	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		Completed	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		Completed	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		Completed	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		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

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
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	10/01/2016	03/31/2018	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	10/01/2016	03/31/2018	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	10/01/2016	03/31/2018	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	10/01/2016	03/31/2018	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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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 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	03/31/2018	03/31/2018	DY3 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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
- 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:										

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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	12/31/2017	12/31/2017	DY3 Q3
Task Timely access for navigator when connecting members to services.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
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	12/31/2017	12/31/2017	DY3 Q3
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

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
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_DY2Q4_PROJ2di_MDL2di3_PRES1_CONTR_CCN_Executed_Contracts_2di_DY2Q4_13657.pdf	Examples of contracts executed in DY2Q4 for this project.	04/27/2017 10:30 AM
Survey the targeted population about healthcare needs in the PPS' region.	sculley	Other	44_DY2Q4_PROJ2di_MDL2di3_PRES4_OTH_Care_Compass_Network_Panel_Second_Year_Overview_(2016)_13666.pptx	DY2 overview report provided by RMS.	04/27/2017 10:39 AM
Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	sculley	Rosters	44_DY2Q4_PROJ2di_MDL2di3_PRES5_ROST_PPS_Providers_Trained_in_PAM_13672.xlsx	PPS Providers trained in PAM	04/27/2017 10:41 AM
	sculley	Training Documentation	44_DY2Q4_PROJ2di_MDL2di3_PRES5_TRAIN_Training_Materials_Template_13669.xlsx	Milestone 5 training materials template	04/27/2017 10:41 AM
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	sculley	Documentation/Certification	44_DY2Q4_PROJ2di_MDL2di3_PRES6_DOC_MCO_Agreements_with_Partners_13680.xlsx	List of existing MCO/Partner agreements	04/27/2017 10:45 AM

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
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.					
Include beneficiaries in development team to promote preventive care.	sculley	Rosters	44_DY2Q4_PROJ2di_MDL2di3_PRES8_ROST_RMS_Group_1_List_13683.xlsx	The list of contributing patient members in the RMS Panel.	04/27/2017 10:49 AM
Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	sculley	Training Documentation	44_DY2Q4_PROJ2di_MDL2di3_PRES13_TRAIN_DSRIP_Training_Deck_September_2015_13687.pdf	Training material.	04/27/2017 10:56 AM
	sculley	Training Documentation	44_DY2Q4_PROJ2di_MDL2di3_PRES13_TRAIN_Training_Materials_Template_13686.xlsx	Training materials template.	04/27/2017 10:55 AM
	sculley	Rosters	44_DY2Q4_PROJ2di_MDL2di3_PRES13_ROST_Navigator_Training_Roster_13684.xlsx	Navigator training roster.	04/27/2017 10:54 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_DY2Q4_PROJ2di_MDL2di3_PRES14_CONTR_CCN_Executed_contracts_2di_DY2Q4_13697.pdf	Samples of new contracts executed for 2di in DY2Q4.	04/27/2017 10:58 AM
	sculley	Contracts and Agreements	44_DY2Q4_PROJ2di_MDL2di3_PRES14_CONTR_CCN_Executed_contracts_2ci_DY2Q4_13693.pdf	Samples of new contracts executed for 2ci in DY2Q4.	04/27/2017 10:57 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	This Milestone was completed and passed in DY1Q3. During the DY2Q4 reporting period, the PPS has engaged five additional Community Based Organizations with executed contracts for 2di which are as follows: -CASA Trinity of Chemung County - Finger Lakes Addiction Recovery Services -Tioga Opportunities -Rehabilitation Support Services -Rescue Mission Alliance (Ithaca Rescue Mission) The new contracts have been uploaded as supporting documentation. 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, Q4 timeframe. Additional contracts are in draft and will be reported through this Milestone for future quarterly reports.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	This Milestone was completed and passed in DY1Q3 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.	Milestone 3 was completed and passed in DY2Q2 and there are no changes to report.
Survey the targeted population about healthcare needs in the PPS' region.	This Milestone was completed and passed in DY1Q3. During the DY2Q4 reporting period, there were no new RMS Panel surveys conducted, however we do have a complete report of our second-year panel overview. As of DY2Q4, the total Medicaid or uninsured members engaged in participating in RMS surveys included 318 members. During DY2 time period, Care Compass was able to accomplish the following: □ CCN panel grew 70% (468) from DY 2 to 1,059 members (as of 2/8/2017). □ Social Media was the most effective panel recruitment technique based upon ROI. □ Utilized CCN community partners' Facebook pages (e.g., UHS, Lourdes, and Cortland Regional Medical Center). □ Updated panel invite cards and redistributed to CCN partners and participating stakeholders. □ Maintained an active CCN panel oversight committee interaction. □ Meet every 2 weeks. □ Engaged existing panel members approximately every 6 weeks in an online activity. □ Segmented and engaged loyal panel members with a 'Thank You' letter from CCN, as well as an incentive to encourage further participation. CCN has engaged a multi-year engagement with Research & Marketing Strategies, Inc (RMS) for the continued engagement of the RMS Panel members and will continue reporting panel engagement progress in future quarters. The DY2 overview report provided by RMS has been uploaded as supporting documentation.
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 completed and passed in DY1Q3, however we have changes to report. A total of 35 people have been trained in patient activation techniques in DY2Q4 representing four contracted partners (United Way of Broome County, Tioga Opportunities, Access to Independence, and Family Health Network of Central New York) as a result of having executed a contract with CCN to participate in the Patient Activation project. A list of the training dates and the list of PPS Providers trained in PAM have been uploaded as supporting documentation.
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	Milestone 6 and associated steps are due for completion in DY2Q4 and are being reported as complete. On 2/20/17, the CCN Coordinating Council met to review the payor agreements that our partners currently have with MCOs and Network PCPs. Information gathered provided our PPS with strategies for documentation of the methodology for communication between MCOs and PCPs. A total of 59 entities in our PPS currently have contracts with a total of 17 Medicaid Managed Care Organizations to ensure proactive work with the member and the assigned PCP to help reconnect the beneficiary to his/her designated PCP. These entities are made up of healthcare systems such as Our Lady of Lourdes Memorial Hospital, United Healthcare Services, Guthrie, and Cayuga Regional Medical Center, and several independent physician practices (MCO Agreements with Partners.xls). In discussions with partner organizations to understand processes and procedures existing today, there was no need for CCN to do additional work to research legal requirements or to create new processes/procedures for connecting patients to PCPs. There are organizations doing this today so they already understand the legal requirements and have existing processes in place (Steps 6b, 6c, 6d and 6e – Complete). The process and protocol though the MCO to our healthcare systems, CBOs, and independent physicians is robust in keeping engagement with the patient. For the healthcare systems and physician practices, the MCO develops a patient gap analysis which is based on the utilization of patients, specifically in preventative and primary care. Through the MCO's provider relation staff, outreach to the healthcare system or physician practice is made, and on-site visits occur with the physician champion of the practice, billing, analytics, a member of quality, to review the list and

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
and federal regulations as outlined in 42 CFR §438.104.	develop strategies of engagement for the non-and low utilizers. This also correlates with the quality metrics and measures healthcare systems and physician practices are held to for Centers for Medicaid/Medicare Services (CMS). With the CBOs, the MCO develops training and coordination for the CBO to engage with the patient in the community to make sure there is not a gap in insurance enrollment and continuous coverage of care is occurring. In addition, CCN continues to have open discussions with MCOs. Robert Carangelo, Director of Finance for CCN, continues to hold monthly meetings with MCOs to discuss VBP arrangements, education, project specific requirements and the like.
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.	
Include beneficiaries in development team to promote preventive care.	This Milestone was completed and passed in DY1Q3, however we have updates to report. As of DY2Q4, the RMS panel is comprised of 318 Medicaid Members and uninsured individuals who reside in the PPS nine county regions, 42 of which began participating in our surveys in the DY2Q4 timeframe. Ongoing panel management continues to be an effort of the PPS in DY2Q4 and beyond to account for variation and changes in Medicaid enrollment status. The RMS Panel vendor has been engaged to continually look for new group participation from Medicaid members to ensure consistent participation levels are retained. 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. The list of contributing patient members in the RMS Panel has been uploaded as supporting documentation.
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.	Milestone 9 is due for completion in DY2Q4, however Care Compass Network (CCN) is deferring the due date of the milestone to DY3Q4. CCN is currently identifying processes and protocols for DY3 to support assessing individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. CCN will also continue to make efforts to contract with Managed Care Organizations (MCO) to help the Low and Non-Utilizer population identified in the PPS to receive connection and follow-thru. CCN will be utilizing the Community Based Organizations located in the PPS to outreach and engage the target population.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
• 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.	
Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	
Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	This Milestone was completed and passed in DY1Q3. For DY2Q4, Care Compass Network (CCN) contracted with one new organization (United Way of Broome County) to provide connectivity to healthcare services and resources in the community. United Way of Broome County is the 2-1-1 serving the Susquehanna Region as well as supporting the community of Broome County with resources for health, education and financial stability.
Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	Milestone 12 was completed and passed in DY1Q2 with no changes to report.
Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	This Milestone was completed and passed in DY1Q2. During the DY2Q4 reporting period, a total of 35 people from Family Health Network of Central New York, United Way of Broome County, Access to Independence and Tioga Opportunities (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 91 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: United Way of Broome County, Tioga Opportunities, Access to Independence and Family Health Network of Central New York. The roster of trained navigators, training dates and training material have been uploaded as supporting documentation.
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 completed and passed in DY2Q2. For DY2Q4, CCN continues to contract for the Community Navigation project (2ci), including four 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. The 5 new contracted partners for 2di also have navigators within their organization to support direct hand-offs to navigators. The list of new contracts executed for 2ci and 2di have been uploaded as supporting documentation.
Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	Milestone 15 was completed and passed in DY2Q3 with no changes to report.
Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	Milestone 16 and two remaining steps are due for completion in DY2Q4, however Care Compass Network (CCN) is deferring the due date of the milestone and remaining steps to DY3Q3. CCN is currently collaborating with the healthcare systems and community based organizations to learn about their process and procedures for intake and scheduling staff to receive navigator calls. This information will inform CCN of the strategy for best accomplishing implementation of this for the communities CCN supports.
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 was completed and passed in DY2Q3 with no changes to report.

Milestone Review Status

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

New York State Department Of Health
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 #4	Pass & Complete	
Milestone #5	Pass & Complete	
Milestone #6	Pass & Complete	
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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	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

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment	
CG-CAHPS 2016 Survey Results of Uninsured	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

Instructions :

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 3.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	5,563
	Percent(%) of Commitment	1.09%	4.11%	13.01%	23.98%
IA Approved	Quarterly Update	0	555	0	5,451
	Percent(%) of Commitment	0.00%	4.11%	0.00%	23.50%

Warning: PPS Reported - Please note that your patients engaged to date (5,563) does not meet your committed amount (23,196) for 'DY2,Q4'

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
brosetti	Rosters	44_DY2Q4_PROJ3ai_MDL3ai2_PES_ROST_3ai_M1M2_Actively_Engaged_DY2Q4_12982.xlsx	3ai M1M2 Actively Engaged roster	04/26/2017 02:11 PM

Narrative Text :

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

There has been significant improvement in the reported patient engagement from 1509 reported in DY2 Q3 quarterly report due to the rapid change and alignment to DOH's minimum actively engaged definition. As of DY2Q4, CCN has a total of 17 primary care sites participating in 3ai Model 1 and actively reporting patient engagement numbers for speed and scale. Out of the seventeen primary care sites, six sites are co-located with a licensed behavioral health specialists. All other sites are implementing systems and workflow changes while actively recruiting for a licensed behavioral health specialist. Currently, CCN has two sites participating in 3ai Model 2 who are reporting speed and scale.

CCN acknowledges that our partners are having a difficult time recruiting and retaining of licensed behavioral health specialist to co-locate in a

Care Compass Network (PPS ID:44)

PCMH primary care clinic. For PCMH sites that are conducting screenings without co-location, there are care protocols in place as supported by the U.S. Preventive Services Task Force (USPSTF) Grade B recommendation in screenings.

• Adults - 2002 -U.S. Preventive Services Task Force (USPSTF) recommends screening adults for depression to improve detection and patient outcomes, provided that effective systems are in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (Grade B)
• Teens • 2009 -USPSTF recommends screening adolescents aged 12–18 years for major depressive disorder in primary care, provided that systems are in place to ensure further evaluation, psychotherapy, and follow-up (Grade B) • http://www.teenscreen.org/home • PHQ-A (Modified PHQ-9 for Adolescents)

Sharp. L.K. & Lipsky, M.S. (2002). American Family Physician, 66 (6), 1001-1008.
Screening for Depression
Screening for Major Depressive Disorder in Children and Adolescents, March 2009. U.S. Preventive Services Task Force.
www.uspreventiveservicestaskforce.org/uspstf/uspschdepr.htm
Original Article by Williams et al. Pediatrics, 2009 716-735

Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its Actively Engaged commitments for DY2,Q4.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 3.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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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	12/31/2016	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		On Hold	04/01/2015	03/31/2018	04/01/2015	03/31/2020	03/31/2020	DY5 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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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		Completed	04/01/2015	03/31/2018	04/01/2015	03/31/2017	03/31/2017	DY2 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		Completed	04/01/2015	03/31/2018	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	Completed	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		Completed	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		Completed	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	03/31/2020	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	03/31/2020	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	03/31/2020	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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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	Completed	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		Completed	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		Completed	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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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		Completed	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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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.	sculley	Other	44_DY2Q4_PROJ3ai_MDL3ai3_PRES6_OTH_3ai_M2_Milestone_6_Collaborativ_Care_meeting_minutes,_agenda,_attendees,_membership_15674.pdf	Remediation file - inventory of meeting schedules, and examples of meetings pertaining to development of collaborative evidence-based standards of care.	06/20/2017 08:47 AM
	sculley	Other	44_DY2Q4_PROJ3ai_MDL3ai3_PRES6_OTH_3ai_M2_Milestone_6_July_26th_Cornell_University_Collaborative_Care_15673.pdf	Remediation file - evidence of the July 26th collaborative care meeting.	06/20/2017 08:46 AM
	sculley	Other	44_DY2Q4_PROJ3ai_MDL3ai3_PRES6_OTH_3ai_M2_Miletone_6_remediation_15672.docx	Remediation file - narrative for 3ai Model 2 Milestone 6.	06/20/2017 08:45 AM
	brosetti	Training Documentation	44_DY2Q4_PROJ3ai_MDL3ai3_PRES6_TRAIN_CCN_BH_training_12200.pdf	CCN BH Training	04/25/2017 02:05 PM
	brosetti	Other	44_DY2Q4_PROJ3ai_MDL3ai3_PRES6_OTH_NYS_Regulations_for_licensed_clinics_12199.pdf	NYS Regs for licensed clinics	04/25/2017 02:03 PM
	brosetti	Meeting Materials	44_DY2Q4_PROJ3ai_MDL3ai3_PRES6_MM_CCN_Clinical_Governance_Behavioral_Health_Subcommittee_for_upload_12197.pdf	CCN Clinical Governance Behavioral Health Subcommittee	04/25/2017 02:02 PM
	brosetti	Quarterly Report (no attachment necessary)	44_DY2Q4_PROJ3ai_MDL3ai3_PRES6_QR_DY2Q4_Milestone_6_Narrative_12194.docx	DY2Q4 Milestone 6 Narrative	04/25/2017 02:00 PM
Use EHRs or other technical platforms to track all patients engaged in this project.	brosetti	Documentation/Certification	44_DY2Q4_PROJ3ai_MDL3ai3_PRES8_DOC_DSRIP_Approval_Letter_3_24_17_12205.pdf	DSRIP Approval Letter	04/25/2017 02:15 PM
Use EHRs or other technical platforms to track all patients engaged in this project.	brosetti	Rosters	44_DY2Q4_PROJ3ai_MDL3ai3_PRES4_ROST_CCN_Multiple_Services_Report_DY2_12087.xlsx	CCN Multiple Services Report DY2	04/25/2017 11:27 AM
	brosetti	Rosters	44_DY2Q4_PROJ3ai_MDL3ai3_PRES4_ROST_CCN_Multiple_Services_Report_DY2_-_across_partners.csv_12086.xlsx	CCN Multiple Services Report DY2 - across partners	04/25/2017 11:26 AM
	brosetti	Screenshots	44_DY2Q4_PROJ3ai_MDL3ai3_PRES4_SS_IPC_screenshots_12082.pdf	IPC screenshots	04/25/2017 11:23 AM
	brosetti	Screenshots	44_DY2Q4_PROJ3ai_MDL3ai3_PRES4_SS_Lourdes_Patient_Screenshot_12080.docx	Lourdes Patient Screenshots	04/25/2017 11:18 AM
	brosetti	Rosters	44_DY2Q4_PROJ3ai_MDL3ai3_PRES4_ROST_3ai_Patient_Registry_12077.xlsx	3ai Patient Registry	04/25/2017 11:16 AM
	brosetti	Quarterly Report (no attachment necessary)	44_DY2Q4_PROJ3ai_MDL3ai3_PRES4_QR_Narratives_for_Milestones_4_12071.docx	Milestone 4 Narrative	04/25/2017 11:09 AM

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.	There are no milestones or steps due for completion for DY2, Q4, however, Care Compass Network is on track in meeting this milestone by the deadline. CCN is moving Step 1h to on hold since the content and ask of the step is not relevant to fulfilling the milestone objectives (Step 1h – On Hold).

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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. To align with Department of Health's minimal reporting requirements, CCN added additional behavioral health screenings that qualify for reimbursement under the 3ai project including the PHQ-2 plus all nationally-accepted best practices that are age-appropriate behavioral health screening tools. The clinical guideline (CGC-CG-26) was vetted through the four Regional Performing Units' quality subcommittees, endorsed by the Clinical Governance Committee in January 2017.
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.	Milestone 3 and the remaining steps are not due for completion in DY2Q4 however Steps 3g and 3h are being reported as complete. Clinical Guideline CGC-CG-40 - Mental Health First Aid (MHFA) Training was selected and endorsed by the Clinical Governance Committee for client facing staff and community based organization partners to develop a deeper understanding and early recognition of the signs/symptoms of the most common mental health issues such as depression, substance abuse, anxiety, suicide ideation and mental health crisis. CCN will offer the training at no charge to our partners across the PPS with primary preference given to partners participating in the 3ai and 4aiii projects. We anticipate the first MHFA training to be scheduled for June 8th, 2017. CCN will continue to offer the trainings on a consistent basis to our partners across the PPS to directly support the NYS Prevention Agenda (Step 3g – Complete). Step 3h is being reported as complete with the endorsement of the 3ai – model 1 implementation project toolkit by the Clinical Governance Committee in March 2017. The toolkit is intended to assist and provide guidance to partner organizations on how to incorporate and integrate evidence based behavioral health screening, documentation and follow up care into their current workflow. The Implementation toolkit (CGC-CG-37) also contains previous clinical guidelines endorsed by CCN's Clinical Governance Committee (Step 3h – Complete). Components of 3.a.i - Integration of Behavioral Health with Primary Care – Model 1 implementation toolkit: o Process workflow map o Key Roles in an integrated care o CGC-CG-05 – Clinical guideline for Proposed PHQ-2/PHQ-9 Treatment Actions o CGC-CG-26 – Approved Behavioral Health Screening Tools o Community/Outpatient/Inpatient Resources for patients o Health Home Eligibility Criterion o CGC-CG-16 - Clinical guideline for Crisis Stabilization services and interventions o CGC-CG-28 - Clinical guideline for Warm handoff o CGC-CG-30 - Clinical guideline for Project TEACH o CGC-CG-35 - Clinical guideline for Project ECHO o CGC-CG-31 - Clinical guideline for Screening for Clinical Depression and follow up care The PMO, Workforce and Partner Relations staff will support the direct training and implementation of the toolkit to contracted partners for model 1. As each collaborative model of care develops, CCN will support partners and provide resources and opportunities for cross training between behavioral health and primary care staff. Step 3i is in progress and will be monitored by the PMO by requesting documents and materials as part of a self-audit process.
Use EHRs or other technical platforms to track all patients engaged in this project.	Please see uploaded Milestone 4 Narrative.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Co-locate primary care services at behavioral health sites.	
Develop collaborative evidence-based standards of care including medication management and care engagement process.	Please refer to uploaded DY2Q4 Milestone 6 Narrative
Conduct preventive care screenings, including physical and behavioral health screenings.	
Use EHRs or other technical platforms to track all patients engaged in this project.	Milestone 8 and subsequent steps were completed in DY2Q3, however, there are updates to report. One of our partners, Family Counseling Services of Cortland County received the necessary waiver on March 24, 2017 to provide Primary Care Services at their Article 31 Mental Health Clinic (Step 8c - Complete). CCN has uploaded a copy of their approval letter for supporting documentation. Step 8c was previously put on hold, but we are reporting it as complete with the DSRIP approval attached for one of our partners. CCN attempted to update the step in MAPP, but was unable to.
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.	

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 & Ongoing	
Milestone #6	Pass & Complete	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Complete	
Milestone #9	Pass & Ongoing	

New York State Department Of Health
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 #10	Pass & Ongoing	
Milestone #11	Pass & Ongoing	
Milestone #12	Pass & Ongoing	
Milestone #13	Pass & Ongoing	
Milestone #14	Pass & Ongoing	
Milestone #15	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 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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

Instructions :

Care Compass Network (PPS ID:44)

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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 3.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	3,018
	Percent(%) of Commitment	0.00%	7.18%	11.23%	261.98%
IA Approved	Quarterly Update	0	31	0	2,923
	Percent(%) of Commitment	0.00%	7.18%	0.00%	253.73%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
espape	Other	44_DY2Q4_PROJ3aii_MDL3aii2_PES_OTH_REDLINE-NY_DSRIP_Validation_Protocols_Revised_March_2017_13975.pdf	DSRIP Reporting and Validation Protocols: Domain 1 Milestones-Minimum Standards for PPS Supporting Documentation and IA Validation Process (Version 1.2 March 2017)	04/27/2017 04:19 PM
espape	Other	44_DY2Q4_PROJ3aii_MDL3aii2_PES_OTH_SPCS_Attestation_of_Anonymous_Calls_March2017_13702.pdf	CCN Partner Attestation (by Suicide Prevention and Crisis Service) of crisis services provided through anonymous engagements.	04/27/2017 11:01 AM
espape	Rosters	44_DY2Q4_PROJ3aii_MDL3aii2_PES_ROST_DY2_Total_Crisis_ActivelyEngaged_13696.xlsx	CCN Actively Engaged Patient Roster, including 504 with an identified CIN and 148 with Name and Birthdate, but no CIN.	04/27/2017 11:00 AM

Narrative Text :

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

Care Compass Network had submitted a total of 3.018 behavioral health crisis services, including phone-based and face to face de-escalation services. In 504 instances, name, date of birth, and CIN have been included. In 148 instances, name and date of birth have been included. In 2,366

instances, the engagement was anonymous in nature. We have included an attestation by the partner (Suicide Prevention and Crisis Service) regarding these crisis services. We included anonymous engagements in our total Actively Engaged counts as allowed by guidance included in the DSRIP Reporting and Validation Protocols: Domain 1 Milestones- Minimum Standards for PPS Supporting Documentation and IA Validation Process (Version 1.2 March 2017), page 61).

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 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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
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	03/31/2018	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	03/31/2018	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	03/31/2018	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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
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	Completed	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		Completed	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	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Providers Associated with Completion: United Health Serv Hosp Inc										
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		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

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
services/crisis oriented-psychiatric services, and overall readiness/willingness to engage in 3aii related work. Based on the initial assessments, the 3aii Project Team expects to engage with United Health Services, Inc., Cayuga Medical Center, and Cortland Regional Medical Center for this project.										
Task 5d. On at least an annual basis, the 3aii Project Team and PMO will present to each regional performance unit Behavioral Health Subcommittee (e.g., 3aii Quality Committee) an evaluation and report of crisis-oriented psychiatric services availability, geographic access, wait times, etc. to identify areas for improved access. As required and advised by the BH Quality Committee, the PMO will implement improvement plans (e.g., such as improvement efforts or program expansion efforts).		Project		Completed	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	03/31/2018	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	03/31/2018	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	03/31/2018	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	03/31/2018	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	03/31/2018	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		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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

DSRIP Implementation Plan Project

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
initially identified a Phase I approach for collaboration with Cortland Regional Medical Center and Cayuga Medical Center for the expansion of access to observation units. In Phase II the 3aii Project Team will identify strategies for the remaining regions/providers.										
Task 6f. CCN PMO to contract with PPS CBOs to maintain community-based respite beds (safety net clinics and/or safety net behavioral health providers) that offer crisis intervention and observation services within the community for those individuals who can be stabilized outside of hospital setting.		Project		In Progress	04/01/2015	03/31/2018	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	03/31/2018	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		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
Committee, approved by the Board of Directors, and subsequently recertified on, at minimum, an annual basis by the Clinical Governance Committee.										
Task 7e. The 3aii Project Team will identify strategies to provide/deliver mobile crisis teams/services throughout the PPS as needs exist (e.g., by RPU.)		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		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
8g. 3aii Team to identify EHR or other IT platform(s) for behavioral health screening/assessment tool, collection, sharing and storage of data. EHR or other IT platform(s) to meets several requirements which facilitate intervention services (for example, integrated medical/behavioral health record, ability to track patients, ability to report agency-level performance metrics, RHIO/SHIN-NY connectivity, alerts and secure messaging). CCN PMO to coordinate review and approval of IT solutions with the IT Committee (and the associated review processes) and align vendor solutions with project needs as well as the broader IT Vision of the PPS.										
Task 8h. The PPS will execute a contract with the selected vendor for the delivery of services. The CCN PMO/Provider Relations to oversee roll out of EHR or other IT platform to contracted agencies, providers, and CBOs offering crisis stabilization services. Rollout includes readiness assessment, training, workflow optimization, and go live. (Risk #3) As part of the implementation process, PPS Partners will be required to submit documentation such as certifications, training attestations/rosters, or system reports to confirm achievement of key implementation/integration milestones.		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		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
services. The finalized plans will serve as a baseline for operating/contractual agreements with PPS members participating in project 3aii.										
Task 9c. As part of the Care Compass Network contract, the centralized phone triage provider(s) will be required to use a standard assessment tool, approved by the Clinical Governance Committee and recertified annually.		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	Completed	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		Completed	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		Completed	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		Completed	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		Completed	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		Completed	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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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 10g. CCN PMO regularly reports key quality metrics (including Appendix J metrics Domain 3 Behavioral Health metrics) to RPU Behavioral Health Subcommittees. Behavioral Health Subcommittees identifies opportunities for quality improvement; PMO develops implementation plans, committee and PMO evaluate results of quality improvement initiatives. CCN to distribute service and quality outcome measures to Care Compass Network quality committee(s) as well as to the stakeholders through platforms such as the Stakeholders meeting and/or website.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #11 Use EHRs or other technical platforms to track all patients engaged in this project.	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 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	12/31/2016	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	12/31/2016	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	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.	sculley	Other	44_DY2Q4_PROJ3aii_MDL3aii3_PRES5_OTH_3aii_Actively_Engaged_15676.docx	Remediation file - update to 3aii actively engaged number. We were not able to edit module 3.aii.2 to submit an updated number for 3aii patient speed and scale so we added it here	06/20/2017 08:52 AM
	sculley	Other	44_DY2Q4_PROJ3aii_MDL3aii3_PRES5_OTH_3aii_M5_Remediation_15675.docx	Remediation file - narrative for 3aii milestone 5.	06/20/2017 08:51 AM
	espape	Other	44_DY2Q4_PROJ3aii_MDL3aii3_PRES5_OTH_M5_Metric1_item1_ProviderList_14039.xlsx	Provider Engagement for Milestone 5.	04/27/2017 10:11 PM
	espape	Other	44_DY2Q4_PROJ3aii_MDL3aii3_PRES5_OTH_M5_Metric2_Access_to_Psych_Services_Improvement_Plan_13993.pdf	Access to specialty psychiatric services assessment and improvement plan.	04/27/2017 04:54 PM
Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.	sculley	Other	44_DY2Q4_PROJ3aii_MDL3aii3_PRES10_OTH_3aii_M10_M1_Governance_15683.pptx	Remediation file - documentation outlining CCN governance structure.	06/20/2017 09:02 AM
	sculley	Other	44_DY2Q4_PROJ3aii_MDL3aii3_PRES10_OTH_3aii_M10_M1_StaffCategory_15678.xlsx	Remediation file - quality committee membership inclusive of title (staff category) for each member.	06/20/2017 08:57 AM
	sculley	Other	44_DY2Q4_PROJ3aii_MDL3aii3_PRES10_OTH_3aii_M10_Remediation_15677.docx	Remediation file - narrative for 3aii milestone 10	06/20/2017 08:56 AM
	espape	Other	44_DY2Q4_PROJ3aii_MDL3aii3_PRES10_OTH_M10_M5_DashMay2016_14035.pdf	CCN Performance Metric Dashboard	04/27/2017 09:52 PM
	espape	Other	44_DY2Q4_PROJ3aii_MDL3aii3_PRES10_OTH_M10_M4_CG16_3aiiClinicalGuideline_14034.pdf	CCN Clinical Guideline for 3aii Crisis Stabilization partners	04/27/2017 09:49 PM
	espape	Other	44_DY2Q4_PROJ3aii_MDL3aii3_PRES10_OTH_M10_M4_3aii_SelfAudit_14033.pdf	CCN Self Audit for 3aii Partners	04/27/2017 09:47 PM
	espape	Other	44_DY2Q4_PROJ3aii_MDL3aii3_PRES10_OTH_M10_M3_CG37_-_3aiModel1Toolkit_14032.pdf	CCN 3ai Process Workflow and Toolkit	04/27/2017 09:45 PM
	espape	Other	44_DY2Q4_PROJ3aii_MDL3aii3_PRES10_OTH_M10_M3_CG31-_ScreeningforClinicalDepression_14031.pdf	CCN Clinical Guideline for Screening for Clinical Depression	04/27/2017 09:42 PM
	espape	Other	44_DY2Q4_PROJ3aii_MDL3aii3_PRES10_OTH_M10_M2_MAXSeriesReport_14030.pdf	CCN MAX series report	04/27/2017 09:39 PM
	espape	Other	44_DY2Q4_PROJ3aii_MDL3aii3_PRES10_OTH_M10_M1_BHcommittee_slates_14029.pdf	CCN Behavioral Health Committee Charter and Slates	04/27/2017 09:38 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 and passed in DY2Q2. Care Compass Network (CCN) 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 CCN program now 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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	up care, as well as one crisis respite provider. CCN has added mobile teams in the last quarter, including Tompkins County Mental Health, which has expanded their Emergency Outreach Service, The Neighborhood Center (Mobile Crisis Action Team) serving Delaware and Chenango Counties, and the ARC of Chemung, which provides services to the developmentally disabled population in Chemung, Steuben, and Schuyler Counties. Rehabilitation Support Services (RSS) has opened up a one-bed crisis respite room, connected to their group home in Tioga County. CCN continues to reach out to other key behavioral health providers in our service area to provide the core services under the project and identify ways CCN can build up emergency room diversionary services and bridge connections between participating partners. 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 on time.
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 is on track to complete the milestone on time.
Develop written treatment protocols with consensus from participating providers and facilities.	This milestone was completed and passed 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. 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. Care Compass Network participated in a statewide symposium with other PPSs in January 2017. CCN has identified a few areas where extension of the guideline will benefit project partners and improve CCN's overall project impact.
Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.	Milestone 5 and four remaining steps are due for completion in DY2Q4 and are being reported as complete. CCN has contracted with three hospitals which provide specialty psychiatric services and crisis-oriented psychiatric services, including United Health Services, Cortland Regional Medical Center, and Cayuga Medical Center. United Health Services – Binghamton General Hospital (BGH) is a key partner in the Crisis Stabilization project; this hospital has an inpatient mental health unit, an outpatient mental health clinic, and provides in person crisis services to patients in Broome and Tioga counties. The mobile team is part of Comprehensive Psychiatric Emergency Program (CPEP) unit team and is comprised of licensed and masters level clinicians. BGH also houses an inpatient behavioral health unit and serves patients with mental illness and substance abuse disorders. Thus, there is a well-developed process to access inpatient services when necessary (Step 5a and 5c – Complete). Please reference the Participating Provider list Metric 1 document (M1_Metric1_item1_ProviderList.xls). The Care Compass Network Analytics Team has completed an evaluation of specialty psychiatric services in terms of their availability, geographic access, and wait times from providers across the PPS. Major findings include: 1) there is typically upwards of 4 weeks wait time to prescriber services at outpatient mental health clinics for patients who present without urgent needs, 2) there are significant workforce-related challenges to begin to address these gaps in access. CCN's strategy to improve access will encompass both addressing workforce challenges by supporting enhanced recruitment to attract and retain psychiatrists, nurse practitioners of psychiatry, and licensed clinical social workers. Reference attached document for Metric 2 (M5_Metric2_Access to Psychiatric Service Improvement Plan.pdf) (Step 5b – Complete). The results of the access study have been presented and reviewed by the North and South Behavioral Quality Subcommittees March 17, 2017 (South), April 5, 2017 (West), and April 6, 2017 (North) and will be presented annually to each RPU Behavioral Health subcommittee (Step 5d – Complete).
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 (CCN) is on track to complete this milestone on time.
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 previously deployed three mobile teams to provide crisis stabilization services using evidence-based protocols in the following counties: Broome (two teams), Tioga, Chemung, and Schuyler. During DSRIP Year 2, Q4, new teams have deployed which cover Tompkins County (Tompkins County Mental Health clinic), Delaware and Chenango Counties (The Neighborhood Center --Mobile Crisis Assessment Team (MCAT)). Additionally, the

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	ARC of Chemung runs a NY START program which provides crisis services (among others) to the developmentally disabled persons in Steuben, Chemung, and Schuyler Counties. While the population served by this partner is limited, these services can make a large impact on Emergency Department usage and hospitalization, as the services are tailored to the developmentally disabled population.
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 (CCN) is on track to complete this milestone on time.
Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.	Care Compass Network (CCN) is on track to complete this milestone on time.
Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.	Milestone 10 and the five remaining steps are due for completion in DY2Q4 and are being reported as complete. Care Compass Network (CCN) has a well-established Behavioral Health Quality Committee structure with active engagement and is marking this milestone complete. Each Regional Performance Unit within the CCN area (North, East, South, and West) has its own committee whose charter is focused on the integration of primary care and behavioral health and other behavioral health initiatives. See the attached document which combines the charters and slates from the four committees and documents completion of Metric 1 (M10_M1_BHcommittee_slates.pdf) (Step 10a – Complete). The charters include such functions as overseeing project execution and implementing standardized metrics to monitor service quality, project performance, and DSRIP performance measures. These committees 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 (Step 10f – Complete). CCN regularly reports on the Appendix J metrics, including those related to the Behavioral Health Projects. Typically, these have been extracts from the MAPP Dashboards, focusing on the PPS as a whole or digging into county-level data to provide an RPU focus (Step 10g—Complete). In addition, the committees have identified opportunities for improvement and use of rapid cycle improvement methodologies. CCN participated in the MAX series and the progress of the MAX team was regularly reported on. Quality committee members had the opportunity to help guide the MAX team in developing a workflow to introduce regular depression screening into their primary care practice and begin offering short term, brief behavioral health interventions by the behavioral health consultant. See attached document M10_M2_MAXreport.pdf as documentation for Metric 2 (Step 10b- Complete). Over the course of the last year, CCN's medical chart review results for the Screening for Clinical Depression quality metric were reviewed by the committees. Out of those discussions, the committees co-developed a clinical guideline which establishes a standard process and requirements for follow up and documentation based on the score of a depression screen (M10_M3_CGC31-ScreeningforClinicalDepression.pdf). The committees also helped shape a 3ai process map (M10_M3_3aiToolKit.pdf). These materials were approved by the Clinical Governance Committee on February 23, 2017 and March 23, 2017, respectively. These documents are process improvement resources for partners to support widespread use of standardized screening tools for clinical depression. In addition, they outline requirements for appropriate follow up and documentation according to the screening results. These documents serve as documentation for Metric 3 (Step 10c – Complete.) The 3aii Project Team requested 3aii Partners to conduct self-audits of crisis stabilization services to ensure those services conform to project requirements set forth in CCN's clinical guideline for the project (See attached document M10_M4_CG16_3aiiClinicalGuideline.pdf). The quality committees reviewed the results of the self-audit and contributed to finding. The final report is included here (M10_M4_3aii_SelfAudit.pdf); this serves as documentation that Metric 4 is complete (Step 10d – Complete). CCN has used the Clinical Governance Committee, quality subcommittees (Behavioral Health, Disease Management, and Onboarding), as well as the operating groups, Project Advisory Council, and Board meeting forums as a way to communicate our progress and performance on the DSRIP service and quality outcome measures to all partners. A recent metric dashboard is attached as documentation, completing Metric 5 (M10_M5_PerformanceDashboard.pdf) (Step 10e- Complete).
Use EHRs or other technical platforms to track all patients engaged in this project.	Care Compass Network completed and passed this milestone in DY2 Q3. There are no updates.

New York State Department Of Health
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 #1	Pass & Complete	
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Ongoing	
Milestone #4	Pass & Complete	
Milestone #5	Fail	PPS failed to engage sufficient number of Safety Net Hospitals to meet Provider Level commitment.
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Complete	
Milestone #8	Pass & Ongoing	
Milestone #9	Pass & Ongoing	
Milestone #10	Pass & Complete	
Milestone #11	Pass & Complete	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 3.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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

Instructions :

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project 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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 3.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	782
	Percent(%) of Commitment	0.00%	0.00%	12.94%	54.01%
IA Approved	Quarterly Update	0	0	0	782
	Percent(%) of Commitment	0.00%	0.00%	0.00%	54.01%

Warning: PPS Reported - Please note that your patients engaged to date (782) does not meet your committed amount (1,448) for 'DY2,Q4'

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
rachaelm	Report(s)	44_DY2Q4_PROJ3bi_MDL3bi2_PES_RPT_CVD_Goal_DY2Q4_14173.xlsx	Report of Actively Engaged Medicaid Members	04/28/2017 11:08 AM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its Actively Engaged commitments for DY2,Q4

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 3.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		Completed	04/01/2015	03/31/2018	04/01/2015	03/31/2017	03/31/2017	DY2 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

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
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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
/ 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	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 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	12/31/2016	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	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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
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	12/31/2016	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	03/31/2018	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	03/31/2018	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	03/31/2018	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	03/31/2018	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	03/31/2018	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	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 5f. Develop process for provider feedback.		Project		In Progress	04/01/2015	03/31/2018	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	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

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
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		Completed	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		Completed	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	Completed	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		Completed	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		Completed	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		Completed	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		Completed	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		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

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
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		Completed	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		Completed	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	Completed	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		Completed	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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
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	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

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
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		Completed	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		On Hold	04/01/2015	03/31/2017	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 11c. Engage pharmacists in recommending once daily regimens as substitutions for other regimens.		Project		On Hold	04/01/2015	03/31/2017	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 11d. Engage managed care payers in offering once daily regimens as formulary options.		Project		On Hold	04/01/2015	03/31/2017	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 11e. Develop guideline promoting once-daily regimens and fixed-dose combination pills.		Project		Completed			01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task 11f. Obtain feedback and endorsement from the Clinical Governance Committee.		Project		Completed			01/01/2017	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		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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

DSRIP Implementation Plan Project

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
12e. Once approved, the 3bi Project Team and PMO will conduct a survey/assessment with partners to understand current system capabilities. As identified, system functionality deficiencies or gaps will be reported to the IT Committee and PPS partner 3bi Project Champion for identification of remediation solutions.										
Task 12f. The IT Workgroup will identify EMR reporting requirements to document and verify utilization and implementation of standards of care within the EMR which are in place to document patient driven self-management goals in the medical record and review of said goals.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 12g. PPS Partner status reports will be reported to the PPS Disease Management Quality Committee for review and any necessary improvements to be pursued as appropriate.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	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		Completed	04/01/2015	12/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
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	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

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
Task PPS has developed and implemented protocols for home blood pressure monitoring.		Project		Completed	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-up if blood pressure results are abnormal.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff on warm referral and follow-up process.		Project		Completed	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		Completed	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	Completed	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		Completed	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		Completed	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		On Hold	04/01/2015	03/31/2017	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 15d. Develop process for BP screening outside of office setting in a community "hot spot".		Project		On Hold	04/01/2015	03/31/2017	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 15e. Assess technical capabilities of contracted partner organizations.		Project		Completed			01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task 15f. Provide technical assistance where partner organizations cannot generate these lists.		Project		Completed			01/01/2017	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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 #16 Facilitate referrals to NYS Smoker's Quitline.	DY2 Q4	Project	N/A	Completed	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		Completed	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		Completed	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		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 16d. Educate providers and office staff on referral process and beneficiary education.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	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	Completed	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		Provider	Practitioner - Primary Care	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

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
procedures which reflect principles and initiatives of Million Hearts Campaign.			Provider (PCP)							
Providers Associated with Completion: Anis Uzma Md										
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)	On Hold	04/01/2015	03/31/2017	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.		Provider	Mental Health	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Providers Associated with Completion: Our Lady Of Lourdes Mem										
Task 18d. Develop methods to risk stratify the population with CV or potential CV disease.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 18e. Create processes to screen BPs with beneficiary health care contact and in the community in conjunction with the Clinical Governance Committee and, more specifically, the disease management subcommittees.		Project		Completed	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		Completed	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	03/31/2018	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	03/31/2018	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		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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

DSRIP Implementation Plan Project

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
population review to understand the affected cardiovascular disease population in the PPS by associated MCO.										
Task 19c. Risk Statify - Following the affected patient review, the population will be risk stratified to identify high risk versus rising risk cardiovascular populations.		Project		In Progress	04/01/2015	03/31/2018	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	03/31/2018	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 the PPS allocation of rising versus high risk populations. Note that this will need to be performed in for each Managed Care Organizations network.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task PPS has engaged at least 80% of their PCPs in this activity.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 20b. Identify PCPs and evaluate their ability to meet the project requirements.		Project		Completed	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		Completed	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
Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	rachaelm	Training Documentation	44_DY2Q4_PROJ3bi_MDL3bi3_PRES6_TRAIN_FHNCNY_Train_CDSMP_Document2_14186.pdf	Sample training document from partner organization used to train their staff on protocols listed.	04/28/2017 11:19 AM
	rachaelm	Contracts and Agreements	44_DY2Q4_PROJ3bi_MDL3bi3_PRES6_CONTR_FHN_Appendix_C_3bi_14184.pdf	Sample agreement demonstrating the language in the agreements requesting partner organizations train their staff on these items.	04/28/2017 11:18 AM

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	rachaelm	Other	44_DY2Q4_PROJ3bi_MDL3bi3_PRES6_OTH_Inventory_of_Policies_&_Procedures_14183.xlsx	List/Inventory of policies and procedures related to standardized treatment protocols for hypertension and elevated cholesterol.	04/28/2017 11:17 AM
	rachaelm	Policies/Procedures	44_DY2Q4_PROJ3bi_MDL3bi3_PRES6_P&P_CGC-CG-12_Algorithm_Based_on_AHA-13_Report_on_Lipids_14182.pdf	Policies and procedures related to standardized treatment protocols for hypertension and elevated cholesterol.	04/28/2017 11:16 AM
	rachaelm	Policies/Procedures	44_DY2Q4_PROJ3bi_MDL3bi3_PRES6_P&P_CGC-CG-11_Algorithm_Based_on_JNC-8_14178.pdf	Policies and procedures related to standardized treatment protocols for hypertension and elevated cholesterol.	04/28/2017 11:14 AM
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.	sculley	Other	44_DY2Q4_PROJ3bi_MDL3bi3_PRES7_OTH_Partner_care_coordination_policies_15687.pdf	Remediation file - additional examples of partner care coordination policies.	06/20/2017 09:20 AM
	sculley	Other	44_DY2Q4_PROJ3bi_MDL3bi3_PRES7_OTH_Allscripts_Touchworks_11.5_CHPL_15686.pdf	Remediation file - vendor certification documentation for last vendor.	06/20/2017 09:15 AM
	sculley	Other	44_DY2Q4_PROJ3bi_MDL3bi3_PRES7_OTH_3bi_M7_Remediation_15685.docx	Remediation file - narrative for 3bi milestone 7.	06/20/2017 09:14 AM
	rachaelm	Other	44_DY2Q4_PROJ3bi_MDL3bi3_PRES7_OTH_Pop_Health_Roadmap_Draft_09072016_14202.pptx	Population Health Roadmap.	04/28/2017 11:40 AM
	rachaelm	Policies/Procedures	44_DY2Q4_PROJ3bi_MDL3bi3_PRES7_P&P_Care_Transition_Flowchart_for_UHS_(003)_14201.pdf	Care coordination policies and procedures & Documentation of Process and Workflow including responsible resources at each stage of the workflow.	04/28/2017 11:38 AM
	rachaelm	Policies/Procedures	44_DY2Q4_PROJ3bi_MDL3bi3_PRES7_P&P_Care_Transitions_Post-Acute_Care_Flowchart_14199.pdf	Care coordination policies and procedures & Documentation of Process and Workflow including responsible resources at each stage of the workflow.	04/28/2017 11:37 AM
	rachaelm	Policies/Procedures	44_DY2Q4_PROJ3bi_MDL3bi3_PRES7_P&P_Medicaid_Health_Home_Referrals_upon_Hospital_Discharge_Final_for_approval_14198.pdf	Care coordination policies and procedures.	04/28/2017 11:36 AM
	rachaelm	EHR/HIE Reports and Documentation	44_DY2Q4_PROJ3bi_MDL3bi3_PRES7_EHR_CHPL_Documentation_14197.pdf	Vendor System Documentation - Evidence that the system is an EHR certified vendor (Clinically Interoperable System is in place for all participating providers); CHPL Documentation.	04/28/2017 11:35 AM
	rachaelm	EHR/HIE Reports and Documentation	44_DY2Q4_PROJ3bi_MDL3bi3_PRES7_EHR_Vendor_System_Documentation_-_Certified_Health_IT_Product_List_14192.xlsx	Vendor System Documentation - Evidence that the system is EHR certified vendor (Clinically Interoperable System is in place for all participating providers); 3bi Partner-EHR list.	04/28/2017 11:27 AM
	rachaelm	Quarterly Report (no attachment necessary)	44_DY2Q4_PROJ3bi_MDL3bi3_PRES7_QR_Milestone_7_Quarterly_Report_Narrative_14191.docx	Milestone 7 Quarterly Report Narrative	04/28/2017 11:27 AM
Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	rachaelm	Contracts and Agreements	44_DY2Q4_PROJ3bi_MDL3bi3_PRES9_CONTR_FHN_Appendix_C_3bi_14223.pdf	Sample agreement referencing policies and procedures as requirement for project participation uploaded in "Section I. Prerequisites for Participation.	04/28/2017 11:58 AM

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
				b.".	
	rachaelm	Policies/Procedures	44_DY2Q4_PROJ3bi_MDL3bi3_PRES9_P&P_CGC-CG-25_Guideline_for_How_to_Take_Blood_Pressure_14222.pdf	Policies and procedures - Documentation of the policies and procedures developed by the PPS to ensure blood pressure measurements are taken correctly with the correct equipment.	04/28/2017 11:58 AM
	rachaelm	Policies/Procedures	44_DY2Q4_PROJ3bi_MDL3bi3_PRES9_P&P_CGC-CG-24_Home_blood_pressure_monitoring_guidelines_14221.pdf	Policies and procedures - Documentation of the policies and procedures developed by the PPS to ensure blood pressure measurements are taken correctly with the correct equipment.	04/28/2017 11:56 AM
Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	rachaelm	Policies/Procedures	44_DY2Q4_PROJ3bi_MDL3bi3_PRES11_P&P_CGC-CG-12_Algorithm_Based_on_AHA-13_Report_on_Lipids_14235.pdf	Policies and procedures - Documentation for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.	04/28/2017 12:04 PM
Develop and implement protocols for home blood pressure monitoring with follow up support.	sculley	Other	44_DY2Q4_PROJ3bi_MDL3bi3_PRES14_OTH_COACH_Blood_Pressure_Log_R_15691.PDF	Remediation file - examples of policies and procedures.	06/20/2017 09:25 AM
	sculley	Other	44_DY2Q4_PROJ3bi_MDL3bi3_PRES14_OTH_COACH_Patient_Ed_How_is_High_BP_Treated_R_15690.PDF	Remediation file - examples of policies and procedures.	06/20/2017 09:24 AM
	sculley	Other	44_DY2Q4_PROJ3bi_MDL3bi3_PRES14_OTH_COACH_Patient_Ed_High_Blood_Pressure_R_15689.PDF	Remediation file - examples of policies and procedures.	06/20/2017 09:23 AM
	sculley	Other	44_DY2Q4_PROJ3bi_MDL3bi3_PRES14_OTH_3bi_M14_Remediation_15688.docx	Remediation file - narrative for 3bi milestone 14.	06/20/2017 09:22 AM
	rachaelm	Training Documentation	44_DY2Q4_PROJ3bi_MDL3bi3_PRES14_TRAIN_Lourdes_20170221.DSRIP_Blood_Pressure_Module_Owego_sign_in_14250.pdf	Sample training sign-in.	04/28/2017 12:23 PM
	rachaelm	Policies/Procedures	44_DY2Q4_PROJ3bi_MDL3bi3_PRES14_P&P_CGC-CG-24_Home_blood_pressure_monitoring_guidelines_14249.pdf	Policies and procedures	04/28/2017 12:21 PM
	rachaelm	Training Documentation	44_DY2Q4_PROJ3bi_MDL3bi3_PRES14_TRAIN_CGC-CG-28_Warm_Definition_14246.pdf	Written Training Materials & Policies and Procedures	04/28/2017 12:19 PM
	rachaelm	Policies/Procedures	44_DY2Q4_PROJ3bi_MDL3bi3_PRES14_P&P_CGC-CG-25_Guideline_for_How_to_Take_Blood_Pressure_14245.pdf	Policies and procedures	04/28/2017 12:16 PM
Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	rachaelm	Other	44_DY2Q4_PROJ3bi_MDL3bi3_PRES15_OTH_fhncny_cvdgoal_vstlapse_20170320_140000_14256.xlsx	Sample report further demonstrating partner organizations' ability to generate these lists.	04/28/2017 12:29 PM
	rachaelm	EHR/HIE Reports and Documentation	44_DY2Q4_PROJ3bi_MDL3bi3_PRES15_EHR_CHPL_Documentation_14254.pdf	Vendor System Documentation - Evidence that the system is an EHR certified vendor; CHPL	04/28/2017 12:28 PM

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
				Documentation of Partner Organizations' EHRs.	
	rachaelm	EHR/HIE Reports and Documentation	44_DY2Q4_PROJ3bi_MDL3bi3_PRES15_EHR_Vendor_System_Documentation_-_Certified_Health_IT_Product_List_14253.xlsx	Vendor System Documentation - Evidence that the system is an EHR certified vendor; Partner-EHR list.	04/28/2017 12:27 PM
Facilitate referrals to NYS Smoker's Quitline.	rachaelm	Policies/Procedures	44_DY2Q4_PROJ3bi_MDL3bi3_PRES16_P&P_CGC-CG-39_NYS_Smoker's_Quitline_Referral_Process_14260.pdf	Policies and Procedures of referral process including warm transfer protocols - Documentation of the referral process, protocols for including warm transfers.	04/28/2017 12:37 PM
	rachaelm	Policies/Procedures	44_DY2Q4_PROJ3bi_MDL3bi3_PRES16_P&P_CGC-CG-28_Warm_Definition_14258.pdf	Policies and Procedures of referral process including warm transfer protocols - Documentation of the referral process, protocols for including warm transfers.	04/28/2017 12:35 PM
Adopt strategies from the Million Hearts Campaign.	sculley	Other	44_DY2Q4_PROJ3bi_MDL3bi3_PRES18_OTH_PIT_Replacement_Template_Guidance_Document_15693.docx	Remediation file - guidance used by CCN for submitting provider level engagement.	06/20/2017 09:27 AM
	sculley	Other	44_DY2Q4_PROJ3bi_MDL3bi3_PRES18_OTH_3bi_M18_Remediation_15692.docx	Remediation file - narrative for 3bi milestone 18.	06/20/2017 09:27 AM
	rachaelm	Report(s)	44_DY2Q4_PROJ3bi_MDL3bi3_PRES18_RPT_M18_ProviderList_14275.xlsx	Provider-Level Report - Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	04/28/2017 12:57 PM
	rachaelm	Training Documentation	44_DY2Q4_PROJ3bi_MDL3bi3_PRES18_TRAIN_Keeping_a_Million_Hearts_Beating_How_Integrated_Care_can_Reduce_Heart_Disease_Power_Point_Final_2.28.17_14274.pptx	Training endorsed by PPS to Behavioral Health Providers.	04/28/2017 12:56 PM
	rachaelm	Policies/Procedures	44_DY2Q4_PROJ3bi_MDL3bi3_PRES18_P&P_CGC-CG-28_Warm_Definition_14273.pdf	Policies and Procedures - Documentation of the policies and procedures to implement the principles and initiatives of the Million Hearts Campaign.	04/28/2017 12:55 PM
	rachaelm	Policies/Procedures	44_DY2Q4_PROJ3bi_MDL3bi3_PRES18_P&P_CGC-CG-25_Guideline_for_How_to_Take_Blood_Pressure_14270.pdf	Policies and Procedures - Documentation of the policies and procedures to implement the principles and initiatives of the Million Hearts Campaign.	04/28/2017 12:54 PM
	rachaelm	Policies/Procedures	44_DY2Q4_PROJ3bi_MDL3bi3_PRES18_P&P_CGC-CG-14_The_5_As_of_Tobacco_Control_14268.pdf	Policies and Procedures - Documentation of the policies and procedures to implement the principles and initiatives of the Million Hearts Campaign.	04/28/2017 12:53 PM
	rachaelm	Policies/Procedures	44_DY2Q4_PROJ3bi_MDL3bi3_PRES18_P&P_CGC-CG-12_Algorithm_Based_on_AHA-13_Report_on_Lipids_14267.pdf	Policies and Procedures - Documentation of the policies and procedures to implement the principles and initiatives of the Million Hearts Campaign.	04/28/2017 12:52 PM

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	rachaelm	Policies/Procedures	44_DY2Q4_PROJ3bi_MDL3bi3_PRES18_P&P_CGC-CG-11_Algorithm_Based_on_JNC-8_14266.pdf	Policies and Procedures - Documentation of the policies and procedures to implement the principles and initiatives of the Million Hearts Campaign.	04/28/2017 12:52 PM
	rachaelm	Quarterly Report (no attachment necessary)	44_DY2Q4_PROJ3bi_MDL3bi3_PRES18_QR_Milestone_18_Quarterly_Report_Narrative_14264.docx	Milestone 18 Quarterly Report Narrative	04/28/2017 12:47 PM
Engage a majority (at least 80%) of primary care providers in this project.	sculley	Other	44_DY2Q4_PROJ3bi_MDL3bi3_PRES20_OTH_3bi_M20_Remediation_15694.docx	Remediation file - narrative for 3bi milestone 20.	06/20/2017 09:30 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.	Milestone 1 and the associated steps are not due for completion in DY2Q4 however Step 1b is being reported as complete. In June of 2015, the Pre-Engagement Assessment was developed and distributed with the help of the CBO Engagement Council, a group dedicated to ensuring that critical community partners were involved in DSRIP efforts. This group performed individual outreach and disseminated the Pre-Engagement Assessment to identified organizations with follow-up as needed. As additional organizations attested to work with the PPS, this assessment was sent to help capture a standard baseline set of information including current IT and population health systems utilized by the network (Step 1b - Complete).
Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	
Use EHRs or other technical platforms to track all patients engaged in this project.	Milestone 4 was completed and passed in DY2Q3, no changes.
Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	
Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	Milestone 6 and two remaining steps are due for completion in DY2Q4 and are being reported as complete. 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 (Step 6b - Complete) and the Algorithm based on American Heart Association (AHA) 13 for hyperlipidemia (Step 6c - Complete). Language was incorporated into project-specific agreements to ensure these standards are adopted by each organization Care Compass Network contracts with for project implementation (Step 6a – Complete). 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 topics will be available through the HWapps platform, Care Compass Network's learning management system. Furthermore, during DY3, the PPS intends to hold education days to cover these topics. During DY2, partner organizations engaged in Project 3bi signed agreements listing these standards as requirements and Care Compass Network received reports of trainings that occurred throughout the year which partner organizations were seeking reimbursement for

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	(Step 6d – Complete). Both the Algorithm based on Joint National Committee (JNC) 8 for hypertension and the Algorithm based on American Heart Association (AHA) 13 for hyperlipidemia guidelines endorsed by the Clinical Governance Committee have been uploaded to the inventory list attached to substantiate the completion of this Milestone as well as a sample document from Family Health Network used to train their staff on these protocols. These materials are policies and procedures related to standardized treatment protocols for hypertension. Additionally, a sample agreement is attached to demonstrate the language in the agreements requesting partner organizations train their staff on these items.
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.	Please refer to the uploaded document labeled Milestone 7 Quarterly Report Narrative since the narrative exceeded the character limit.
Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	
Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	Milestone 9 and three remaining steps are due in DY2Q4 and are being reported as complete. 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 (Step 9a and 9b - Complete). 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 contract agreements to ensure these guidelines, including the competency, are adopted by each organization Care Compass Network contracts with (Steps 9e and 9f – Complete). Care Compass Network supports partner organizations training their own staff on these as long as the training deployed meets the requirements. Partner organizations, who executed agreements to adopt the guidelines provided by CCN, reported trainings that occurred throughout the year which partner organizations were seeking reimbursement for. The aforementioned guidelines are uploaded to substantiate completion of this Milestone in addition to a sample agreement referencing these in Section I. Prerequisites for Participation. b.
Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	
Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	Milestone 11 and all subsequent steps are due for completion in DY2Q4 of which four steps are being reported as complete and three steps are being placed on hold. On November 30, 2015, the Clinical Governance Committee endorsed the Algorithm based on American Heart Association 2013 (AHA-13) guidelines which include formularies that are population specific and promote adherence (Step 11e. and 11f. - Complete). This guideline outlines statin therapy medications that meet the once-daily, fixed-dose criteria (Step 11a – Complete). The Project Team has continued to discuss the barrier presented by Medicaid as a payor in that, beyond what is covered in the AHA-13 guidelines, there are not really any other covered once-daily regimens and fixed-dose combination pills. Meanwhile, Steps 11b. – 11d. are placed "On Hold". Regarding alerts, many providers have communicated about "alert fatigue" in that this is a largely ineffective way of implementing guidelines such as these due to the large number of alerts already used or critical alerts that need to be integrated. As for pharmacists, a Multi-PPS 3bi Team has met monthly over the course of the DSRIP waiver period in which approaching pharmacists to help with this has been discussed. Due to issues with Medicaid covered benefits and some disagreement about which drugs to include on a standard list, this effort has not led to many answers. While discussion of other preferential drugs may yield some uncovered regimens, we would need to coordinate with our contracted partner organizations to make headway with changing coverage.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	Language was incorporated into project-specific agreements to ensure these standards are adopted by each organization Care Compass Network contracts with. The AHA-13 guidelines are uploaded to substantiate completion of this Milestone.
Document patient driven self-management goals in the medical record and review with patients at each visit.	
Follow up with referrals to community based programs to document participation and behavioral and health status changes.	Milestone 13 and associated steps are not due for completion in DY2Q4, however Step 13d is being reported as complete. Throughout the Demonstration Year, many community-based partner organizations have worked to develop the capacity to host Stanford's Chronic Disease Self-Management Program (CDSMP) for beneficiaries to support lifestyle changes and the development of self-management techniques (Step 13d. - Complete). While work continues into DY3, with Master Trainers within the program to develop Peer Leaders throughout the PPS, this community intervention has been successfully identified with groundwork laid and the intent to build momentum to scale the program up. In June of 2016, several partner organizations sent their staff to Master Trainer training. These organizations seek to complete their certification before June of 2017 so that they may be qualified to lead courses for the Peer Leaders and, consequently, increase prevalence of the program throughout the region.
Develop and implement protocols for home blood pressure monitoring with follow up support.	Milestone 14 and four remaining steps are due for completion in DY2Q4 and are being reported as complete. 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 (Step 14a, 14b., and 14d. - Complete). Included in this quarter's submission are blood pressure monitoring guidelines and training sign-in sample (to substantiate completion of Steps 14a. and 14b.) and a warm definition guideline (to substantiate completion of Step 14c.). 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 (Step 14c. – Complete). Within the terms of this project, the PPS also provided reimbursement for follow-up for these patients including collection of the method of follow-up and whether or not the patient made it to their follow-up appointment (Step 14f. – Complete). Care Compass Network supports partner organizations training their own staff on the protocols for home blood pressure monitoring and warm hand-offs 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, Care Compass Network's learning management system. Language was incorporated into project-specific agreements to ensure these standards are adopted by each organization contracted with Care Compass Network contracts. The blood pressure monitoring guidelines are uploaded to substantiate completion of this Milestone and apply to all Metrics.
Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	Milestone 15 and associated steps are due for completion in DY2Q4 and are being reported as complete with the exception of Steps 15c and 15d which are placed on hold. Care Compass Network has developed contracts for work requiring partner organizations to develop lists of hypertensive patients and schedule follow-up. The organization must also report the method by which they initiated follow-up. Each office setting, clinical and non-clinical, has a process for scheduling patients and for doing blood pressure screenings. The PPS does not intend to create processes to dictate and overwrite specific processes in place today. After further review by the PPS, steps 15c and 15d are on hold as development of these are not required for completion of the milestone (Step 15c and 15d – On Hold). The PPS worked with its partner organizations to ensure that they have the technical capabilities to do automated scheduling (Step 15e - Complete) demonstrated by the EHR-certification for the vendors used. Use of a certified vendor demonstrates their capability to generate lists of beneficiaries (Step 15b. – Complete) and conduct outreach where necessary. So far, Care Compass Network has collected a list of partner organizations' EHRs currently being utilized and cross-referenced them with vendor certification (Step 15e. - Complete) in order to determine whether or not this activity is currently possible. Furthermore, during DY2, the PPS made funds available for partner organizations to apply for funding for IT needs in the event there were barriers to DSRIP project implementation (Step 15f. - Complete). A list of contracted partner organizations and the EHRs they are using is attached along with reports from the Certified Health IT Product list to demonstrate CMS certification. During DY2, Q4, reports were also received from some partner organizations regarding their follow-up efforts for these patients. A sample report is also attached for review, further demonstrating partner organizations' ability to generate these lists.
Facilitate referrals to NYS Smoker's Quitline.	Milestone 16 and associated steps are due for completion in DY2Q4 and are being reported as complete. Currently, Care Compass Network reimburses providers for

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	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 EHR wherever possible. Health Systems for a Tobacco Free New York also presented at an East RPU meeting in early March. 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. A guideline outlining the process by which Medicaid Members can be referred to the Quitline was endorsed by the Clinical Governance Committee on March 23, 2017 (Complete – Step 16a. and Step 16b.). The guideline outlines both the Fax-to-Quit and Refer-to-Quit program, facilitating both fax and online referrals. Inherent with the Quitline process is feedback to the provider referring (Complete – Step 16c.). Education preceding DSRIP work really paved the way for awareness of these referral processes (Complete – Step 16d.), though the guideline may serve as an additional educational tool for those that might be aware of one method of referral but not the other. The guideline has been uploaded to substantiate completion of the milestone. CCN will continue to request feedback on the referral process through discussions with Stakeholders as part of implementation.
Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	
Adopt strategies from the Million Hearts Campaign.	Please refer to the uploaded document labeled Milestone 18 Quarterly Report Narrative since the narrative exceeded the character limit. NOTE: While "Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Lives Campaign. (Non-PCP Practitioners)" should be marked as "Complete" and these providers are included in the Provider-Level reporting document, MAPP does not list any providers in the module and so, the report could not Save without marking this element as "On Hold".
Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	
Engage a majority (at least 80%) of primary care providers in this project.	Milestone 20 and associated steps are due for completion in DY2Q4, however CCN needs to defer completion of the milestone and step 20a to a future quarter. As of March 31, 2017, four of the major health systems including Guthrie, Lourdes, Family Health Network, and UHS have signed contracts for project work but using those sites reporting as a basis for how many PCPs are engaged, the PPS is shy of its provider engagement estimates. Conservatively, about 32% are reporting actively engaged patients. The focused effort to execute updated contracts and increased interest due to increased incentives for this project makes engaging 80% of PCPs within the first half of DY3 a real possibility. Care Compass Network plans to remediate this in the coming months as efforts to increase provider engagement continue as identified in the Mid-Point Assessment action plans. As contracting commences for DY3, Q1, Care Compass Network has significantly altered reimbursement for project efforts with feedback solicited from the network. With the numerous project requirements, Care Compass Network will intentionally seek to gain input from providers and assist them in implementation. Further updates will be provided in future quarters in order to keep the IA apprised of efforts to meet the requirements of this milestone. The end date for the milestone and step 20a has been changed to DY3Q3. Still, Steps 20b. and 20c. are being marked as "Complete". Throughout DY2, partner relations staff met with providers and discussed their ability to meet project requirements and educate them on DSRIP projects. Much of this feedback has been used to inform the next phase of contracting and updated requirements and payment terms. Care Compass Network anticipates the new model to be a draw for a much larger percentage of PCPs in the upcoming year. Achievement of the Milestone as a whole hinges upon contract roll-out for the new year considering the groundwork of identifying PCPs and their education in DY2.

New York State Department Of Health
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 #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Ongoing	
Milestone #4	Pass & Complete	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Complete	
Milestone #7	Pass & Complete	
Milestone #8	Pass & Ongoing	
Milestone #9	Pass & Complete	
Milestone #10	Pass & Ongoing	
Milestone #11	Pass & Complete	
Milestone #12	Pass & Ongoing	
Milestone #13	Pass & Ongoing	
Milestone #14	Pass & Complete	
Milestone #15	Pass & Complete	
Milestone #16	Pass & Complete	
Milestone #17	Pass & Ongoing	
Milestone #18	Fail	The PPS failed to meet the Provider Level commitments of this Project for PCP and Non-PCP provider types.
Milestone #19	Pass & Ongoing	
Milestone #20	Fail	The PPS failed to meet the Provider Level commitment of this Project for the PCP provider type.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 3.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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 3.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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 3.g.i.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	865
	Percent(%) of Commitment	0.00%	0.00%	0.00%	191.80%
IA Approved	Quarterly Update	0	0	0	865
	Percent(%) of Commitment	0.00%	0.00%	0.00%	191.80%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
swooleve	Baseline or Performance Documentation	44_DY2Q4_PROJ3gi_MDL3gi2_PES_BASE_3gi_Actively_engaged_DY2_13524.xlsx	Actively engaged members file	04/27/2017 04:57 AM

Narrative Text :

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

Through a contracting push late in DY2Q4, the PPS was able to secure a good amount of key primary care physician practices who have or will be achieving PCMH 2014 Level 3 certification prior to March 31, 2018. Effective and appropriate incentives were applied to the project to help with this push as well as to aid in clarifying for partnering organizations that disease treatment, coupled with treatments considered more palliative in nature are appropriate to be considered for palliative care members. The use of the approved clinical guideline CGC-CG-09 Clinical Triggers for PCMH Referral to Palliative Care helps primary care physicians start to understand the members who need enhanced care services through robust palliative care.

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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 3.g.i.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	Completed	04/01/2015	03/31/2017	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)	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Providers Associated with Completion: Woglom Russell C Md										
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	Completed	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		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
2b. Develop Pre-Engagement Assessment and disperse among potential partners within PPS.										
Task 2c. Analyze data from Pre-Engagement Assessment to ascertain what hospice providers already exist within the PPS.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2d. Include available hospice providers in community resources developed by Project 2.c.i.		Project		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	Completed	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		Completed	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		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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
education/training forums where the clinical guidelines will be discussed. Clarity, transparency, and accountability to the clinical guidelines (among other topics) will be discussed as agreement from all partners is met. Re-assessment of clinical guidelines will formally occur annually by the Clinical Governance Committee, or more frequently as identified by the project team and/or regional PPS 3gi quality committees (e.g., Disease Management).										
Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	DY2 Q4	Project	N/A	Completed	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		Completed	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		Completed	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		Completed	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	Completed	04/01/2015	03/31/2017	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		Completed	04/01/2015	03/31/2020	04/01/2015	03/31/2017	03/31/2017	DY2 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		Completed	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		Completed	04/01/2015	03/31/2017	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	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

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
this project.										
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	03/31/2017	03/31/2017	DY2 Q4
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		Completed	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
Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.	sculley	Other	44_DY2Q4_PROJ3gi_MDL3gi3_PRES1_OTH_UPDATED_3gi_List_of_Providers_at_Participating_sites_15699.xlsx	Remediation file - updated list of engaged PCP providers including PCMH status.	06/20/2017 09:41 AM
	sculley	Other	44_DY2Q4_PROJ3gi_MDL3gi3_PRES1_OTH_CCN_3gi_Partner_Engagement_15696.xlsx	Remediation file - updated provider engagement numbers for project 3gi.	06/20/2017 09:36 AM
	sculley	Other	44_DY2Q4_PROJ3gi_MDL3gi3_PRES1_OTH_3gi_Milestone_1_Remediation_15695.docx	Remediation file - narrative for 3gi milestone 1.	06/20/2017 09:36 AM
	swooleve	Other	44_DY2Q4_PROJ3gi_MDL3gi3_PRES1_OTH_3gi_List_of_Providers_at_Participating_sites_that_reported_13907.xlsx	Engaged Provider listing with PCMH 2014 Level 3 status	04/27/2017 02:22 PM
	swooleve	Contracts and Agreements	44_DY2Q4_PROJ3gi_MDL3gi3_PRES1_CONTR_UHSH_Appendix_C_3gi_13526.pdf	UHSH Appendix C for 3.g.i Project participation	04/27/2017 05:05 AM
	swooleve	Other	44_DY2Q4_PROJ3gi_MDL3gi3_PRES1_OTH_DY2,_Q4_3gi_Inventory_of_Agreements_PCP_Template_-_CCN_13525.xlsx	Inventory of Agreements	04/27/2017 05:02 AM
Develop partnerships with community and provider resources including Hospice to bring the palliative	swooleve	Other	44_DY2Q4_PROJ3gi_MDL3gi3_PRES2_OTH_DY2,_Q4_3gi_Inventory_of_Agreements_CBO_Template_-	3,g,i Inventory of agreements with community based providers/Hospice	04/27/2017 05:09 AM

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
care supports and services into the practice.			_CCN_13527.xlsx		
Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	swooleve	Other	44_DY2Q4_PROJ3gi_MDL3gi3_PRES3_OTH_DY2Q4_3gi_Milestone3_Narrative.doc_13530.docx	Narrative for Milestone 3	04/27/2017 05:21 AM
	swooleve	Other	44_DY2Q4_PROJ3gi_MDL3gi3_PRES3_OTH_DY2,_Q4_inventory_of_3gi_agreements_13529.pdf	Inventory of all agreements for project participation and adoption of clinical guidelines and trainings	04/27/2017 05:20 AM
	swooleve	Other	44_DY2Q4_PROJ3gi_MDL3gi3_PRES3_OTH_3gi_Milestone_3_Clinical_Guidelines_and_Training_Documents_13528.pdf	Clinical Guidelines and Training Documents	04/27/2017 05:17 AM
Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	swooleve	Other	44_DY2Q4_PROJ3gi_MDL3gi3_PRES4_OTH_Inventory_of_policies_and_training_documents_13531.xlsx	Inventory of policies and trainings	04/27/2017 05:31 AM
Engage with Medicaid Managed Care to address coverage of services.	swooleve	Other	44_DY2Q4_PROJ3gi_MDL3gi3_PRES5_OTH_TRANSITION_OF_CARE_MANAGEMENT_DOCUMENTATION_-_Guthrie_13534.docx	TCM Pulled from an EHR showing project specific requirements captured	04/27/2017 05:42 AM
	swooleve	Other	44_DY2Q4_PROJ3gi_MDL3gi3_PRES5_OTH_Inventory_Of_MCO_Agreements_13533.xlsx	Inventory of agreements with managed care organizations covering project specific requierments	04/27/2017 05:41 AM
	swooleve	Other	44_DY2Q4_PROJ3gi_MDL3gi3_PRES5_OTH_DY2Q4_3gi_Milestone5_Narrative_13532.docx	Milestone 5 narrative	04/27/2017 05:38 AM
Use EHRs or other IT platforms to track all patients engaged in this project.	swooleve	Other	44_DY2Q4_PROJ3gi_MDL3gi3_PRES6_OTH_DY2Q4_3gi_Milestone6_Narrative_13538.docx	Milestone 6 Narrative	04/27/2017 05:59 AM
	swooleve	Other	44_DY2Q4_PROJ3gi_MDL3gi3_PRES6_OTH_CCN_Multiple_Services_Report_DY2_13537.xlsx	DSRIP Year 2 Registry of Actively Engaged Patients receiving multiple services under Different CCN Project - Roles	04/27/2017 05:58 AM
	swooleve	Other	44_DY2Q4_PROJ3gi_MDL3gi3_PRES6_OTH_CCN_Multiple_Services_Report_DY2_-_across_partners.csv_13536.xlsx	DSRIP Year 2 Registry of Actively Engaged Patients receiving multiple services by Different CCN Partners	04/27/2017 05:56 AM
	swooleve	Other	44_DY2Q4_PROJ3gi_MDL3gi3_PRES6_OTH_3gi_Actively_engaged_DY2_13535.xlsx	3,g,i Actively Engaged Members	04/27/2017 05:53 AM

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 in DY2Q4 and are being reported as complete. In November of 2016, through Project 2.a.i, the Care Compass Network (CCN) Performing Provider System (PPS) incentivized all primary care practice sites to pursue and complete NCQA PCMH 2014 Level 3 certification. The requirements under the 3.g.i project only required sites to achieve PCMH 2014 Level 1 certification, however, the incentives under 2.a.i led the way to help practice sites develop a roadmap to achieve PCMH 2014 Level 3 certification. Across the nine-county PPS, 88 primary care practice sites were identified as having the patient panel and ability to participate within DSRIP related project as well as having achieved or are pursuing PCMH 2014 Level 3 certification. Of these 88 sites, twelve have already achieved PCMH 2014 Level 3 certification and 76 are in the process of obtaining their NCQA certification.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	To date four major medical groups across the nine-counties, Guthrie Medical System (Guthrie), Our Lady of Lourdes Memorial Hospital, Inc. (Lourdes) physician group, Cayuga Medical Associates (CMA) the Cayuga Medical Centers physician practices, and United Health Services Hospitals, Inc. (UHSH) for the United Medical Associates (UMA) physician group, have executed and began implementing project 3.g.i. The Federally Qualified Health Center (FQHC), Family Health Network of New York (FHN) in Cortland County, and Radomir Stevanovic, MD, an independent primary care physician in Tompkins County, have also entered into an agreement with CCN committing to the integration of palliative care through the 3.g.i project specific appendix C. Each of these locations also have an active partner agreement for incentivization in completion of NCQA PCMH 2014 Level 3 certification with 5 practices sites having already achieved PCMH 2014 Level 3 certification. For participating sites that have submitted data for DY2 showing that a palliative care services has been provided within a PCMH, that is or will be PCMH 2014 Level 3 certified by 3/31/2018, there are 27 practice sites with 112 unique primary care clinicians currently offering palliative care services to their member population (reference 3.g.i List of Providers at Participating sites that reported.xlsx). CCN has not only met the milestone requirements, but, through dedication of the partnering providers and incentivizing for the highest level of standards, the PPS as a whole will exceed the project specific requirement to obtain a more sustainable program. CCN has uploaded the inventory of agreements with non PCMH certified organizations but pursuing PCMH as well as some agreements to committing to integrate palliative care.
Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	Milestone 2 is due for completion in DY2Q4 and is being reported as complete. 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 all five Hospice and Palliative Care agencies to work as part of the interdisciplinary team with primary care physicians within a PCMH and bring community based palliative care services and supports into the member's home. Project 3.g.i has a very active project team comprised of 1-2 members from 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 hospital under UHSH), 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. CCN has uploaded the agreements between the PPS and the community/provider resources including hospice to substantiate completion of the milestone.
Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	Please refer to the uploaded document labeled DY2Q4 3gi Milestone3 Narrative.doc since the narrative exceeded the character limit.
Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	Milestone 4 and remaining three steps are due for completion in DY2Q4 and are being reported as complete. From October of 2015 to present, the project team has actively worked on the creation and adoption of clinical guidelines agreed upon by all members of the PPS, that are intended for use for training and education to providers in the community as well as to aid in educating Medicaid members on how to begin the discussions with staff and caregivers. In this timeframe, the Board of Directors (BOD) has approved the following training guidelines: CGC-CG-017: WHO Definition of Palliative Care, CGC-CG-18-CGC-CG-21 The Conversation Project Starter kits, CGC-CG-32 CAPC Training Requirements and CGC-CG-34 The Standardized Home Visit check list 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 RPU Quality Subcommittees through the Clinical Governance Committee (CGC) and the Board of Directors. The CGC decided the Integrated Palliative Outcome Scale (IPOS) was set forth as a requirement from DOH and therefore did not need approval from CGC, however, CGC requested to be informed of updates to the document as well as any and all training materials created for implementation. An IPOS training guide with quick reference section was created in March of 2017 and presented to the CGC, and subsequently posted to the CCN SharePoint site as well as distributed to contracted partners. Each clinical guideline has an associated training through the agency providing the services, such as eMOLST through Compassion and Support (Excellus and Dr. Bomba) or has an approved training guideline created by CCN. UHSH, the largest health care system within the PPS encompassing 4 hospitals, a Medicaid Health Home, a skilled nursing facility, a home health agency and thirty primary care practice sites, has already integrated eMOLST into their EHR across their enterprise network. Through this full integration, Dr. Bomba and Katie Orem from Compassion and Support, have completed UHSH specific training to all personnel on the integration, implementation and use of the eMOLST system coupled with advance care planning training (Step 4a, 4b and 4d - Complete). Through the contracted membership with the Center to Advance Palliative Care (CAPC) the PPS was able to offer an even broader training curriculum that offers

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	continuing education units for clinical staff across the PPS, although membership is offered to all who would gain knowledge through inclusion for the project specific requirements. All of the online training modules are well researched and evidence based. The CAPC administration account allows the PPS to track and monitor the self-training efforts of the key staff enrolled in CAPC (Milestone 4 - Complete). The list of training materials developed for the project has been uploaded to substantiate completion of the milestone.
Engage with Medicaid Managed Care to address coverage of services.	Please refer to the uploaded document labeled DY2Q4 3gi Milestone5 Narrative.doc since the narrative exceeded the character limit.
Use EHRs or other IT platforms to track all patients engaged in this project.	Please refer to the uploaded document labeled DY2Q4 3gi Milestone6 Narrative.doc since the narrative exceeded the character limit.

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 & Complete	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 3.g.i.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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

Instructions :

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

Instructions :

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

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

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.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	12/31/2017	12/31/2017	DY3 Q3
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.	Completed	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	12/31/2016	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	12/31/2017	12/31/2017	DY3 Q3
Task 2a. On an as needed basis, engage DOH / OMH/ OASAS for feedback and recommendations on	Completed	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

Care Compass Network (PPS ID:44)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	12/31/2016	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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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 steps are due for completion in DY2Q4 however, Care Compass Network is deferring the due date of the milestone to 12/31/2017 as we continue to make progress towards the identification and selection of evidence based targeted interventions across the PPS. CCN's strategy continues to focus on improving the health and well-being of our community which will require behavioral changes in the workforce, especially with PCMH and integrated care. CCN has endorsed and will pay registration fees for four licensed behavioral health specialists from Our Lady of Lourdes Memorial Hospital, Inc. to attend a DBT Level 3 training in August 2017. This intensive evidence based training will provide a resource that is lacking in our region for adolescents and adults with Borderline Personality Disorder and other emotional self-regulation disorders. We are investigating the funding mechanism to offer this training PPS wide. The Project Management Team has been working with the Workforce team to identify evidence based trainings as part of the PPS wide training strategy. Some of the evidence based interventions below were incorporated: 1. Motivational Interviewing 2. Mental Health First Aid Training 3. Cognitive Behavioral Therapy – Behavioral Activation 4. SBIRT – Screening, Brief Intervention and Referral to Treatment 5. DBT – Dialectic Behavioral Training 6. FIT – Feedback Informed Treatment Step 1c is being reported as complete with the endorsement of CGC-CG-40 - Mental Health First Aid Training by the CCN Clinical Governance Committee in March 2016 as the evidence based educational program for the PPS and contracted partners participating in the 3ai and 4aiii projects. The training will assist providers, clinic staff, schools and community based organizations to respond and recognize the early 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 and suicide ideation (Step 1c – Complete). One of the goals of the PPS is to ensure the direct continuation and support of the NYS prevention agenda, especially targeting awareness in the community and workforce. Mental Health First Aid Training is one of the NYS prevention agenda initiative. We have contracted with one of our partners, (Mental Health Association of the Southern Tier) who will provide the initial evidence based training to staff of Partner Organizations. CCN anticipates the first training to be offered on June 8th, 2017. We will be providing updates quarterly as we approve additional evidence based trainings and interventions.
Milestone 2 - Expand efforts with DOH and OMH to implement 'Collaborative Care' in primary care settings throughout NYS.	Milestone 2 and the remaining step are due for completion in DY2Q4, however CCN is deferring the due date of the Milestone to 12/31/2017 to allow additional time for primary care sites to implement collaborative or integrated care across the PPS. CCN anticipates more primary care sites to implement evidence based screenings and provide coordinated care as they work on achieving PCMH 2014 Level 3 certification. 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 community based services. One actionable item is the creation of the 4aiii Implementation toolkit which was endorsed by the CCN Clinical Governance Committee in February 2017 under CGC-CG-36. The 4aiii workflow process map which will assist partners such as clinics and community based organizations with the implementation related to evidence based screening tools, protocols, interventions, community resources, Health Home referrals, follow up care and proper documentation. Training will be facilitated by CCN Partner Relations, Workforce and PMO to contracted partners. CCN is reporting Step 2a as complete with input and feedback received from DOH, OMH and OASAS staff who are actively involved in the CCN quality subcommittees (Step 2a – Complete).

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Milestone 3 - Share data and information on MEB health promotion and MEB disorder prevention and treatment.	Milestone and its associated steps are not due for DY2, Q4.
Mid-Point Assessment	

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.a.iii.3 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project 4.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.

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.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.	Completed	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	12/31/2016	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.	Completed	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.	Completed	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

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Milestone 1 - Increase community partner participation in COPD prevention and management.	rachaelm	Meeting Materials	44_DY2Q4_PROJ4bii_MDL4bii2_PPS1327_MM_TFBT_meeting_minutes_2017_01_20_(002)_12787.docx	Tobacco Free Coalition Meeting Minutes	04/26/2017 11:59 AM
	rachaelm	Policies/Procedures	44_DY2Q4_PROJ4bii_MDL4bii2_PPS1327_P&P_CGC-CG-15_Treatment_of_COPD_and_GOLD_Standards_12786.pdf	CGC-CG-15 Treatment of COPD and GOLD Standards	04/26/2017 11:59 AM
	rachaelm	Policies/Procedures	44_DY2Q4_PROJ4bii_MDL4bii2_PPS1327_P&P_CGC-CG-14_The_5_As_of_Tobacco_Control_12785.pdf	CGC-CG-14 The 5 As of Tobacco Control	04/26/2017 11:58 AM
	rachaelm	Policies/Procedures	44_DY2Q4_PROJ4bii_MDL4bii2_PPS1327_P&P_CGC-CG-13_Chronic_Disease_Self-Management_Program_Guidelines_12783.pdf	CGC-CG-13 Chronic Disease Self-Management Program Guidelines	04/26/2017 11:58 AM
	rachaelm	Contracts and Agreements	44_DY2Q4_PROJ4bii_MDL4bii2_PPS1327_CONTR_Corning_Appendix_C_4bii_12782.pdf	Appendix C 4bii	04/26/2017 11:57 AM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Milestone 1 - Increase community partner participation in COPD prevention and management.	Milestone 1 and the remaining two steps are due for completion in DY2Q4 and are being reported as complete. Step 1a. was marked as complete in DY2, Q3 since a Pre-Engagement Assessment was released in June 2015 with partner organizations beginning to contract for Project 4.b.ii in DY2, Q3. During DY2, Q4, the Project Manager has sought to join local tobacco free coalitions, one of which a Project Lead for 4bii actively has participated in and provided DSRIP updates to throughout the year. Central New York's Regional Center for Tobacco Cessation Systems at St. Joseph's is in contact with a number of partner organizations. This resource has been leveraged to provide consistent messaging for smoking cessation for patients and smoke free environments for the facilities participating in the project (Step 1b - Complete). The opportunity to attend their Tobacco Cessation Summit in March was also advertised throughout the PPS. Furthermore, CDSMP workshops have begun to be rolled out across the PPS as Master Trainers seek to complete their certification and others already certified continue their work. Some creative solutions have been explored regarding how patients are educated about the availability of these courses. Some West RPU funds have been designated for DSRIP Year 3 to educate care coordinators within the Guthrie system about local CDSMP workshops and the impact it can have on their patients with chronic illnesses. The Project Team will seek to glean lessons learned from this effort to determine its broader implications for the PPS (Step 1c - Complete). In order to substantiate completion of this Milestone, a sample contract for project work has been attached to demonstrate the scope of services currently covered by this project along with two PPS clinical guidelines and meeting minutes from the Tobacco Free Broome and Tioga Coalition Meeting.
Milestone 2 - Establish PPS wide COPD screening protocols and clinical practice guidelines.	
Milestone 3 - Increase pulmonary function testing (PFT)for COPD at risk adults.	
Milestone 4 - Improve adherence to timely follow up of abnormal PFT screening results.	
Mid-Point Assessment	

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	

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

DSRIP Implementation Plan Project

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:	06/20/2017 11:44 AM

Comments:

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Status Log				
Quarterly Report (DY,Q)	**Status**	**Lead Representative Name**	**User ID**	**Date Timestamp**
DY2, Q4	Adjudicated	Mark Ropiecki	mrurak	06/30/2017 01:21 PM

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Comments Log			
Status	**Comments**	**User ID**	**Date Timestamp**
Adjudicated	The DY2, Q4 Quarterly Report has been adjudicated.	mrurak	06/30/2017 01:21 PM
Submitted	Care Compass Network responses to the IA requests for DY2, Q4 report.	ropiecki	06/20/2017 11:44 AM
Returned	The DY2, Q4 Quarterly Report has been returned for Remediation.	mrurak	05/31/2017 05:17 PM
Submitted	DY2, Q4 Quarterly Report for Care Compass Network	ropiecki	04/28/2017 04:19 PM

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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 & Complete	
	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 & Complete	
	Milestone #2 Develop an IT Change Management Strategy.	Pass & Complete	
	Milestone #3 Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	Pass & Complete	
	Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	Pass & Complete	
	Milestone #5 Develop a data security and confidentiality plan.	Pass & Complete	
Section 06	Module 6.1 - Prescribed Milestones		
	Milestone #1 Establish reporting structure for PPS-wide performance reporting and communication.	Pass & Complete	
	Milestone #2 Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	Pass & Complete	
Section 07	Module 7.1 - Prescribed Milestones		
	Milestone #1 Develop Practitioners communication and engagement plan.	Pass & Complete	
	Milestone #2 Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	Pass & Complete	
Section 08	Module 8.1 - Prescribed Milestones		

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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 & Complete	
	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 & Complete	
	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 & Complete	
	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 & Complete	
	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 & Complete	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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 & Complete	
	Milestone #4 Educate all staff on care pathways and INTERACT principles.	Pass & Complete	
	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 & Complete	
	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 & Complete	
	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 & Complete	
	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 & Complete	
	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	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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 & Complete	
	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	Fail	IA
	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 & Complete	
	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	

Care Compass Network (PPS ID:44)

Project ID	Module Name / Milestone #	Review Status	
	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	Fail	
	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 & Complete	
	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 & Complete	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project ID	Module Name / Milestone #	Review Status	
	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.	Fail	
	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 & Complete	
	Milestone #11 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Complete	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project ID	Module Name / Milestone #	Review Status	
3.b.i	Module 3.b.i.2 - Patient Engagement Speed	Fail	
	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 & Complete	
	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 & Complete	
	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 & Complete	
	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 & Complete	
	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 & Complete	
	Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	Pass & Complete	
	Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	Pass & Complete	
	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.	Fail	
	Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	Pass & Ongoing	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project ID	Module Name / Milestone #	Review Status
	Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	Fail
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 & Complete
	Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	Pass & Complete
	Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	Pass & Complete
	Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	Pass & Complete
	Milestone #5 Engage with Medicaid Managed Care to address coverage of services.	Pass & Complete
	Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.	Pass & Complete
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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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	-

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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)	✓	✓									

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)	✓	✓		✓	✓	✓					

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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)	✓	✓		✓	✓						

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)	✓	✓		✓	✓						

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)	✓	✓									

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)	✓	✓			✓	✓					

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)	✓	✓									

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)	✓	✓									

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)	✓	✓									

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)	✓	✓								✓	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)	✓	✓									

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)	✓	✓									

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)	✓	✓								✓	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)	✓	✓		✓	✓						

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)	✓	✓								✓	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)	✓	✓		✓	✓						

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)	✓	✓		✓	✓						

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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)											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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	✓	✓									

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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	✓	✓		✓	✓	✓	✓		✓		

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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	✓	✓		✓	✓						

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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	✓			✓	✓						

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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	✓	✓		✓	✓			✓			✓

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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	✓						✓				

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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	✓	✓			✓						

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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	✓	✓		✓	✓						

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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	✓	✓		✓	✓						

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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	✓	✓		✓	✓						

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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	✓	✓									

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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	✓	✓						✓	✓	✓	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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	✓		✓								

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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	✓	✓									

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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	✓	✓		✓	✓	✓					

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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	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	✓	✓									

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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	✓	✓								✓	

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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	✓			✓	✓						

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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	✓	✓		✓	✓						

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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	✓	✓									

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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	✓	✓									

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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	✓			✓							

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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											

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

* 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**
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
sculley	Templates	44_DY2Q4_PPP_TRAIN_DY2Q4_PIT_Replacement_Care_Compass_13944.xlsx	This is the Replacement PIT file for Care Compass Network for DY2, Q4	04/27/2017 03:25 PM

Narrative Text :