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)

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: DY1, 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 Report (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 & 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 1.2 - PPS Budget Report (Quarterly)

Instructions :

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

Benchmarks

Waiver Revenue DY1	Total Waiver Revenue	Undistributed Revenue YTD	Undistributed Revenue Total
33,827,204	213,618,544	30,791,445	210,582,785

Budget Items	DY1 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	**521,561**	**2,828,812**	**2,412,486**	**46.03%**	**94,911,787**	**97.11%**
Administration	500,363					
Implementation	21,198					
Revenue Loss	**0**	**0**	**0**		**61,436,396**	**100.00%**
Hospitals	0					
Physicians	0					
Internal PPS Provider Bonus Payments	**0**	**0**	**469,388**	**100.00%**	**20,000,001**	**100.00%**
Cost of non-covered services	**0**	**0**	**0**		**0**	
Other	**206,947**	**206,947**	**37,500**	**15.34%**	**36,439,553**	**99.44%**
Expected Loss Due to Unmet Goals	206,947					
Contingency/Sustainability	0					
Total Expenditures	**728,508**	**3,035,759**				

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 (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
PPS PMO	3,062,649	3,972,040	4,079,485	4,174,969	4,256,334	19,545,477
Uncategorized						0
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 & 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 1.4 - PPS Flow of Funds (Ongoing) - DEFUNCT MODULE - READ ONLY

Instructions :

Defunct Module - Please refer to the 'DY1 Q4 Module 1.4 Ongoing Funds Flow PIT Report' on the Reports page under the PPS Reports tab to view your quarterly flow of funds reporting based on your PIT file.

Benchmarks

Waiver Revenue DY1	Total Waiver Revenue	Undistributed Revenue YTD	Undistributed Revenue Total
33,827,204	213,618,544	33,827,204	213,618,544

Funds Flow Items	DY1 Q4 Quarterly Amount - Update	Total Amount Disbursed	Percent Spent By Project	DY Adjusted Difference	Cumulative Difference
			Projects Selected By PPS		
Total Funds Distributed	**0**	**0**			

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
sculley	Other	44_MDL0118_1_4_20160610133553_Funds_Flow_Attestation.pdf	DY1Q4 Funds Flow Attestation.	06/10/2016 01:36 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

IPQR Module 1.7 - 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.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 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	

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
		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	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task Step 1 - Establish CBO Council which will lead the CBO facilitation process as related to the various DSRIP requirements. The CBO Council should include membership allocated by RPU.	Completed	Complete - Starting 5/12/15 the CBO Engagement Council convened and includes representation from across each RPU. From the CBO Engagement Council leads were nominated for each RPU and efforts have begun to coordinate engagement with Stakeholders from across the PPS. During Q1, the CBO Engagement Council achieved the development and distribution of the Pre Engagement Survey, as coordinated with input from the IT consultants from WeiserMazars, the Coordinating Council (PPS Project Leads), and the Stakeholders PAC meeting.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - The CBO Council should coordinate the development of a CBO contact list for each Regional Performing Unit (RPU). The list should consider impacting factors, such as overlapping RPU and/or overlapping PPS involvement as well as the inclusion of critical factors within each region including but not limited to local government agencies, state agencies, and both nonprofit and private community-based organizations (CBOs).	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3 - Leveraging the CBO Contact List, an outreach plan for CBO contracting should be developed at the RPU level accounting for the scope and diversity of organizations listed. This task will be executed by the PPS RPU Provider	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	In Progress	Workforce communication & engagement plan, including plans for two-way communication with all levels of the workforce, signed off by PPS workforce governance body (e.g. workforce transformation committee).	04/01/2015	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	In Progress	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	In Progress	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.	In Progress	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.	In Progress	Explain your plans for contracting with CBOs and their continuing role as your PPS develops over time; detail how many CBOs you will be contracting with and by when; explain how they will be included in project delivery and in the development of your PPS network.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 2 - Distribute the PPS Contract to CBO members. Utilize PPS Provider Relations professionals to coordinate the overall contracting process.	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	rachaelm	Meeting Materials	44_MDL0203_1_4_20160427154559_Meeting_Schedule_Templates.pdf	Evidence of Committee meeting agendas, attendance/sign-in sheets, and committee meeting minutes	04/27/2016 03:45 PM
	rachaelm	Other	44_MDL0203_1_4_20160427154517_IT_strategy_and_structure.pdf	Updated organization charts for the governing body and for each subcommittee, as applicable when changes to members occur	04/27/2016 03:45 PM
	rachaelm	Other	44_MDL0203_1_4_20160427154426_Governance_Committee_Template_DY1Q4.pdf	Updated contact information for Governance and subcommittees members including: the names of members, their roles, and responsibilities for the governing body and subcommittees	04/27/2016 03:44 PM
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	rachaelm	Other	44_MDL0203_1_4_20160427154855_South_RPU_Onboarding_Committee_Charter_Draft.docx	Charter for the clinical committee (as applicable) and sub-committee structures	04/27/2016 03:48 PM
	rachaelm	Other	44_MDL0203_1_4_20160427154815_DY1,Q4_Clinical_Governance_Template.xlsx	Updated contact information for Clinical Governance structure and clinical subcommittee members	04/27/2016 03:48 PM
	rachaelm	Meeting Materials	44_MDL0203_1_4_20160427154740_DY1,_Q4_Clinical_Governance_Committee_Meeting_Schedule_Template.xlsx	Evidence of Committee meeting agendas, attendance/sign-in sheets, and committee meeting minutes	04/27/2016 03:47 PM
Finalize bylaws and policies or Committee Guidelines where applicable	rachaelm	Meeting Materials	44_MDL0203_1_4_20160427155330_Signed_Meeting_Minutes.pdf	Board of Directors meeting minutes	04/27/2016 03:53 PM
	rachaelm	Other	44_MDL0203_1_4_20160427155255_CCN_Bylaws.pdf	Uploaded copy of the bylaws, charters, and/or its equivalent.	04/27/2016 03:52 PM
	rachaelm	Policies/Procedures	44_MDL0203_1_4_20160427155209_CCN_New_Policies_DY1Q4.pdf	Policies/Guidelines for Committees	04/27/2016 03:52 PM
Establish governance structure reporting and monitoring processes	rachaelm	Other	44_MDL0203_1_4_20160427155612_CGC-Quality_Committee_Reporting_3-24-26.pptx	Document clarifying 2-way communication process for CGC and quality committees	04/27/2016 03:56 PM
	rachaelm	Meeting Materials	44_MDL0203_1_4_20160427155542_CGC_Minutes_022516.doc	Minutes for meeting discussing two-way reporting process	04/27/2016 03:55 PM
	rachaelm	Other	44_MDL0203_1_4_20160427155506_CCN_Proof_of_2way_Reporting.pdf	Two-way reporting process overview	04/27/2016 03:55 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
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	rachaelm	Templates	44_MDL0203_1_4_20160427155853_DY1,_Q4_Community_Engagement_Template_-_CCN.xlsx	A list of the community engagement activities completed to date	04/27/2016 03:58 PM
	rachaelm	Other	44_MDL0203_1_4_20160427155836_Combined_Communications_Plan_and_Timeline_4-21-16.pdf	The Community Engagement Plan	04/27/2016 03:58 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize governance structure and sub-committee structure	This milestone was reported as complete in the DY1, Q2 report. As part of the continued reporting, changes have been over viewed in this narrative. During the Care Compass Network (CCN) March 8 2016 Board of Directors meeting, the board approved development of an IT & Data Security subcommittee to report to the IT Informatics & Data Governance Committee (see IT Strategic Plan page 9). This new subcommittee will focus on monitoring data privacy and security of the PPS and will formally report through the IT Governance Committee and also report via dotted line to the PPS Compliance & Audit Committee. The subcommittee charter and slate of members will be developed during future meetings. This new subcommittee will continue with development of a formal security program for CCN (ensure appropriate policies & procedures exist and are adhered to, conduct, at a minimum, annual reviews and risk assessments, etc.), and comply with Department of Health requirements for handling of Medicaid claims data. In the uploaded documents we have included the updated organization charts. Additionally, there have been changes in membership to a few of the governing body committees and subcommittees as well as with the Board of Directors. In January 2016 Pete Chermak was added to the Compliance and Audit Committee. Mr. Chermak is the Director of Corporate Responsibility /HIPAA Responsibility at Our Lady of Lourdes Memorial Hospital Inc. In February 2016, the IT, Informatics & Data Governance Committee added Susan Carman, the Chief Information Officer at UHS. In March 2016 the IT Technology Advisory Subcommittee added Joe Tokash, the Director of Technology and Clinical Systems at Guthrie. Lastly there was one change to the Board of Directors during DY1Q4. Keith Chadwick, a CBO Board Member from Family and Children's Society had entered into retired and formally resigned from the Care Compass Network Board of Directors. The Board accepted Mr. Chadwick's resignation during the February 9, 2016 Board of Directors meeting. Additionally, the board approved the creation of a Nominating Committee responsible for identification of qualified candidates who will perform the required search and subsequently present a slate of qualified candidates to the Board of Directors.
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 DY1Q4 however, in March 2016 a new member was added to the Clinical Governance Committee to replace a member that retired. John Giannone, MD was added to the Clinical Governance Committee as a member, in replacement of the recently retired Tina Utley-Edwards, Executive Director of the Chenango Health Network. Additionally the South Regional Performing Unit (RPU) Onboarding committee charter was updated and a member replaced (from the same organization) due to the original member no longer being able to commit the necessary time. Maribel Ascencio, Care Coordinator with Mental Health Association (MHA) has been replaced by Sarah Soules, Care Coordinator with Mental Health Association (MHA). Lastly, the East RPU replaced Tina Utley-Edwards on the East RPU Quality Committee with Theresa Davis. The updated South RPU Onboarding committee charter and Clinical Governance Committees template have been uploaded as part of the supporting documentation for ongoing reporting of this completed milestone.
Finalize bylaws and policies or Committee Guidelines where	This milestone was reported as complete in the DY1, Q2 report however we have changes to report. The Bylaws were updated to add a Nominating Committee

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
applicable	for the Board of Directors. The Nominating Committee will consist of up to 3 members recommended by the Chairperson of the Board and up to 3 members as recommended by Chairperson of the PAC Executive Council. This model includes board level involvement to ensure the proper skills or gaps (if any) are identified during the nominations process and also includes equal input from the community base via the existing and active PAC Executive Council to ensure community stakeholders are properly represented at the board. The Board approved the Bylaw revisions at the March 8, 2016 Board of Directors meeting. Regarding Policies/Guideline updates, the Conflict of Interest policy (CCN_CC10) was updated to be consistent with the December, 2015 amendments to the Nonprofit Revitalization Act of 2013, guidance from the Charities Bureau, and provisions for unanticipated Conflicts of Interest at a meeting of the Board. Additionally an RFP Policy (CCN_FN3), RPU Budget Policy (CCN_FN4) and Policy Administration (CCN_AD1) were created during the DY1Q4 timeframe. These 4 policies were approved by the Board of Directors at the March 8, 2016 Board of Directors meeting. Lastly, the Finance Committee and Value Based Payment Subcommittee Charters were developed and endorsed by the Finance Committee and approved by the Board of Directors at the February 9, 2016 Board meeting. These committees had already been seated and operated under privileges allowed as per the CCN Bylaws, however adopted formal charters as means of best practices. We have uploaded those two charters and meeting minutes from the board meeting as supporting documentation.
Establish governance structure reporting and monitoring processes	Yes there are updates to report. This milestone was reported as complete in the DY1, Q3 report. Each of the 4 governing body committees continues to report out to the Board of Directors and to the PAC Executive Council as per the governance structure reporting and monitoring process. Additionally, a standing Board of Directors update remains on each agenda for the 4 governing body committee meetings held monthly. At the February 2016 Clinical Governance Committee (CGC) meeting the 2-way communication process between the CGC and the RPU Operating Committees as well as the RPU Quality Committees was clarified. We have included the presentation overview showing the process that was agreed upon for use regarding 2-way communication between the CGC and the RPU quality committees. Additionally, an RPU Lead meeting is held twice a month to communicate Care Compass Network activities to the RPU Leads for them to communicate to their respective RPU as well as for the RPU Leads to communicate concerns from the RPU Operating Committees to Care Compass Network.
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	This milestone was reported as complete in the DY1, Q3 report. We continue to have DSRIP Awareness-healthcare transformation educational sessions across the PPS. Our Marketing Manager, Molly Lane, joined Care Compass Network in January 2016 and has since been working on the various deliverables we had planned as part of the Community Engagement Plan timeline. We have completed the practitioner communication and engagement plan, and we have started to use our Partner Facebook pages to get more interest in our RMS Panel during DY1Q4. We hope to have our CCN Quarterly Newsletter out in May 2016 along with our Poster Campaign to guide consumers to the Care Compass Network website. Additionally in May we will be starting our Social Media Campaign. 12 community engagement events were held in the January – March 2016 timeframe. We have uploaded the latest Community Engagement Plan with updates where specific tasks were completed in the DY1Q4 and we have uploaded the list of community engagement activities completed by 3/31/16.
Finalize partnership agreements or contracts with CBOs	Milestones 6, 7, 8 and 9 are not due in DY1, Q4 however we continue to make progress regarding these deliverables. Milestones 6, 7 and 9 are deliverables with respect to contracting. From a CBO perspective, as of April 8, 2016 we have contracts executed with three Community Based Organizations, three Skilled Nursing Facilities, and one Mental Health Provider. We have several more contracts in final review with Providers in Care Compass Network. To date we have had at least one contracting discussion with almost 90 additional potential CBO partners. The CCN contracting approach involves heavy collaboration and education and allowed for aggregating concerns of the CBOs such as dealing with existing revenue streams (e.g., avoiding real/perceived 'double dipping'), getting started with EMR or RHIO development, and understanding healthcare financial modeling associated with VBP and per member/per month ("PMPM") models. As a result the contracting approach at CCN moves at a slower pace when compared to other PPSs, but results in a highly engaged CBO base that is more aware of what they sign up for and can make better educated decisions about what to sign-up for. This approach and success was recently recognized at the April 2016 NY APRS Executive Conference where CCN, FLPPS, and Staten Island presented standout approaches for engaging the CBO community through joint panel discussion with moderator Peggy Chan.

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
	Regarding activities with respect to the Workforce Communication Plan, the draft details of this plan were presented to the Workforce Development Transition Team (WDTT) at the March 29, 2016 meeting. During the meeting Anne Kinney, the Workforce Development Manager presented the four sub groups of the general workforce requested feedback in the best ways to communicate with each group. The team decided to use survey monkey to comprehensively collect this information. The survey will be distributed to all members of the Workforce Development Transition Team, Care Compass Network contracted partners, and members of the Project Advisory Committee Executive Council. The feedback will be tabulated and presented to the WDTT after completion. Milestones 6-9 are on scheduled to be completed by their respective due dates.
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.)	Milestones 6, 7, 8 and 9 are not due in DY1, Q4 however we continue to make progress regarding these deliverables. Milestones 6, 7 and 9 are deliverables with respect to contracting. From a CBO perspective, as of April 8, 2016 we have contracts executed with three Community Based Organizations, three Skilled Nursing Facilities, and one Mental Health Provider. We have several more contracts in final review with Providers in Care Compass Network. To date we have had at least one contracting discussion with almost 90 additional potential CBO partners. The CCN contracting approach involves heavy collaboration and education and allowed for aggregating concerns of the CBOs such as dealing with existing revenue streams (e.g., avoiding real/perceived 'double dipping'), getting started with EMR or RHIO development, and understanding healthcare financial modeling associated with VBP and per member/per month ("PMPM") models. As a result the contracting approach at CCN moves at a slower pace when compared to other PPSs, but results in a highly engaged CBO base that is more aware of what they sign up for and can make better educated decisions about what to sign-up for. This approach and success was recently recognized at the April 2016 NY APRS Executive Conference where CCN, FLPPS, and Staten Island presented standout approaches for engaging the CBO community through joint panel discussion with moderator Peggy Chan. Regarding activities with respect to the Workforce Communication Plan, the draft details of this plan were presented to the Workforce Development Transition Team (WDTT) at the March 29, 2016 meeting. During the meeting Anne Kinney, the Workforce Development Manager presented the four sub groups of the general workforce requested feedback in the best ways to communicate with each group. The team decided to use survey monkey to comprehensively collect this information. The survey will be distributed to all members of the Workforce Development Transition Team, Care Compass Network contracted partners, and members of the Project Advisory Committee Executive Council. The feedback will be tabulated and presented to the WDTT after completion. Milestones 6-9 are on scheduled to be completed by their respective due dates.
Finalize workforce communication and engagement plan	Milestones 6, 7, 8 and 9 are not due in DY1, Q4 however we continue to make progress regarding these deliverables. Milestones 6, 7 and 9 are deliverables with respect to contracting. From a CBO perspective, as of April 8, 2016 we have contracts executed with three Community Based Organizations, three Skilled Nursing Facilities, and one Mental Health Provider. We have several more contracts in final review with Providers in Care Compass Network. To date we have had at least one contracting discussion with almost 90 additional potential CBO partners. The CCN contracting approach involves heavy collaboration and education and allowed for aggregating concerns of the CBOs such as dealing with existing revenue streams (e.g., avoiding real/perceived 'double dipping'), getting started with EMR or RHIO development, and understanding healthcare financial modeling associated with VBP and per member/per month ("PMPM") models. As a result the contracting approach at CCN moves at a slower pace when compared to other PPSs, but results in a highly engaged CBO base that is more aware of what they sign up for and can make better educated decisions about what to sign-up for. This approach and success was recently recognized at the April 2016 NY APRS Executive Conference where CCN, FLPPS, and Staten Island presented standout approaches for engaging the CBO community through joint panel discussion with moderator Peggy Chan. Regarding activities with respect to the Workforce Communication Plan, the draft details of this plan were presented to the Workforce Development Transition Team (WDTT) at the March 29, 2016 meeting. During the meeting Anne Kinney, the Workforce Development Manager presented the four sub groups of the general workforce requested feedback in the best ways to communicate with each group. The team decided to use survey monkey to comprehensively collect

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
	this information. The survey will be distributed to all members of the Workforce Development Transition Team, Care Compass Network contracted partners, and members of the Project Advisory Committee Executive Council. The feedback will be tabulated and presented to the WDTT after completion. Milestones 6-9 are on scheduled to be completed by their respective due dates.
Inclusion of CBOs in PPS Implementation.	Milestones 6, 7, 8 and 9 are not due in DY1, Q4 however we continue to make progress regarding these deliverables. Milestones 6, 7 and 9 are deliverables with respect to contracting. From a CBO perspective, as of April 8, 2016 we have contracts executed with three Community Based Organizations, three Skilled Nursing Facilities, and one Mental Health Provider. We have several more contracts in final review with Providers in Care Compass Network. To date we have had at least one contracting discussion with almost 90 additional potential CBO partners. The CCN contracting approach involves heavy collaboration and education and allowed for aggregating concerns of the CBOs such as dealing with existing revenue streams (e.g., avoiding real/perceived 'double dipping'), getting started with EMR or RHIO development, and understanding healthcare financial modeling associated with VBP and per member/per month ("PMPM") models. As a result the contracting approach at CCN moves at a slower pace when compared to other PPSs, but results in a highly engaged CBO base that is more aware of what they sign up for and can make better educated decisions about what to sign-up for. This approach and success was recently recognized at the April 2016 NY APRS Executive Conference where CCN, FLPPS, and Staten Island presented standout approaches for engaging the CBO community through joint panel discussion with moderator Peggy Chan. Regarding activities with respect to the Workforce Communication Plan, the draft details of this plan were presented to the Workforce Development Transition Team (WDTT) at the March 29, 2016 meeting. During the meeting Anne Kinney, the Workforce Development Manager presented the four sub groups of the general workforce requested feedback in the best ways to communicate with each group. The team decided to use survey monkey to comprehensively collect this information. The survey will be distributed to all members of the Workforce Development Transition Team, Care Compass Network contracted partners, and members of the Project Advisory Committee Executive Council. The feedback will be tabulated and presented to the WDTT after completion. Milestones 6-9 are on scheduled to be completed by their respective due dates.

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 & Ongoing	
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)

IPQR Module 2.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

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

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

IPQR Module 2.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

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

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, Interim Executive Director	The CBO Engagement Council is an interim council responsible for the integration of RPU Leads and their associated teams as they plan the development of RPUs. This allows for the development of RPU operations to coordinate at the PPS level. Primary goals include the identification of PPS members within each RPU, identification of education concerns and development of education opportunities at the PPS and local RPU level.

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 detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	In Progress	This milestone must be completed by 09/30/2016. Value-based payment plan, signed off by PPS board.	04/01/2015	03/31/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	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	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
levels of evolution as movement towards fully implemented VBP occurs. The self-assessment survey will include the following (per the state): Degree of experience operating in VBP models and preferred compensation modalities; Degree of sophistication in ability to negotiate plan contracts, monitor and report on service types; Estimated volume of Medicaid Managed Care spending received by the network. Estimate of total cost of care for specific services (modeled along bundles Status of requisite IT linkages for network funds flow monitoring. Provider ability (financial stability) and willingness to take downside risk in a risk sharing arrangement. Level of assistance needed to negotiate plan options with Medicaid Managed Care (High, Moderate, Low).									
Task Step 7 - Distribute the readiness self-assessment survey to all providers to establish accurate baseline.	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	

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 12 - PPS Board to sign off on preference for PPS providers to contract with MCO's at their own discretion.	Completed	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	In Progress	This milestone must be completed by 3/31/2017. Value-based payment plan, signed off by PPS board.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	YES
Task Step 1 - Obtain clarification of VBP requirements from NYS Department of Health and guidance from legal counsel, as well as Department of Justice in regards to the requirements.	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 2 - Analyze the NYSDOH data related to the risk-adjusted cost of care, as well as the potential (shared) savings, at both the total population level as per care bundle and subpopulation per the VBP Roadmap, in order to identify best possible opportunities for PPS providers in their move towards VBP.	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 3 - Expand upon VBP Baseline Assessment creating a matrix of existing mechanisms both helping and hindering the implementation of the VBP model, including NYS VBP Roadmap, existing ACO and MCO models, and other VBP models in the current marketplace.	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 4 - Analyze matrix of existing mechanisms both helping and hindering the implementation of VBP at the provider level of our PPS in order to identify which providers are best equipped to lead the movement towards VBP based on their current level of VBP engagement.	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 5 - Identify within the PPS providers who fall	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	

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
into one of three tiers: 1) Established - Providers currently utilizing VBP models 2) Enthusiastic and/or Equipped - Providers who are eager to pursue the movement towards VBP models and/or equipped to do so based on the helping/hindering matrix 3) Providers who need additional resources in order to start the movement towards utilizing a VBP model.									
Task Step 6 - Coordinate regional payor forums with PPS providers.	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 7 - Re-assess current landscape of VBP adoption throughout PPS by updating VBP Baseline Assessment, reviewing new information if available from the state and feedback from PPS Providers and MCOs regarding the payor forums, as well as lessons learned from early adopters.	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 8 - Perform Gap Analysis based on updated matrix of PPS landscape.	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 9 - Coordinate additional regional payor forums with PPS providers based on Gap Analysis.	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 10 - Collectively review the level of VBP engagement and continue to encourage open dialogue among the PPS providers regarding VBP models and adoption.	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	

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 11 - Update, modify and finalize VBP Adoption Plan.									
Milestone #6 Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Task TBD	On Hold	Note - On Hold while awaiting milestone DSRIP reporting year and quarter to be set.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Milestone #7 Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Task TBD	On Hold	Note - On Hold while awaiting milestone DSRIP reporting year and quarter to be set.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Milestone #8 >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Task TBD	On Hold	Note - On Hold while awaiting milestone DSRIP reporting year and quarter to be set.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	

IA Instructions / Quarterly Update

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

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	mrbobc	Policies/Procedures	44_MDL0303_1_4_20160428142956_CCN_Financial_Assessments.pdf	These are the cover sheets and assessments used in the network financial health assessment. The simple one was for partners serving less than 1k-2k M/A members, detailed for 2k+.	04/28/2016 02:29 PM

NYS Confidentiality – High

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
	mrbobc	Policies/Procedures	44_MDL0303_1_4_20160428142705_Finance_-_Network_Financial_Assessment.pdf	This procedure outlines how Care Compass Network will conduct its regular review of network financial health and contains all of the information requested in the documentation.	04/28/2016 02:27 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize PPS finance structure, including reporting structure	There are no updates for the DY1, Q4 submission for this milestone as it was reported complete for DY1, Q2 and has no changes.
Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	This Milestone is due for completion at DY1, Q4 and has 13 associated steps for implementation targeted for completion between DY1, Q3 and DY1, Q4. These 13 steps outline the PPSs approach for identifying providers in the CCN network that are financially fragile, defines the approach for monitoring and performing this assessment, as well as defining key indicators. Steps 1-9 which were due in DY1, Q3 were reported as complete in DY1, Q3. The PPS initially created a Partner Organization database of PPS members (Step 1 – Complete DY1,Q3) based off of information gathered during the DSRIP application period. None were VAPAP or IAAF providers. As time has progressed in DY1, we have been adding to our Partner Organization list as organizations have come forward expressing their interest via letter of attestation to participate with Care Compass Network. These partners have been formally added to the PPS' performance network during the open enrollment period in MAPP, completed in DY1, Q3. As of 9/30, the PPS began developing an assessment tool for partner organization financial sustainability leveraging existing tools such as the toolkit leveraged to determine financial sustainability for PPS Lead Entity Organizations during the initial DSRIP application period (Step 2 – Complete DY1, Q3). To ensure compliance with the annual financial assessment survey requirement, CCN has made completion of the assessment a component of the Partner Organization contract. The assessment tool was reviewed by the Finance Committee at its regular monthly meeting on October 29th, 2015, (Steps 3-4 – Complete – DY1, Q3) after which distribution of the survey commenced on November 30th (Step 5 – Complete – DY1, Q3) with a request to have them returned by December 18th for compilation into a complete data set (Step 6 – Complete DY1, Q3). 40 assessment requests were sent out, and as of March 31st, 19 had been returned (45% response rate). These assessments were sent to a third- party consultant to aggregate and report on to the CCN Finance Committee, ensuring compliance was achieved with regard to anti-trust laws. Based on the received assessments, the Finance Manager analyzed the survey results from the third-party consultant and identified those providers who were determined to be financially fragile and sent out a report of those organizations to the Finance Committee on 12/31/2015 (Steps 7 and 8 – Complete DY1, Q3) with no comments. Based on criteria set forth in the Network Financial Health Assessment Procedure, no organizations were found to be financially fragile (Steps 9, 10, 11, 12, 13 - Complete). The Network Financial Health Assessment will be completed again in Q3 of each Demonstration Year to ensure Network stability. This milestone is being reported as complete and appropriate documentation is attached.
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	There are no updates for the DY1, Q4 submission for this milestone as it was reported complete for DY1, Q3 and has no changes.
Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	This Milestone was previously due for completion in DY1, Q4, however as per DOH guidance provided on 02/12/2016 the due date is delayed due to incomplete documentation requirements. As a result Care Compass Network (CCN) is deferring this milestone to DY2, Q2. This milestone has 12 associated steps for implementation targeted for completion between DY1, Q2 and DY1, Q4. All steps for this Milestone have been completed as scheduled. The Finance Committee discussed the Value-Based Payment (VBP) planning efforts, including summary of items prepared by HANYS as well as CCN commitment as outlined in the

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
	DSRIP application during the August 3 meeting. The Finance Committee agreed on August 3 to coordinate the establishment of the VBP subcommittee chaired by John Collett, CFO, Cayuga Medical Center which was seated and met on August 10. The VBP subcommittee is comprised of membership representing hospitals, homecare agencies, skilled nursing homes, outpatient services, and CBOs (Step 1 – Q2 Complete). Throughout Q2 the VBP subcommittee completed three meetings, the outcomes and minutes from which were subsequently presented at the following Finance Committee meeting. As part of the DY1Q2 deliverables, the VBP Committee has cultivated pathways (Step 2 – Q2 Complete) between the committee and the rest of the system in order to survey and educate the current landscape of existing VBP arrangements amongst providers within the PPS. An education and communication plan was created and reviewed at the VBP committee meeting on 09/14/2015 (Step 3 – Q2 Complete) and approved by the VBP subcommittee on 09/14/2015, being based on the VBP roadmap as released on July 22nd, 2015 by New York State Department of Health. On September 30th, 2015 a contract was executed with a vendor with a high level of expertise and experience in Value-Based Payment arrangements, securing educational resources for the outreach endeavors with the anticipation of completing those endeavors by December 31st, 2015 (Step 4 – Q2 Complete). Successful completion of the endeavors is defined as a VBP presentation at each of the RPUs (North/South/East/West) as well as the PAC (Total 5 times). Presentations were completed in the East on 12/09/2015, the PAC on 12/11/2015, the South on 12/16/2015, and the West and North on 12/17/2015 (Step 5 – Q3 Complete). The PAC presentation was a recorded webinar and has been made available on the Care Compass Network website for those who were unable to attend an in-person presentation. The readiness self-assessment survey was reviewed by the Value-Based Payment Committee on October 19th, 2015 and was open for a comment period through October 30th, 2015 (Step 6 – Q3 Complete), after which the survey was sent to partner organizations on November 30th (Step 7 – Q3 Complete). The survey was sent to 40 organizations, and as of 03/31/2016 25 of them had been returned (62.5% response rate). The Finance Manager had collected, assembled, and analyzed results of the surveys received through December of 2015 (Step 8 – Q3 Complete). The VBP baseline assessment was prepared based on the survey results (Step 9 – Q4 Complete) and shared with providers as well as the VBP Sub-Committee, Finance Committee, PAC, and Coordinating Council (Step 10 – Q4 Complete). All received feedback was incorporated into the baseline (Step 11 – Q4 Complete), and on 03/08/2016 the CCN Board of Directors approved a resolution regarding their preference for the role of the PPS in VBP contracting (Step 12 – Q4 Complete). The milestone completion date has been delayed to DY2, Q2 in line with recent guidance from the DoH (Received on 02/12/2016) regarding documentation requirements for milestone completion.
Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	This Milestone is due for completion at DY2, Q3 comprised of 11 associated steps to implementation, none of which are due in the DY1, Q4 timeframe. As a framework towards achieving this milestone, the PPS Finance Committee and Value Based Payment (VBP) subcommittee, which reports to the Finance Committee, were established in Q2. Related VBP roadmap planning and education associated with Financial Sustainability Milestone 4 remain in progress and are on target for completion by the DY1, Q4 due date. In Q3 the VBP subcommittee has reviewed upcoming project plan deliverables, the final VBP roadmap issued July 23, 2015, the communication and education plan for the PPS, and has also participated on several information sessions such as a HANYS call and attending the PPS meeting in Rye Brook, NY, as well as having sent out the VBP assessment as prescribed in Financial Sustainability Milestone 4. The VBP subcommittee has been meeting at minimum monthly and is scheduled to continue doing so throughout DY2. Additionally, the PPS has reviewed the update to the VBP plan and is incorporating the changes into the plan due DY2, Q3. Overall progress towards meeting this milestone is on track with no barriers identified.
Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	
Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	
>=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs	

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
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 & Ongoing	
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:

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 Manager	Bob Carangelo / Care Compass Network	Responsible for development and management of the Finance Office and its specific functions. The individual will provide guidance and oversight around the Funds Flow Plan, the Financial Stability Plan, and other relevant processes. The responsibilities include ensuring that funds are managed and distributed according to the approved plan, that reporting requirements are met and that communication regarding the Finance related functions is timely and accurate. Responsible for the daily operation of the Finance Office, including programmatic development of the infrastructure tools critical to the Funds Flow Plan and the related banking, accounts payable and general ledger functions. Primary contact for the PPS Lead finance function for conducting DSRIP related business and responsible for their organization's execution of their DSRIP related finance responsibilities and participation in finance related strategies.
Financial 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 Manager and Finance Committee to determine and monitor the reporting protocols/requirements for the PPS providers, the governing body, and DOH.
Accounts Payable Staff	Purchased Services - UHS AP Department	Coordinated by the CCN Finance Manager, the AP service acquired through UHS, Inc. is responsible for the day-to-day operations of the Accounts Payable function, including drafting policies and procedures when needed, monitoring the accounts

Care Compass Network (PPS ID:44)

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		payable system, and implementing PPS protocols around reporting and AP check write related to the DSRIP funds distribution.
Reporting Analyst(s)	Multiple	Responsible for the preparation of reporting requirements for review by the responsible party, including the Finance Manager, RPU Project Manager, etc.
Banking Staff	Purchased Services - UHS	Responsible for the day-to-day operations of the Banking function, including the processing of the DSRIP funds received from DOH and reporting of the status of funds expected and received as well as reconciliation of bank related statements.
PPS Compliance Officer	Rebecca Kennis, Care Compass Network Compliance Officer	Responsible for overall development and maintanence of PPS Compliance program, including items such as training, data security, user agreements, privacy, and technology compliance with reports to the Board of Directors.
External Auditor	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, Interim Executive Director	PPS DSRIP Executive Director	The DSRIP Executive Director has overarching responsibility for oversight of the DSRIP initiative for the PPS
Mark Ropiecki, Director Project Management	PPS Project Management Director	PMO oversight and leadership for finance related projects, VBP strategy, and for the overall implementation plan deliverables that affect finance function reporting
Dawn Sculley, Project Manager - South RPU Emily Pape, Project Manager - West RPU Stephanie Woolever, Project Manager - East RPU Joseph Sexton, Project Manager - North RPU Richard Boland, Project Manager Emily Balmer, Project Manager Bouakham Rosetti, Project Manager	PPS Project Managers	Collaboration with finance re: PPS Project Implementation, status of projects, reporting required to meet DOH requirements.
Amy Gecan, Director System Integration and Operations (Cayuga Medical Center)	North RPU Lead	Alignment of RPU needs at the Governance Level, Coordination of Common Projects where PPS overlap occurs, general oversight of project implementation at the local level.
Greg Rittenhouse Christina Kisacky (UHS)	East 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.
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	CPPS Compliance Officer Advisor	Consulting arrangement to help provide oversight of PPS Compliance Plan and related training, education, and reporting requirements of the plan.
Rebecca Kennis, Care Compass Network Compliance Officer	PPS Compliance Officer	PPS Compliance Officer responsible for overall development and implementation of the Compliance function. Also provides Data Security and Privacy Officer roles.
Internal Audit	TBD Manager Internal Audit	Oversight of internal control functions; completion of audit processes related to funds flow, network provider reporting, and

Care Compass Network (PPS ID:44)

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

Care Compass Network (PPS ID:44)

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
		including the importance of waivers or regulatory relief, construction / renovation projects, and other items related to DSRIP. Communication with them regarding DSRIP status, results, future strategies and their role in DSRIP success will be important.
To Be Determined in DY1	PPS External Audit Function	Provision of annual and quarterly (when needed) review of PPS internal control, operations, and financials.

IPQR Module 3.7 - IT Expectations

Instructions :

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

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

IPQR Module 3.8 - Progress Reporting

Instructions :

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

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

IPQR Module 3.9 - IA Monitoring

Instructions :

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	In Progress	This milestone must be completed by 6/30/2016. Cultural competency training strategy, signed off by PPS Board. The	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES

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.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 2 - Collect and aggregate incoming region-specific cultural competency/health literacy needs identified from contracted PPS Partners in their Nathan Kline Cultural Competency Assessments and the PPS CNA.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3 - Identify region-neutral, overarching concepts of Cultural Competency and patient engagement strategies.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4 - Combine both region-neutral and region-specific concepts of Cultural Competency and patient engagement strategies. These concepts to include, but are not limited to: bias, stereotyping, language barriers, geographical implications, race, educational level as it pertains to literacy/health literacy, etc.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5 - CCC to work with PPS Workforce Development Team, PPS Partner Human Resources/Employee Development departments, and Communication Team to create a standardized checklist of required training to be completed by all front line and management staff of all PPS Partners on a regular basis.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize cultural competency / health literacy strategy.	rachaelm	Other	44_MDL0403_1_4_20160427125226_CCHL_Strategy.doc	Cultural Competency & Health Literacy Strategy as revised by the Cultural Competency & Health Literacy Committee	04/27/2016 12:52 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize cultural competency / health literacy strategy.	This Milestone was completed in DY1, Q3 inclusive of documentation and responses provide during the DY1, Q3 report and remediation period. Moving into DY1, Q4 the CCN CC/HL strategy remains under implementation with focus on the upcoming Milestone 2 completion due in DY2, Q1. The Cultural Competency & Health Literacy Committee will use the CC/HL Strategic plan, along with the related Training Strategy for formal presentation to the Board of Directors in advance of the DY2, Q1 due date. In accordance with the plan outlined in the uploaded documentation, the online panel has been engaged regarding implementation and cultural competency specifically in the PPS region. The Cultural Competency & Health Literacy Committee will be looking to see these opinions about cultural competency change over the DSRIP demonstration period following the roll-out of training.
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	With the Cultural Competency and Health Literacy strategy completed and approved on time (DY1, Q2) as well as Milestone 1 (DY1, Q3), Milestone 2 is on track for its projected DY2, Q1 completion. In accordance with this plan gaps in training will be identified at the organizational level, in addition to region-specific and PPS-wide cultural competency and health literacy needs. This approach will facilitate an efficient and tailored approach to training Care Compass Network (CCN) partner clinicians and other related impacted workforce. As the Nathan Kline Assessment Survey (NKAS) results are received following the execution of contracts, the Cultural Competency & Health Literacy Committee (CCC) may begin to revise the content of the training strategy originally informed by the results of the Community Needs Assessment and its findings regarding health disparities. In the meantime, as contracts are executed and surveys are distributed, the CCC looks to use its cultural competency & health literacy strategy to inform its training approach and its checklist development. This approach and documented

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
	training strategy is anticipated to be presented to the Board of Directors in June 2016. In future submissions, the PPS will demonstrate how this changes as a result of NKAS findings. To support the close-knit relationship between Workforce and Cultural Competency and Health Literacy projects, the Workforce project lead continues to attend CCC meetings. In January 2016, CCN hired a Workforce Manager who dually oversees training requirements as part of the Cultural Competency & Health Literacy program. This will enable the relationship required to execute Step 5, create a comprehensive checklist of training requirements, and allow for a cohesive PPS approach to training requirements associated with both Workforce and Cultural Competency programs. Once this has been completed, Step 6 will begin and training will remain as a standing item on each CCC agenda. Overall, Milestone 2 is on track for completion by the DY2, Q1 target.

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & 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 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 Anne Kinney, Workforce Development Manager / Care Compass Network Multiple Members	Responsible for ongoing training.
Cultural Competency Committee	Anne Bishop / UHS Anne Kinney, Workforce Development Manager / Care Compass Network 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	Molly Lane / Care Compass Network	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.

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 4.7 - 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.	In Progress	IT change management strategy, signed off by PPS Board. The strategy should include: -- Your approach to governance of the change process; -- A communication plan to manage communication and involvement of all stakeholders, including users; -- An education and training plan; -- An impact / risk assessment for the entire IT change process; and -- Defined workflows for authorizing and implementing IT changes	04/01/2015	03/31/2016	04/01/2015	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	In Progress	PPS plan for engaging attributed members in Qualifying Entities, signed off by PPS Board. The plan should include your approach to outreach into culturally and linguistically isolated communities.	04/01/2015	03/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	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.	In Progress	See Narrative			03/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Milestone #5 Develop a data security and confidentiality plan.	In Progress	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)	In Progress	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)	In Progress	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	In Progress	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	

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
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)	In Progress	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	Other	44_MDL0503_1_4_20160429092408_M3_ITRoadmap.pptx	IT roadmap inclusive of strategy & gap analysis	04/29/2016 09:24 AM
	rachaelm	Templates	44_MDL0503_1_4_20160429092244_IT_and_Data_Governance_Committee_Meeting_Schedules_(DOH_Template).xlsx	List of IT & Data Governance Committee meetings	04/29/2016 09:22 AM
Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	sculley	Other	44_MDL0503_1_4_20160610144646_M3_DY1_Q4_Remediation_Response.pdf	CCN DY1Q4 Remediation response to IA.	06/10/2016 02:46 PM
	rachaelm	Other	44_MDL0503_1_4_20160429093237_M3.DEAA.pdf	DEAA	04/29/2016 09:32 AM
	rachaelm	Other	44_MDL0503_1_4_20160429093133_IT_and_Data_Governance_Committee_Meeting_Schedules_(DOH_Template).xlsx	Meeting schedule	04/29/2016 09:31 AM
	rachaelm	Meeting Materials	44_MDL0503_1_4_20160429092932_M3_Signed_Meeting_Minutes_030816.pdf	Signed Board of Director meeting minutes substantiating approval of IT Roadmap	04/29/2016 09:29 AM
	rachaelm	Templates	44_MDL0503_1_4_20160429092851_M3_Training_Schedule_Template.xlsx	Training Schedule	04/29/2016 09:28 AM
	rachaelm	Other	44_MDL0503_1_4_20160429092825_M3_ITRoadmap.pptx	A copy of the clinical data sharing and interoperable systems roadmap	04/29/2016 09:28 AM
Develop a specific plan for engaging attributed	rachaelm	Other	44_MDL0503_1_4_20160429094237_M4_IT_Enga	Tabulated engagement gap analysis results	04/29/2016 09:42 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
members in Qualifying Entities			gement_Gap_Analysis.xlsx		
	rachaelm	Templates	44_MDL0503_1_4_20160429094158_M4_CCN_Dashboard.xlsx	Template to illustrate partner organizations' performance and engagement	04/29/2016 09:41 AM
	rachaelm	Templates	44_MDL0503_1_4_20160429094017_M4_Reporting_Template.xlsx	Reporting templates to be used to collect partner organizations' engagement with population	04/29/2016 09:40 AM
	rachaelm	Contracts and Agreements	44_MDL0503_1_4_20160429093939_M4_CCN_Partner_Agreement_final.pdf	Standard agreement used to engage partner organizations	04/29/2016 09:39 AM
	rachaelm	Quarterly Report (no attachment necessary)	44_MDL0503_1_4_20160429093827_M4_Narrative.docx	Quarterly report narrative (exceeded character limit)	04/29/2016 09:38 AM
Develop a data security and confidentiality plan.	sculley	Other	44_MDL0503_1_4_20160610161004_IT_Milestone_5_DY1Q4_Remediation_Response.pdf	DY1Q4 Remediation Reponse	06/10/2016 04:10 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 is comprised of six steps to completion; the final two steps and overall milestone which are scheduled for completion in DY1, Q4 and are being reported as such. CCN has been working with consultants from WeiserMazars since early 2015 to develop an overall IT Systems and Processes Roadmap, aligned with the deliverables associated with this Milestone. The roadmap has been completed and incorporates alternative strategies for attainment of the IT Vision, DSRIP goals, and addressing the gaps identified (Step 5 - Complete). Note: The alternative strategies are presented on pages 51-55 of M3_ITRoadmap.ppt . The approved Action Plan addresses the time, resources, dependencies and cost associated with each item (Step 6 - Complete). Note: This material is presented on pages 60-71 of M3_ITRoadmap.ppt. The milestone is being reported as completed. During completion of the IT Roadmap and Action Plan, representatives from each of the three PPS Qualified Entities (QE) / RHIOs were included in the assessments and served as members of the Technical Advisory Subcommittee. WeiserMazars held meetings with representatives from the RHIOs to document their services provided (dial tone versus upgraded services). These RHIOs hold standing invites to the Technical Advisory Subcommittee as shown by Strategic Plan page 25 (M3_ITRoadmap.ppt) and are typically represented by Dennis Sherba, Interim COO (HealthLinkNY), Karen Romano, Provider Engagement Services Director (HealtheConnections), and Gloria Hitchcock, Care Improvement Initiatives Director (Rochester RHIO). Note: The Technical Advisory Subcommittee charter is presented on page 97 of M3_ITRoadmap.ppt. In addition to the review of IT needs with the CCN PMO and Project Leads, the QEs were also interviewed by WeiserMazars during the assessment phase of the roadmap development (as shown on page 76 of M3_ITRoadmap.ppt). A pre-engagement survey was sent to all partner organizations to assess the readiness level for data sharing and implementation of IT Platforms. This showed that there are significant gaps for many of the technologies needed by CCN to meet DSRIP goals. The gap analysis by technology is shown on pages 41-42 of the Strategic Plan (M3_ITRoadmap.ppt). Note: Interview List provided in Appendix A on pages 73-76; Pre-Engagement Survey responses on pages 77-87 of M3_ITRoadmap.ppt. Milestone 1 and Milestone 3 are interrelated. During creation of the IT Roadmap for Milestone 3, many of the items required for completing Milestone 1 were done. The PPS established a solid IT Governance structure, data was gathered and needs assessments performed from PPS partners and QEs, an IT Vision was developed (including analytics, population health, EMR technology, telehealth, and home monitoring), gap analyses were conducted to assess the current IT

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	environment so that DSRIP goals can be achieved, alternative IT strategies were defined, and an action plan was developed to include timeframes in which components of the plan should be initiated, the time necessary to complete, required resources, and dependencies with other initiatives and associated costs.
Develop an IT Change Management Strategy.	The IT Systems & Processes Milestone 2 is comprised of six steps to completion. Steps one through four have previously been reported as complete. The final two steps (five and six) and overall milestone which are scheduled for completion in DY1, Q4. Steps five & six are being reported as complete in DY1, Q4 and Care Compass Network (CCN) is deferring completion of the overall milestone to DY2, Q3. As previously reported, CCN has embedded the Change Management process into the Provider Relations function by allowing change management to function at the local Regional Performance Unit level. CCN has established the framework for Change Management sub-committees at the RPU level, totaling four sub-committees, which will report monthly to the overarching IT Informatics and Data Governance Committee (see IT Strategic Plan page 20). Members of a Change Management subcommittee and RPU Operating Groups will be identified based on recommended expertise and knowledge (see IT Strategic Plan page 21) and subsequently educated on CCN's Change Management Process established by the IT Informatics and Data Governance Committee. The primary functions of the subcommittee are review and assess the clinical and technological impacts/risks to IT systems/processes proposed, recommend appropriate changes to clinical workflows to ensure required data elements are captured in support of DSRIP goals, provide appropriate change management advice and recommendations to the IT Informatics and Data Governance Committee, and authorizing and monitoring IT changes in each of the four RPUs. The Change Management Process details steps for changes made across the PPS and for changes made within an individual entity. Communication of changes is to be bi-lateral between the entities and IT Governance. (Steps 5 & 6 – Complete). At this time CCN is deferring completion of the overall milestone to DY2, Q3, as the seating of the Change Management Committee infrastructure would be slightly premature at this time. CCN is finalizing more than 100 partner contracts and is concurrently planning for significant IT investments, partially through requirements of project implementation as well as through requirements associated with a capital award for approximately $14M CRFP dollars dedicated to the CCN IT domain. Given recent board approval for the CCN IT Strategic Plan and recent announcement of CRFP awards CCN has acquired consulting services to provide interim CIO services, which includes on-site reviews and deeper analysis of existing partner capabilities prior to the final submission of CRFP applications/responses. Given the scope and impact of these components of the IT plan, the overarching IT Informatics and Data Governance Committee has continued to meet monthly and remained active in reviewing the approach, progress, and timing of related work. Following the completion of these items CCN will modify the Change Manage framework at the PPS level (as appropriate) prior to seating the RPU based sub-committees.
Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	The IT Systems and Processes Milestone 3 was reported as complete in DY1, Q3; however, it failed the IA review with a note indicating the documentation submitted was insufficient to demonstrate completion of the milestone. ("In order to complete this milestone the PPS should ensure the IT Roadmap previously provided includes a section noting that this contract, with protections for DEAA compliance, has been issued and secured with all providers within the PPS network.") This non-AV driving milestone was only noted as a failure due to lack of documentation related to DEAA compliance within the IT Roadmap. We are submitting the complete and Board approved IT Roadmap. The IT Roadmap calls attention to Care Compass Network's (CCN) commitment to IT Security, including securing BAAs with all partners. Please reference page 9 of the IT Strategic Plan (M3_ITRoadmap.ppt). CCN contracting includes three core elements, a terms and conditions contract, project based appendix, and reciprocal BAA. A fourth, the DEAA, is an executed document that will exist between Care Compass Network and the NYS Department of Health only. The DEAA will provide rights for the State to send CCN patient level details from the claims warehouse, and for CCN to send related information to business associates for whom it has completed the BAA process with. As of DY1, Q4 CCN has submitted the requisite DEAA materials for CCN and the prior lead entity UHS to receive and house such data. Furthermore, CCN does not immediately foresee the need to add or modify this DEAA arrangement in the near future.

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
	CCNs partner agreements and BAAs hold partner organizations to CCN data security and privacy policies and the requirements of the DEAA with the State as part of the contract process. Attached are templates of the CCN Partner Agreement (ref. page 9, Section 6.1 (f) of M3.DEAA.pdf), BAA (ref. pp. 28-38 of M3.DEAA.pdf), and CCN's executed DEAA under the business name Southern Tier Regional Integrated Performing Provider System (STRIPPS) (ref. pp. 39-63 of M3.DEAA.pdf) and the amended DEAA under the NewCo Care Compass Network (ref. pp. 64-74 of M3.DEAA.pdf). The IT Roadmap calls attention to CCN's commitment to IT Security, including securing BAAs with all partners. Please reference page 9 of the Strategic Plan (M3_ITRoadmap.ppt). As partners contract with CCN the BAA and partner agreements are executed and copies of the BAA are submitted to DOH via the CCN Security & Compliance Officer. The IT Roadmap was approved in December 2015 by the IT and Data Governance Committee. This was presented to the CCN Board of Directors and approved on March 8, 2016. The complete and approved IT Roadmap and Strategic Action Plan is attached (M3_ITRoadmap.ppt). Signed minutes from the March 8, 2016 Board of Directors meeting are attached, reference Section II, pages 1-2 (M3_Signed Meeting Minutes 030816.pdf). Attached are the Meeting Schedule and Training Schedule. Meetings have continued to be held throughout the quarter. There were no training sessions held this quarter.
Develop a specific plan for engaging attributed members in Qualifying Entities	See attached documentation for quarterly report narrative.
Develop a data security and confidentiality plan.	Care Compass Network has updated the due date of Milestone 5 to DY2, Q1 to correspond with the implementation of the SSP workbook submissions, as directed by DOH. The steps in this milestone have also been edited to correspond to the DOH scheduled SSP workbook submission schedule. Progress continues to be made on completion of each of the 18 prescribed security workbooks and CCN is on track to complete the steps and milestone within the new time frames.

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Complete	
Milestone #4	Pass & Ongoing	
Milestone #5	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 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	WeiserMazars Consulting Service (TBD at a future date)	Responsible for IT Governance, IT Landscaping - (Needs/Gap Assessment), Change Management, and IT Architecture.
Data Security & Information Technology Officer	TBD	Responsible for data security and confidentiality plan, Data Exchange Plan, and DEAA oversight.
Project Management Lead	Mark Ropiecki / Care Compass Network	Responsible for development and monitoring of Project Portfolio, Risk Register, Vendor Contracts, and Progress Reports.
IT Project Manager	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 Penny Thoman / 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.	In Progress	Finalized performance reporting training program.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Step 1 - After performing current state analyses and designing workflows, the PPS Workforce Strategy Team will create a dedicated training team to integrate new reporting processes and clinical metric monitoring workflows into retraining curriculum at the RPU level.	Completed	See Narrative.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2 - This training team will integrate Lean, Six Sigma and other performance improvement programs into performance reporting/ Rapid Cycle Evaluation (RCE) training regime at the RPU level.	In Progress	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 3 - Develop training module to provider champions, critical stakeholders and partners at the RPU level; use their feedback to refine training program throughout the network, including specific program for new hires.	In Progress	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4 - Develop schedule to roll out training to all RPU sites across the PPS network, using training at central hubs for smaller providers; specific thresholds will also be defined for minimum numbers to undertake training.	In Progress	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 5 - In collaboration with the PPS PMO, the training team will identify decision-making providers, partners and staff at each RPU to train in advance of PPS-wide training; these individuals will become performance management champions in their individual providers / sites and will work alongside the practitioner champions for those sites.	In Progress	See Narrative.	04/01/2015	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)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 6 - Roll out training to RPUs/provider sites.	In Progress	See Narrative.	04/01/2015	09/30/2016	04/01/2015	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

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish reporting structure for PPS-wide performance reporting and communication.	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.	The first step for Performance Reporting Milestone 2 indicates "After performing current state analysis and designing workflows, the PPS Workforce Strategy Team will create a dedicated training team to integrate new reporting processes and clinical metric monitoring workflows into retraining curriculum at the RPU level." This step (Step 1) is foundational to the following steps in this milestone, which leverage the training team developed as a result of Step 1. With the contract executed for use of the HWapps platform in DY1, Q4, Care Compass Network is positioned better than ever to roll out appropriate training to provider champions, critical stakeholders, and major decision-makers across the PPS. In addition to making these trainings available within each RPU, the PPS can maintain these trainings and their availability through HWapps to ensure that all of the appropriate players have access to Rapid Cycle Evaluation training and are equipped to manage performance. During DY2,Q1 and DY2,Q2, the PPS will aim to identify appropriate training and begin dissemination in line with Steps 2-6 of this Milestone.

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 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.

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	Dawn Sculley (South), Joseph Sexton (North), Stephanie Woolever (East) & Bouakham Rosetti (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) Penny Thoman (West)	Responsible for spreading and embedding common culture of continuous performance monitoring and improvement throughout Practitioner Professional Peer Groups. Responsible to PPS Clinical Governance Quality Committee for provider involvement in performance monitoring processes.
PPS IT and Data Analytics Group	Multiple	Responsible for ensuring the implementation, support, and updating of all IT and reporting systems to support performance monitoring framework. Also responsible for ensuring that the systems used provide valuable, accurate, and actionable measurement for providers and staff.
South RPU Lead	Keith Leahey, Executive Director (Mental Health Association) & Wayne Mitteer, Strategy Adviser (Lourdes)	Responsible for identification and tracking of metrics related to projects, including their role in the performance reporting structures and processes in place for PPS level Clinical Governannce Committee.
North RPU Lead	Amy Gecan, Director System Integration and Operations (Cayuga Medical Center)	Responsible for identification and tracking of metrics related to projects, including their role in the performance reporting structures and processes in place for PPS level Clinical Governannce Committee.
East RPU Lead	Greg Rittenhouse, VP, COO, Home Care (UHS)	Responsible for identification and tracking of metrics related to projects, including their role in the performance reporting structures and processes in place for PPS level Clinical Governannce Committee.
West RPU Leads	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	Respondible for monitoring, tech support, and the upgrading of IT and reporting systems.
Providers	Organizations immediately responsible for delivering on the performance monitoring processes established across the PPS.	Responsible for promoting a culture of excellence and employing standardized care practices to improve patient care outcomes.
PPS Governance Body	Ultimately responsible for PPS meeting or exceeding our targets.	Responsible for prioritizing and improving patient care and financial outcomes for the entire PPS - Acts as a high-profile, organization-wide champion for a common culture, standardized reporting processes, care guidelines, and operating procedures. Additionally, the governing body is responsible for monthly executive meetings with patient outcomes as the main agenda item and reviewing patient outcome reports prepared by the sub-Committees.
PPS Finance Governance Committee	Responsible for collecting, analyzing, and handling financial outcomes from performance management system.	Responsible for electing key decision-makers to champion the performance management cause within the DSRIP projects and interfacing with the Clinical Quality Committee.
PPS Clinical Quality Governance Committee	Ultimately responsible for all clinical quality improvement across the whole network.	Responsible for monthly Executive Report for the Governance Body which includes patient care metrics updates as well as electing several key decision makers to champion the performance management cause within the DSRIP projects and interfacing with the Finance Committee.
External Stakeholders		
Managed Care Organizations (MCOs)	Providing data to the PPS, shared savings	Responsible for providing key information to the PPS and arranging shared shavings agreements with the PPS in the later stages of DSRIP.
Community Based Organizations (CBO's)	Non health care providers who serve target population	The RHIO's should help in connecting CBO's to PPS. The Interfaces with CBO datasources would help in obtaining nonclinical data for PPS. Some of the measures are reportable and process measures would help in tracking the metrics.
County Dept. of Health or Mental Health	Healthcare Organizations which are not Hospitals, Primary	Responsible for providing timely clinical data to PPS on usage and

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	03/31/2016	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.	rachaelm	Templates	44_MDL0703_1_4_20160427153227_DY1,_Q4Practitioner_Engagement_Meeting_Schedule_Template.xlsx	Practitioner Engagement Meetings during DY1, Q4 timeframe	04/27/2016 03:32 PM
Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	rachaelm	Other	44_MDL0703_1_4_20160427153614_Pre-Contracting_Dashboard.xlsx	Document lists meetings occurring with partner organizations to orient them to DSRIP and associated projects	04/27/2016 03:36 PM
	rachaelm	Templates	44_MDL0703_1_4_20160427153516_Practitioner_Engagement_DY1Q4_Training_Schedule_Template.xlsx	List of training outlined in implementation plan executed to date	04/27/2016 03:35 PM
	rachaelm	Other	44_MDL0703_1_4_20160427153406_Practitioner_Training_&_Education_Plan.docx	A copy of the training & education plan that articulates goals of DSRIP program and benefits of an integrated delivery system in achieving those goals as well as forums to be used.	04/27/2016 03:34 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop Practitioners communication and engagement plan.	No updates to report. Efforts to communicate and engage practitioner continues as it has in DY1, Q3.
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.	The CBO Engagement Council began meeting in May of 2015 to create structure and support around the Regional Performing Units (RPUs) and further increase the PPS' ability to engage beneficiaries in the respective local communities. In June, the RPUs began developing leadership teams regarding the development of strategies and plans at the local level, as well as education and communication of CCN DSRIP plans. These RPU groups, facilitated by the Provider Relations team and various other presenters, will be critical to the creation and execution of standardized DSRIP training programs (Complete – Step 1). DSRIP 101 presentations were hosted for the RPUs and stakeholders as requested. Additionally, Care Compass Network hosted VBP presentations for its East RPU (12/09/2015), PAC (recorded on 12/11/2015), South RPU (12/16/2015), West RPU (12/17/2015), and North RPU (12/17/2015) (Complete - Step 2a. & Step 2b.) Also included in the documentation supporting completion of this Milestone is a Pre-Contracting Dashboard that provider relations staff at the PPS have maintained to track conversations with partner organizations. Many times DSRIP 101 presentations are brought to these meetings and project activities are explained, providing practitioners with one-on-one DSRIP education and creating the opportunity for them to ask questions specific to their impact on their organization and their organization's role in delivery system reform. In the DY1, Q2 period, training programs were initially developed to provide DSRIP general education and will continue to be expanded in DY2. A 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
	Education plan has been included in this submission outlining plans to develop training on topics described in Steps 2c. – 2h as well as appropriate forums by which these may occur (2c., 2d., 2e., & 2f. – pgs. 7, 9, & 11; 2g. – pgs. 7, 9, 10, & 12). This is inclusive of practitioners but also other professional groups to account for the customization of delivery to be most effective for these different audiences. Also included are project-specific trainings at a high level identifying appropriate target audiences (pgs. 13 & 14). Periodically, Care Compass Network will update this plan in order to reflect project plans as they are operationalized. Please note that Step 3 has been placed "On Hold". With the use of HWapps, 65% of training occurring in-person has been deemed inefficient. Furthermore, HWapps provides the functionality to track training by partner throughout the PPS, facilitating achievement of the intent of the original step. While training and education will continue to be rolled out the RPU groups, ensuring opportunity for practitioners in each region, HWapps will allow for modules to be made available virtually for all practitioners and records activity for Care Compass Network to evaluate its effectiveness and use.

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	Dawn Sculley / Care Compass Network Stephanie Woolever / Care Compass Network Bouakham Rosetti / Care Compass Network Joseph Sexton / 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 RPU Provider Relations / Care Compass Network CAP, North RPU Provider Relations / Care Compass Network Penny Thoman, West 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.	In Progress	Population health roadmap, signed off by PPS Board, including: -- The IT infrastructure required to support a population health management approach -- Your overarching plans for achieving PCMH 2014 Level 3 certification in relevant provider organizations --Defined priority target populations and define plans for addressing their health disparities.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1 - Perform a review of existing PPS supporting infrastructure/capabilities, including at minimum Population Health Management System capabilities (e.g., Salient, RHIO, CBO Systems, etc.) as well as the associated Lead System Experts (e.g., knowledge experts) for each system who can be available to support the needs of the PPS, which can be leveraged in addition to the MAPP tool.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 2 - Identify frequent visitors to healthcare organizations using existing systems and algorithms to determine target populations and health disparities within PPS, borrowing Health Homes population health management strategies.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3 - Identify and/or develop standard reports	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5 - Complete workforce assessment for priority practice groups' care management capabilities, including staff skills and resources required to manage the diabetic and cardiovascular disease populations in each geographic area. Identify population health management strategies for overlapping PPS's.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6 - Develop the Population Health Management Road Map and PCMH level 3 overarching plans to be approved by the Board of Directors.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 7 - Leverage the IT Committee and RPU Clinical Quality Committees as the working groups responsible for assessing current state and identifying appropriate providers with regard to PCMH 2014 Level 3 certification, identifying	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 9 - The Clinical Governance Committee will oversee the development of care guidelines for providers on priority clinical issues; establish metrics for each clinical area to monitor progress in managing population health. As these guidelines are established and modified throughout the DSRIP period the Population Health Management team can align and refine the Population Health Roadmap.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 10 - As needed, deploy staff support at provider level (as part of practitioner engagement training plan) to train providers to use and apply information learned from the registries, how to implement established care guidelines, develop disease pathways, determine effectiveness of interventions through team meetings, etc.	In Progress	See Narrative.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Milestone #2 Finalize PPS-wide bed reduction plan.	In Progress	PPS Bed Reduction plan, signed off by PPS Board. This should set out your plan for bed reductions across your network, including behavioral health units/facilities, in line with planned reductions in avoidable admissions and the shift of activity from inpatient to outpatient settings.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task	In Progress	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	

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.	In Progress	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 3 - Using the Board approved Bed Reduction Plan, an ongoing monitoring process will be developed which will allow for monitoring and reporting activities (e.g., Quarterly Reports) related to the Bed Reduction Plan.	In Progress	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4 - Periodic content monitoring will be performed (e.g., quarterly) to summarize current state bed reduction impacts and be reported to the Project Management Office. Significant deviations from the Board approved Bed Reduction Plan will be submitted by the Director of Project Management to the Executive Director for formal review. If significant deviations are confirmed, the Bed Reduction Plan will be re-evaluated to confirm pertinence to the current operating environment, repeating Steps 1-3 above.	In Progress	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	

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.	There are two Milestones for Population Health including a total of 14 steps to completion, none of which are due for completion in the DY1, Q4 report. Each Milestone and Step is in progress with no major issues or barriers which would hinder implementation efforts. Care Compass Network is in the process of developing a Population Health Management Roadmap (Milestone 1). The initial vision for Population Health Management is to be able to identify patient groups (super users, low users, non-users, high-risk, etc.), hot spots, provider groups, etc. to monitor PPS performance with a specific focus on reducing inpatient admissions and Emergency Department visits. The Population Health Management system will ultimately deliver actionable data to healthcare providers, navigators, and care coordinators in order to implement successful health management strategies to redirect care towards the most cost-effective setting or mode. The roadmap towards this goal will reflect current data and IT systems capabilities and the strategy to address the identified needs. Towards this goal Care Compass Network has an established Analytics Team which brings together different levels of expertise from our clinical partners. This team is able to complete analysis tasks to assist Care Compass Network overall strategic decision regarding Speed and Scale, performance against DSRIP Performance Metrics, and project-specific queries. A Project Manager is directing this work and managing the team. In addition, Care Compass Network is finalizing contracts for Phase 1 of a Data Warehouse. This warehouse will bring together the Protected Health Information from NY Department of Health, data from partners' project performance and will allow development of project dashboards, financial operations, quarterly reporting, and allow Care Compass Network to evaluate project success in affecting performance measures. Future phases of the warehouse will bring in clinical data from partners and make actionable data available to our clinical partners to implement health management plans to keep patients healthy and using the appropriate level of health care services. Care Compass Network has also begun developing a Bed Reduction Plan (Milestone 2). In August 2015 the Executive Director presented to the Board of Directors a detailed overview of the Bed Reduction implementation Milestone and steps. This presentation was revisited in September and included a deeper dive into the methodology and overall approach, leading towards components of Step 1. The Bed Reduction Plan will be revisited and finalized in the coming months. Care Compass Network is on track for milestone completion.
Finalize PPS-wide bed reduction plan.	There are two Milestones for Population Health including a total of 14 steps to completion, none of which are due for completion in the DY1, Q4 report. Each Milestone and Step is in progress with no major issues or barriers which would hinder implementation efforts. Care Compass Network is in the process of developing a Population Health Management Roadmap (Milestone 1). The initial vision for Population Health Management is to be able to identify patient groups (super users, low users, non-users, high-risk, etc.), hot spots, provider groups, etc. to monitor PPS performance with a specific focus on reducing inpatient admissions and Emergency Department visits. The Population Health Management system will ultimately deliver actionable data to healthcare providers, navigators, and care coordinators in order to implement successful health management strategies to redirect care towards the most cost-effective setting or mode. The roadmap towards this goal will reflect current data and IT systems capabilities and the strategy to address the identified needs. Towards this goal

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
	Care Compass Network has an established Analytics Team which brings together different levels of expertise from our clinical partners. This team is able to complete analysis tasks to assist Care Compass Network overall strategic decision regarding Speed and Scale, performance against DSRIP Performance Metrics, and project-specific queries. A Project Manager is directing this work and managing the team. In addition, Care Compass Network is finalizing contracts for Phase 1 of a Data Warehouse. This warehouse will bring together the Protected Health Information from NY Department of Health, data from partners' project performance and will allow development of project dashboards, financial operations, quarterly reporting, and allow Care Compass Network to evaluate project success in affecting performance measures. Future phases of the warehouse will bring in clinical data from partners and make actionable data available to our clinical partners to implement health management plans to keep patients healthy and using the appropriate level of health care services. Care Compass Network has also begun developing a Bed Reduction Plan (Milestone 2). In August 2015 the Executive Director presented to the Board of Directors a detailed overview of the Bed Reduction implementation Milestone and steps. This presentation was revisited in September and included a deeper dive into the methodology and overall approach, leading towards components of Step 1. The Bed Reduction Plan will be revisited and finalized in the coming months. Care Compass Network is on track for milestone completion.

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
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 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	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Step 1 - For each RPU in the PPS, define what the target clinical integrated state should look like from a skillset, process, technology and data perspective (including assessment and care protocols and specific attention to care transitions). At a core, the Outreach and Engagement needs for each RPU should be identified, as well as any functional barriers to achieving this from the perspective of both provider organizations and individual clinicians.	In Progress	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 2 - Based on this target state and the gaps identified in the integrated care needs	In Progress	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
assessment, define and prioritize the steps required to close the gaps between current state and desired end state at both the care management and clinical quality level (to include any needs for people, process, technology, or data).									
Task Step 3 - Identify synergies between the RPU needs across the PPS. For example: the need for supportive IT infrastructure to enable data sharing. Leverage the results from this review to standardize work flows where possible.	In Progress	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4 - Conduct engagement exercise with practitioners and other stakeholders, focused on identifying the key clinical (and other) data that will be required to support effective information exchange at transitions of care with provider relations workers and RPU leads/managers operating as champions of this effort.	In Progress	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 5 - Define incentives to encourage the behaviors and practices that underpin the target state (e.g., multi-disciplinary care planning). These incentives might include financial / personnel support to providers looking to improve the efficiency of their operations in order to create more time for coordinated care practices; or the creation of shared back office service functions to improve the efficiency of provider organizations.	In Progress	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 6 - Carry out consultation process on draft strategy with internal and external stakeholders to the transformation (including patients when appropriate).	In Progress	See Narrative.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 7 - Finalize PPS strategy and roadmap	In Progress	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
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	09/30/2016	04/01/2015	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
Perform a clinical integration 'needs assessment'.	rachaelm	Templates	44_MDL0903_1_4_20160428163831_Clinical_Integration_Meeting_Template.xlsx	Clinical Integration meeting list	04/28/2016 04:38 PM
	rachaelm	Meeting Materials	44_MDL0903_1_4_20160428163649_Signed_Meeting_Minutes_020916.pdf	Board of Directors signed meeting minuted wherein Clinical Integration Needs Assessment was approved	04/28/2016 04:36 PM
	rachaelm	Meeting Materials	44_MDL0903_1_4_20160428163605_Clinical_Integration_M1_Meeting_Minutes.pdf	Meeting minutes related to clinical integration-relevant meetings as discussed in narrative	04/28/2016 04:36 PM
	rachaelm	Other	44_MDL0903_1_4_20160428163521_PPS_Provider_Mapping.xls	PPS Provider mapping document	04/28/2016 04:35 PM
	rachaelm	Other	44_MDL0903_1_4_20160428163500_Clinical_Integration_Needs_Assessment.docx	Clinical Integration Needs Assessment	04/28/2016 04:35 PM
	rachaelm	Quarterly Report (no attachment necessary)	44_MDL0903_1_4_20160428163327_Narrative.docx	DY1, Q4 Quarterly Report Narrative (exceeded character limit)	04/28/2016 04:33 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 Narrative Text

Milestone Name	Narrative Text
Perform a clinical integration 'needs assessment'.	See documents attached for quarterly report narrative.
Develop a Clinical Integration strategy.	The PPS has contracted with the Area Health Education Center (AHEC) to complete a workforce analysis which will serve as an input to the Clinical Integration Strategy. The workforce analysis milestone was previously deferred by the DOH following issuance of new guidance related to the workforce project, and as a result we have deferred our Clinical Integration Milestone 2 to align with this new date. The analysis from AHEC is scheduled to be completed by late April/early May 2016, and thus the PPS remains on target to meet the new proposed deadline of DY2, Q2 (9/30/16) for Clinical Integration Milestone 2, "Developing a Clinical Integration Strategy." Once we receive the analysis, the Clinical Integration team will meet with the PPS's Workforce Project Manager to establish how & where resources will need to be deployed and/or trained to facilitate full integration into the IDS. Additionally, the PPS is beginning to leverage existing data warehouses to serve as an interim solution prior to the full build of an internal data warehouse. This will allow the PPS to continue moving towards full clinical integration while still developing the required IT infrastructure.

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 Penny Thoman, Provider Relations / Care Compass Network	Responsible for managing physician relations, performing education, training, and coordinating agreements.
South RPU Lead	Keith Leahey, Executive Director (Mental Health Association) Wayne Mitteer, Strategy Adviser (Lourdes)	Alignment of RPU needs at the Governance Level, including clinical integration.
North RPU Lead	Amy Gecan, Director System Integration and Operations (Cayuga Medical Center)	Alignment of RPU needs at the Governance Level, including clinical integration.
East RPU Lead	Greg Rittenhouse, VP, COO, Home Care (UHS)	Alignment of RPU needs at the Governance Level, including clinical integration.
West RPU Leads	Josie Anderson (Guthrie) & Robin Stawasz (CareFirst)	Alignment of RPU needs at the Governance Level, including clinical integration.

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

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 (* Amy Gecan (Cayuga Medical Ctr)- North RPU * Greg Rittenhouse (UHS) - East RPU * Keith Leahey (Mental Health Association) - South RPU * Robin Stawaz (Care First) - West RPU	RPU Performance Leadership teams will include member(s) of the PMO, including at minimum one Lead Project Manager per RPU, the lead RPU Provider Relations professional, RPU specific Disease Management and Behavioral Health professionals, the RPU Outreach Coordinator, as well as PPS positions which will support multiple RPU's, such as the Workforce Transition Leader, IT Coordinator, PMO Coordinator, and Communications Coordinator. Together, these members will communicate RPU needs to the associated committee/council (e.g., CBO Council, Coordinating Council, Finance Committee, etc.) and drive implementation efforts as related to their functions. The RPU Leadership team members will work closely with CBO members and PPS support teams (e.g., IT, etc.) to oversee the implementation of the phased DSRIP plans for progress, identification and remediation of issues, and report development for periodic PPS meetings as well as quarterly DOH submissions.
Project Leads	Multiple	PPS Project Leads, along with their team, are members of the Coordinating Council and serve as the technical leaders for individual DSRIP projects and organizational sections. The Project Leads provide insight as to the development of integration, staffing, obtainment of consulting services, and otherwise to drive the planning, development, and execution of DSRIP related projects. This includes bringing the right people to the table, including identification of technical leaders from across the PPS, interviewing PPS candidates, or generating Requests for service Proposals for PPS services to be achieved through hired vendors/consultants. The Project Leads are also responsible for understanding the

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

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.

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).	In Progress	Finalized PPS target workforce state, signed off by PPS workforce governance body.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	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.	In Progress	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.	In Progress	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.	In Progress	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	In Progress	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.	In Progress	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.	In Progress	In Process	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 8: The WDTT and workforce consultant will create a detailed target state workforce model to include: number of staff by skill, location, shift, pay category, etc.	In Progress	In Process	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	In Progress	Completed workforce transition roadmap, signed off by PPS workforce governance body.	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task 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	In Progress	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
determine workforce needed, the Gap Analysis to illustrate affects on current positions, the Compensation and Benefits Analysis to show impacts on current positions and salaries and a Communication plan to map out staff involvement.									
Task Step 3: Consolidate all specific workforce changes within the PPS; incorporating speed and scale projections by position, a recruitment plan for new hires (see Detailed Gap Analysis), retraining/re-deployment strategies (see Compensation and Benefit Analysis), training timelines (see Training Strategy) and the creation of a Communication and Engagement Plan.	In Progress	In Process	07/01/2015	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.	In Progress	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.	In Progress	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.	In Progress	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 from HR representatives and consideration for HR policies and Labor agreements.	In Progress	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 2: Compare job skill requirements of Target Workforce State versus skills of jobs to be reduced/eliminated.	In Progress	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 3: Utilizing the results from Milestone 3,	In Progress	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
Step 1 and Step 2, identify eligible staff for re-deployment/retraining through an HR-implemented skill assessment.									
Task Step 4: Confirm impact analysis of existing workers (current state assessment) by identifying staff availability and competency levels, project-specific implementation needs, by member organization, in order to assess: 1) Staff able to fill target state positions through retraining and 2) Staff who could be redeployed directly into target state roles.	In Progress	In Process	07/01/2015	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.	In Progress	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).	In Progress	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.	In Progress	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 retrained or redeployed; 3) Of impacted workers, project number of workers that are expected to achieve full or partial placement.	In Progress	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 9: Reflect gap analysis results as they inform the workforce transition roadmap.	In Progress	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	In Progress	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
(RPU's, project leads, clinical performance units) and approved by governing body.									
Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	In Progress	Compensation and benefit analysis report, signed off by PPS workforce governance body.	07/01/2015	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.	In Progress	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.	In Progress	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.	In Progress	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 input, determine specific impacts to partial placement staff and potential contingencies.	In Progress	In Process	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6: With HR, third party vendor, and Union input, develop and incorporate policies for staff impacted by partial placement or who refuse retraining or re-deployment.	In Progress	In Process	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task	In Progress	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
Step 7: Workforce governing body approves compensation and benefits analysis.									
Milestone #5 Develop training strategy.	In Progress	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.	In Progress	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.	In Progress	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 for performance metrics, VBP, etc.).	In Progress	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4: Explore opportunities to coordinate efforts with existing state-wide education programs.	In Progress	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.	In Progress	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 6: Develop a training strategy to guide the training plan, to include: goals, objectives and guiding principles for the detailed training plan; employee skill assessment; confirm process and approach to training (e.g. voluntary vs. mandatory, etc.).	In Progress	In Process	07/01/2015	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.	In Progress	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.	In Progress	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.	In Progress	In Process	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 10: Generate training plan for approval by governing body.	In Progress	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

No Records Found

NYS Confidentiality – High

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
Define target workforce state (in line with DSRIP program's goals).	There were no milestones or tasks due for the DY1 Q4 report. The Workforce Development and Transition Team have been in place since 2014 and continue to meet monthly, based on Workforce Strategy Milestones. To promote further involvement from the Stakeholders the Workforce Development Team lead, Lenore Boris, JD, PhD. presented a call for additional members during the June 12, 2015 PPS Stakeholders / PAC meeting. Inclusion on the Workforce Development Transition Team is open to any persons who express interest. The Workforce Development team consists of 5 HR Representatives, 2 Union Representatives, Subject Matter Experts from Health Workforce NY (HWNY), key stakeholders from partner organizations in the PPS as well as Care Compass Network (CCN) staff supporting the Workforce Deliverables (Step 1). CCN hired a Workforce Development Manager during DY1 Q4 (Anne Kinney) to manage the Workforce Strategy deliverables for the PPS. The Workforce Development Manager worked with Judith McKinnon from Health Workforce NY to develop a plan to conduct a staffing analysis by project and partner. The plans for collecting data and the tools that have been prepared to do so were presented to the WDTT at their monthly meeting on March 29, 2016.
Create a workforce transition roadmap for achieving defined target workforce state.	There were no milestones or tasks due for the DY1 Q4 report. In order to define the target workforce state a transition roadmap will be created. Once Care Compass Network (CCN) receives the aggregate data from the Compensation and Benefits Survey (expect mid-May 2016) as well as the information that will be gleaned from the project by project analysis, a gap analysis will be performed. The information received will then aid with creating a transition road map to help us determine the path we will take to achieve this plan. On an operational level, the Workforce transition project leader participates in the bi-weekly Coordinating Council, comprised of all PPS project leads and select content experts. Discussions from the Coordinating Council are presented to the PAC Executive Council via the Executive Director for inclusion in the bi-weekly Stakeholders / PAC meeting.
Perform detailed gap analysis between current state assessment of workforce and projected future state.	There were no milestones or tasks due for the DY1 Q4 report, however the PPS continues to make progress towards completing the Workforce Strategy project deliverables commensurate with the respective due dates. The PPS hired a Workforce Development Manager in late January 2016. The Workforce Development Manager (Anne Kinney) is responsible to lead the workforce transformation strategy and initiatives for the PPS. On November 23, 2015, Anita Merrill and members of her team from Health Workforce New York (HWNY), the Workforce Vendor supporting the PPS, provided an overview of the workforce deliverables to the CCN Coordinating Council. In January 2016, HWNY began working with the Care Compass Network project leads to conduct a Project-By-Project Analysis and a Training Analysis as part of the implementation plan for workforce development milestone 3 and 5. Additionally, Care Compass Network has signed into contract with a third party vendor, Iroquois Healthcare Alliance (IHA) in January of 2016, to begin the Compensation and Benefit Analysis required as part of milestone 4. The survey was sent out on March 17, 2016. The utilization of a third party vendor for gathering of this data is required for compliance and program requirements.
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.	There was one step due for Milestone 4 due this quarter. Care Compass Network has signed a contract with Iroquois Healthcare Alliance (IHA) on 1/19/2016 to begin the Compensation and Benefits Analysis required as step 1 of Milestone 4. (Step 1 – complete) The Compensation and Benefit Analysis was distributed to 100 partners on March 17, 2016. The aggregate data analysis is due back from IHA by Mid May 2016. The PPS hired a Workforce Development Manager in late January 2016. The Workforce Development Manager (Anne Kinney) is responsible to lead the workforce transformation strategy and initiatives for the PPS. On November 23, 2015, Anita Merrill and members of her team from Health Workforce New York (HWNY), the Workforce Vendor supporting the PPS, provided an overview of the workforce deliverables to the CCN Coordinating Council. In January 2016, HWNY began working with the Care Compass Network project leads to conduct a Project-By-Project Analysis and a Training Analysis as part of the implementation plan for workforce development milestone 3 and 5.
Develop training strategy.	There were no milestones or tasks due for the DY1 Q4 report; however the PPS continues to make progress towards completing the Workforce Strategy project deliverables. The PPS hired a Workforce Development Manager (Anne Kinney) in late January 2016. The Workforce Development Manager is responsible to lead the workforce transformation strategy and initiatives for the PPS. On November 23, 2015, Anita Merrill and members of her team from Health Workforce New York (HWNY), the Workforce Vendor supporting the PPS, provided an overview of the workforce deliverables to the CCN Coordinating Council. In January 2016, HWNY began working with the Care Compass Network project leads to conduct a Project-By-Project Analysis and a Training Analysis as part of the implementation plan for workforce development milestone 3 and 5. The Workforce Development Manager has been collecting the training needs per project in order to gain a PPS level view of what is needed. Additionally, Care Compass Network has signed into contract with Iroquois Healthcare Alliance (IHA) 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
	January of 2016 to begin the Compensation and Benefit Analysis required as part of milestone 4. The Compensation and Benefit Analysis survey was sent out on March 17, 2016.

Milestone Review Status

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

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

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)	Anne Kinney	Responsible for executing or supporting the execution of the Implementation Plan activities. Staff liason with workforce committee.
PPS Staff	Robin Kinslow-Evans, Interim Executive Director Roseanna Stasik, Executive Assistant Mark Ropiecki, Director, Project Management	Responsible for reviewing and providing timely feedback/input on various aspects of the PPS Workforce Strategy including the hiring and sub-contracting of vendors. Also, interface with leads for funds, communications, governance, coordinating workforcoce issues into MAPP portal.
IT Project Lead & Consultants	Srikanth Poranki, IT Project Lead Bill Ahrens, Senior Manager Jenna Barsky, Senior Consultant Kathleen Grueter, Consultant	Responsible for understanding workforce data, tracking & reporting needs and providing recommendations for solutions.
Workforce Development and Transition Team (Workforce Committee)	Cori Belles, Donna Chapman, Janet Hertzog, Martha Hubbard, Mary Hughs, Debbie Morello, Sage Peak, Baschki Robertson, Sue Ellen Stuart, Jack Salo, Karen Wida, Christopher Samsel, and Elizabeth Berka	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, Interim Executive Director Roseanna Stasik, Executive Assistant Mark Ropiecki, Director, Project Management	PPS Staff	Provide approval at various stages of workforce implementation including the hiring/payments to PPS subcontractors.
TBD	Affected healthcare disciplines	Input will be needed in defining the strategy. Key stakeholders will continually be evaluated throughout DSRIP.
Anne English, Mary Hughs, Cori Belles, Donna Chapman, Sage Peak	Participating Partner HR Representatives	Workforce data & reporting Direct communication link to front-line workers Current state workforce information Potential hiring needs
Multiple	Participating Partner Learning Department Representatives	Training data & reporting Direct link to employee training resources
Janet Hertzog, Martha Hubbard	Local Educational Institution Representatives	Provide insights and information related to the development of the training needs assessment, strategy and plan
Greg Rittenhouse, Shelley Eggleton, Kathy Swezey, Victoria Mirabito, Sue Ellen Stuart, Amy Gecan, Alan Wilmarth, Sue Romanczuk, Nancy Frank, Pam Guth, Deborah Blakeney	Project Leads	Provide information related to sources and destinations of redeployed staff by project
Multiple	Leads at larger PPS member organizations	Employing DSRIP-created positions, providing DSRIP-related training, Project implementation Potential employer, potential training resource, project participant
External Stakeholders		
Educational Institutions	Potential Training Developer	Provide DRSIP-related training needs
Other training providers	Potential training provider/developer	Provide DRSIP-related training needs
SUNY RP2 (squared)	Facilitate creation of SUNY-wide post-secondary training programs	Provide long-term DRSIP-related training needs
SEIU 1099, CSEA, NYSNA	Labor representative	Provide advising around labor issues
AHEC/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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 11.8 - 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 include details on workforce staffing impacts on an annual basis. For each DSRIP year, please indicate the number of individuals in each of the categories below that will be impacted. 'Impacted' is defined as those individuals that are retrained, redeployed, recruited, or whose employment is otherwise affected.

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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 :

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 workforce spend dollar amounts for DY1. The workforce spend amounts should reflect only what was spent during the relevant quarters and is not cumulative across semi-annual periods. Funds may be shifted from one funding type category to another within the workforce strategy spending table; e.g., from Retraining to New Hires.

Benchmarks	
Year	**Amount($)**
Total DY1 Spending Commitment	338,698.00

Funding Type	Workforce Spending Actuals		Total Spending($)	Percent of Commitments Expended
	DY1(Q1/Q2)($)	DY1(Q3/Q4)($)		
Retraining	12,000.00	0.00	12,000.00	118.10%
Redeployment	0.00	0.00	0.00	0.00%
New Hires	19,088.00	19,088.00	38,176.00	102.47%
Other	150,000.00	168,000.00	318,000.00	109.17%
Total Expenditures	**181,088.00**	**187,088.00**	**368,176.00**	**108.70%**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
mrbobc	Other	44_MDL1122_1_4_20160428162829_Blank.txt	A blank file as MAPP stated "Cannot be saved. At least one file must be uploaded when Total Expenditures of 'DY1 Q4' is greater than 0."	04/28/2016 04:29 PM

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 :

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	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 1a. - Develop a Participating Organization (e.g., provider) Network List for the PPS to outline the Partner Organization (e.g., providers, Community Based Organization (CBO), social service organizations, etc.) demographics for the PPS Integrated Delivery System.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 1b. - Establish operating units for the PPS called Regional Performing Units (RPUs) within which the PPS Participating Organizations from across the nine county region can be identified and engaged at a localized level.		Project		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		In Progress	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
Task Step 1f. - When appropriate, engage payers at a PPS leadership level roundtable, to be completed at minimum annually and supported by meeting minutes.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 1g. - The Provider Relations professionals will perform periodic (e.g., quarterly) assessments of PPS Partner Organizations to confirm relationships exist, are active, and overall participation and results are aligned with the contractual terms or overall needs of the PPS (e.g., updated CNA assessment, etc.) As a result of the quarterly reviews, any changes to the Provider Network List will be made and communicated, and the need for priority status may assigned to further engage PPS Participating Organizations where needed.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	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

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 2f. To the extent possible, identify and leverage Health Home-specific IT elements including case management information sharing, care coordination templates, connectivity/relation to the RHIO, etc.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2g. - To integrate the PPS and further promote the development of the integrated delivery system, assign an RPU Lead who will communicate and reinforce updates to and from the Clinical Governance Committee.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2h. - Note: There are currently no ACO's in place, nor in development, within the STRIPPS Partnering Organizations. This project requirement will be periodically reviewed for ongoing ACO pertinence.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	DY2 Q4	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Clinically Interoperable System is in place for all participating providers.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS trains staff on IDS protocols and processes.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3f. - Development of a Standard PPS Care Coordination Plan which will be informed by the Care Coordination needs assessment and developed based on guidance provided by the RPU Quality Committee as well as the Clinical Governance 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		Project		In Progress	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
protocols, education or tutorials may also be provided.										
Task Step 3g. - Implement a process to track performance within the Care Coordination Plan through periodic reporting, including services provided outside of hospitals in order to assist with service integration. RPU adherence to standards established by the Clinical Governance Committee, including Care Coordination Plans, will be monitored by the RPU Quality Committee.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	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		In Progress	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 Step 4h. - Maintain ongoing communication with RHIO to identify potential capabilities relevant to PPS activities.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task Step 4i. - Upon provider completion of project 2.a.i. Project Requirement 5, which includes leveraging a consulting service to assist with a PCMH & Meaningful Use readiness assessment, creation & implementation of the associated implementation plan(s), provide assistance with the application process, and formally document/retain certification related documentation; the PPS IT Coordinator will review and monitor the IT environment to confirm EHR system capabilities are in place are used and functioning as designed ensuring access to real-time data to improve interoperability. Periodic reviews will be performed and include evidence of alerts/secure messaging, availability of training materials, training(s) completed, and percentage of staff trained. The status of these reviews will be reported at minimally quarterly to the IT & Data Governance Committee and/or Clinical Governance Committee as appropriate.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task Step 4j. - The PPS will support partners (e.g., CBOs, providers, etc.) in actively sharing by promoting infrastructure build and/or other requirements as identified by the current state assessment above. As appropriate, partners will be contracted with the PPS for achievement of specific tasks, which will be monitored for completion as reported to the RPU Clinical Quality Committees for review.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	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		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
Net Providers preparation requirements for activation with the RHIO. When needed, utilize the PPS IT Coordinator to coordinate resources needed for Safety Net Provider(s) activation with the appropriate RHIO.										
Task Step 5d. - Using the readiness assessment (See 2.a.i Milestone 1, Step 1c), determine PPS providers' status on achievement of PCMH and Meaningful Use requirements.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 5e. - Identify and contract with a Consulting service to assist with a PCMH readiness assessment and implementation and collaborate with adjacent PPS' (as appropriate).		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 5f. - Leverage the PCMH Readiness Assessment as a baseline to create a Meaningful Use and PCMH implementation plan for PPS providers. The plan will include a current state assessment for each safety net provider and detail key milestones which will allow for a phased implementation approach towards PCMH and Meaningful Use DY3, Q4 requirements.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 5g. - The RPU Provider Relations professionals will assist safety net providers with the associated application(s) throughout each phase of the PCMH Level 3 implementation plan.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 5h. - Obtain and retain certification documentation substantiating safety net providers within the PPS have achieved Meaningful Use and PCMH Level 3 standards.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 6b. - Identify those person(s) responsible for review of population health data and provide requisite HIPAA, PHI, and regulatory training to ensure overall PPS compliance. As applicable, obtain DEAA, BAA, or other required arrangement.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	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 6c. - Identify data elements specified in DSRIP requirements.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6d. - Initiate population health management with available patient data, such as Salient and participating provider clinical systems.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6e. - Identify available patient health registries and population health software.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6f. - Develop a population health stratification approach to confirm EHR completeness and validity.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 6g. - Develop a population health stratification approach to identify patient groups for targeting.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 6h. - Develop a defined population health registry for individual patients for enhanced care management and each RPU.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6i. - Develop a dictionary of registry elements to ensure ease of implementation and standardization of use PPS-wide.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6j. - Develop a monitoring process which allows for the RPU Leads to actively track patients for metrics such as status (engaged/not engaged) and performance against project milestones, to be included in reporting at the PPS level.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 6k. - Perform periodic reviews of user access and system requirements to perform population health management.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	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		Provider	Practitioner - Primary	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
All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.			Care Provider (PCP)							
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 7d. - In conjunction with project 2.a.i. Project Requirement 4, utilize the PPS IT and Data Governance team to identify all participating PCPs for activation with the RHIO. When needed, utilize the PPS IT Coordinator to coordinate resources needed for Primary Care Providers (PCPs) activation with the appropriate RHIO.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 7e. - Identify and contract with a Consulting service to assist with a PCMH readiness assessment and implementation and collaborate with adjacent PPS' (as appropriate).		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 7f. - Leverage the PCMH Readiness Assessment as a baseline to create a Meaningful Use and PCMH implementation plan for PPS providers. The plan will include a current state assessment for each PCP and detail key milestones which will allow for a phased implementation approach towards PCMH and Meaningful Use DY3, Q4 requirements.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 7g. - Monitor primary care access/capacity by performing a PPS survey through existing RMS panel resources and using available provider surveys, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Action plans will be developed, as needed, to address primary care access needs of the PPS.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 7h. - The RPU Provider Relations professional will assist the PCPs with the associated application(s) throughout each phase of the PCMH Level 3 implementation plan.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 7i. - Obtain and retain certification documentation substantiating safety net providers within the PPS have achieved Meaningful Use and PCMH Level 3 standards.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 7j. - Provider Relations professionals will record, monitor,		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
and communicate identified primary care physician needs by their assigned RPU.										
Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	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 Medicaid Managed Care contract(s) are in place that include value-based payments.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 8b. - Analyze the NYSDOH data related to the risk-adjusted cost of care as well as the potential (shared) savings, at both the total population level as per care bundle and subpopulation per the Value Based Purchasing (VBP) Roadmap, in order to identify best possible opportunities for PPS providers in their move towards VBP.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 8c. - Expand upon Baseline Assessment of VBP readiness creating a matrix of existing mechanisms both helping and hindering the implementation of the VBP model, including NYS VBP Roadmap, existing ACO and MCO models (as applicable), and other VBP models in the current marketplace.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 8d. - Analyze matrix of existing mechanisms both helping and hindering the implementation of VBP at the provider level of our PPS in order to identify which providers are best equipped to lead the movement towards VBP based on their current level of VBP engagement.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 8e. - Identify within the PPS providers who fall into one of three tiers: 1) Established - Providers currently utilizing VBP models 2) Enthusiastic and/or Equipped - Providers who are eager to pursue the movement towards VBP models and/or equipped to do so based on the helping/hindering matrix 3) Everyone else.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 8f. - Coordinate regional payor forums with PPS providers.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

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 8g. - Re-assess current landscape of VBP adoption throughout PPS by updating VBP Baseline Assessment, reviewing new information if available from the state and feedback from PPS Providers and MCOs regarding the payor forums as well as lessons learned from early adopters.		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 8h. - Perform Gap Analysis based on updated matrix of PPS landscape.		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 8i. - Coordinate additional regional payor forums with PPS providers based on Gap Analysis.		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 8j. - Collectively review the level of VBP engagement and continue to encourage open dialogue among the PPS providers regarding VBP models and adoption.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 8k. - Update, modify and finalize VBP Adoption Plan		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 9b. - Establish VBP committee comprised of members from PPS constituency with representation from all provider types. VBP Committee will seek to follow & leverage industry wide VBP Prepatory Strategies via HANYS. (Step corresponds with Financial Sustainability Implementation Plan)		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 9c. - Cultivate pathways between VBP Committee and the rest of the system in order to survey and educate current landscape of existing VBP arrangements amongst PPS providers in PPS. (Step corresponds with Financial Sustainability Implementation Plan)		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 9d. - Create education and communication plan, including the myriad components intrinsic to VBP, particularly the different strata of risk. (Step corresponds with Financial Sustainability		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
Implementation Plan)										
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 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)		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
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

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 9k. - Disseminate preliminary results of readiness self-assessment survey analysis for review by PPS Providers. (Step corresponds with Financial Sustainability Implementation Plan)		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 9l. - Update, revise and finalize VBP Baseline Assessment based on Providers & Boards review. (Step corresponds with Financial Sustainability Implementation Plan)		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 9m. - PPS Board to sign off on preference for PPS providers to contract with MCO's at their own discretion. (Step corresponds with Financial Sustainability Implementation Plan)		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 9n. - Established VBP Committee will coordinate with Medicaid MCOs to schedule monthly meetings to discuss utilization trends, performance issues and payment reform based on VBP Adoption Plan.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	DY3 Q4	Project	N/A	In Progress	04/01/2015	06/30/2019	04/01/2015	06/30/2019	06/30/2019	DY5 Q1
Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation		Project		In Progress	04/01/2015	06/30/2019	04/01/2015	06/30/2019	06/30/2019	DY5 Q1
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.		Project		In Progress	04/01/2015	06/30/2019	04/01/2015	06/30/2019	06/30/2019	DY5 Q1
Task Step 10c. - Identify patient subgroups and populations and stratify by assigning risk values.		Project		In Progress	04/01/2015	06/30/2018	04/01/2015	06/30/2018	06/30/2018	DY4 Q1
Task Step 10d. - Conduct a provider analysis exercise to determine if the provider is better categorized as a "Large Organized Group Practice Provider" or an "Independent Provider."		Project		In Progress	04/01/2015	06/30/2018	04/01/2015	06/30/2018	06/30/2018	DY4 Q1
Task Step 10e. - Develop a contracting strategy which correlates DSRIP goals, timelines, patient risk stratification, and physician metrics and results with monetary incentive payments. As part of this process, a compensation model and implementation plan will be developed based on provider categorization. For "Large Organized Group Practice Providers" the PPS will integrate a value based system which focus' on an RVU and quality base.		Project		In Progress	04/01/2015	12/31/2018	04/01/2015	12/31/2018	12/31/2018	DY4 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
As noted in Step 1 above, Partnering Organizations will be contracted at the RPU level through Provider Relations professionals.										
Task Step 10f. - For physicians identified as "Independent Providers" the PPS will pursue value based contracts with their associated Medicaid MCO which includes the elements noted in Step 10b. section of the 2.a.i Implementation Plan.		Project		In Progress	04/01/2015	06/30/2019	04/01/2015	06/30/2019	06/30/2019	DY5 Q1
Task Step 10g. - The Provider Relations professionals, assigned at each RPU, will monitor contract compliance and pertinence of contractual terms to meet DSRIP goals as DSRIP implementation matures and develops. This may be achieved through leveraging the integrated delivery system model, including Population Health professionals as well as the PPS PMO. Results will be reviewed through the PPS PMO performance management process.		Project		In Progress	04/01/2015	06/30/2019	04/01/2015	06/30/2019	06/30/2019	DY5 Q1
Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	DY3 Q4	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 11b. - As noted above in Project 2.a.i Step 1f. and in line with the plan for project 2.d.i., the targeted patient population will be identified and consents subsequently obtained through the use of a robust contracted patient activation outreach worker team, as well as close collaboration with the community-based health navigation team (refer to Project 2.c.i.). These combined efforts, along with the training efforts that will occur through the patient activation training team for safety-net providers in the network, will ensure that the maximum number of individuals complete the PAM. Additionally, the PPS plans to embed the PAM survey in all safety-net practices at a minimum and will implement a process whereby all patients without insurance and all patients with Medicaid coverage will be given the PAM if it is determined they have not yet completed the survey. The PPS plans to leverage the RPU structure to achieve this efficiently and effectively (see attached for RPU structure).		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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 11c. - A comprehensive incentive plan will be developed, which will compensate providers for their participation and will assign a value to each PAM survey that is collected. Additionally, the patient activation training team will work with the provider relations component of the PPS to inform providers about the overall DSRIP initiative and PPS objectives, in addition to patient activation and the PAM.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 11d. - A broad range of responsible individuals will receive training in the PAM, and the efforts will initially start out in the 9 hospitals within the PPS network, so that lessons learned can be applied as the project is expanded to other providers. To this effect, Project 2.a.i will work closely with Project 2.d.i. as well as with the Workforce Department group to ensure that the right skillset is matched up with each of the two position types.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.	There are no milestones or steps due other than some steps which are part of Milestone 9 for Project 2ai. The PPS continued to make progress through DY1Q4 with regards to executing contracts with Providers in the PPS. As of April 8, 2016 we have contracts executed with three Community Based Organizations, three Skilled Nursing Facilities, one Hospital and one Mental Health Provider. We have several more contracts in final review with Providers in Care Compass Network. We have also prioritized our largest contract barrier identified to date by completing draft contracting documents associated with one of our partners who is affiliated with a national Catholic Health System. This system exercises a robust contract review process which occurs at the corporate level (e.g., outside NYS), which is expected to have a longer lead time on completion when compared to other partners. To date we have had contracting discussions with more than 90 of our Partners including each of the five health systems comprised of nine hospitals in the Care Compass Network. In March 2016, an RFP was released seeking consulting services across the PPS to assist with PCMH readiness towards PCMH Level 3 2014 certification. Additionally, as part of the IT Systems and Processes Domain 1 Project, CCN worked with WeiserMazars to develop an IT focused survey for major CCN partners. This survey covered current and planned RHIO connectivity. As new partners are contracted with CCN additional IT data is collected. The new partners are provided the information to connect with the RHIO in their area as well as information on engaging patients/beneficiaries based on the projects they have elected to participate. Care Compass Network continues to make progress on creating an Integrated Delivery System.

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.	While there is no requirement to communicate changes for this milestone there was an update in DY1Q4 in regards to this milestone. As of January 1, 2016 Cayuga Area Preferred (CAP) was officially recognized as an Accountable Care Organization (ACO). CAP had previously been operating in the CCN North RPU as a federally certified Clinically Integrated Network (CIN) representing a population of independent physicians throughout Schuyler, Tompkins, and Cortland counties. The newly established CAP ACO is a clinically integrated network made up of these same 215 primary care physicians, specialty physicians, along with Cayuga Health System and its facilities who are dedicated to bringing a system of high quality, coordinated healthcare to our region. The network provides services to beneficiaries located throughout the Tompkins County Area. Rob Lawlis, the Executive Director of CAP, is a member of the CCN Board of Directors as well as the Chair of the IT, Informatics and Data Governance Committee. CAP is a key partner to Care Compass Network in implementation of this project. During DY2Q1 we expect to begin the implementation of the IT Roadmap and Strategic Action Plan approved by the CCN Board of Directors on March 8, 2016.
Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	For the Care Compass Network 2ai project plan there are only a few reported steps within Milestone 9 due in DY1, Q4. As a result we have provided a general project update for the remaining Milestones. Building the IDS Network: The PPS continued to make progress through DY1Q4 with regards to executing contracts with Providers in the PPS, of note having fully achieved speed and scale targets for 2bvii. Additionally, we have engaged with the KPMG MAX team with a hot spot location which will be contracting with the PPS for 3ai model 1 (integration of primary care and behavioral health). As of DY1, Q4 this location is actively doing the work associated with speed and scale for which numbers will be reported commencing DY2, Q1. Work performed in DY1, Q4 at this site could not be reported due to incomplete contracting status – the site is a part of a national Catholic Health System for which the contract is currently pending national review. This pilot site continues to learn lessons which will be leveraged with additional sites for 3ai models 1 and 2. The site continues to work on process improvement workflows to improve the coordination of care between the primary care physician and the behavioral health specialist. The site has also has adopted best practices such as (1) inclusion of behavioral health specialist embedded at the primary care practice on a full-time basis, (2) integration of PHQ-9 screening with successful referrals, and (3) warm hand-offs between the primary care and behavioral health provider for patients who have a positive screening for the brief intervention and the development of their treatment plan. PCMH Development: The PPS has developed a timeline for PCMH certification and distributed an RFP (March 2016) to vendors to help provide PCMH consulting, site plan development, and application reviews to assist practice sites with PCMH readiness towards PCMH Level 3 2014 certification. IT Strategies: The PPS has engaged with KPMG for the IT Target Operating Model program ("IT TOM") with a specific focus on 2ai. As of DY1, Q4 we have defined the clinical workflows (or Business Requirement Definitions) for all three presented scenarios which is about half of the required work for IT TOM. From these workshops we have learned the following: 1) Our PPS is someone unique in that we have five major entities and three RHIOs as opposed to one lead hospital and one RHIO; we can present best practices to each system but they may need to alter slightly to accommodate their needs and workforce structure. 2) Full collaboration between major entities, CBOs, RHIOs and patient consent are all required to achieve an Integrated Delivery System. 3) It will be a significant effort to create an interface with the many existing EHRs in our PPS. 4) Workforce right-sizing and training will be critical to success and 5)The process improvement methodology can be replicated for any of our other ten projects. The results of these workshops have been included as standing items on the agendas to the IT sub-committees, the IT Informatics and Data Governance Committee as well as the Board of Directors. As part of the IT Systems and Processes Domain 1 Project, CCN distributed a survey to understand our partner's current and planned RHIO connectivity. In March 2016 UHS Hospitals (which applied on behalf of CCN) received a CRFP award of up to $14,332,500 for development of the PPS IT Infrastructure. Following this announcement the PPS hired an Interim CIO to bolster planning around these efforts which will likely include EMR, RHIO, Care Coordination, and Population Health platforms.
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	For the Care Compass Network 2ai project plan there are only a few reported steps within Milestone 9 due in DY1, Q4. As a result we have provided a general project update for the remaining Milestones.

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
exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	Building the IDS Network: The PPS continued to make progress through DY1Q4 with regards to executing contracts with Providers in the PPS, of note having fully achieved speed and scale targets for 2bvii. Additionally, we have engaged with the KPMG MAX team with a hot spot location which will be contracting with the PPS for 3ai model 1 (integration of primary care and behavioral health). As of DY1, Q4 this location is actively doing the work associated with speed and scale for which numbers will be reported commencing DY2, Q1. Work performed in DY1, Q4 at this site could not be reported due to incomplete contracting status – the site is a part of a national Catholic Health System for which the contract is currently pending national review. This pilot site continues to learn lessons which will be leveraged with additional sites for 3ai models 1 and 2. The site continues to work on process improvement workflows to improve the coordination of care between the primary care physician and the behavioral health specialist. The site has also has adopted best practices such as (1) inclusion of behavioral health specialist embedded at the primary care practice on a full-time basis, (2) integration of PHQ-9 screening with successful referrals, and (3) warm hand-offs between the primary care and behavioral health provider for patients who have a positive screening for the brief intervention and the development of their treatment plan. PCMH Development: The PPS has developed a timeline for PCMH certification and distributed an RFP (March 2016) to vendors to help provide PCMH consulting, site plan development, and application reviews to assist practice sites with PCMH readiness towards PCMH Level 3 2014 certification. IT Strategies: The PPS has engaged with KPMG for the IT Target Operating Model program ("IT TOM") with a specific focus on 2ai. As of DY1, Q4 we have defined the clinical workflows (or Business Requirement Definitions) for all three presented scenarios which is about half of the required work for IT TOM. From these workshops we have learned the following: 1) Our PPS is someone unique in that we have five major entities and three RHIOs as opposed to one lead hospital and one RHIO; we can present best practices to each system but they may need to alter slightly to accommodate their needs and workforce structure. 2) Full collaboration between major entities, CBOs, RHIOs and patient consent are all required to achieve an Integrated Delivery System. 3) It will be a significant effort to create an interface with the many existing EHRs in our PPS. 4) Workforce right-sizing and training will be critical to success and 5)The process improvement methodology can be replicated for any of our other ten projects. The results of these workshops have been included as standing items on the agendas to the IT sub-committees, the IT Informatics and Data Governance Committee as well as the Board of Directors. As part of the IT Systems and Processes Domain 1 Project, CCN distributed a survey to understand our partner's current and planned RHIO connectivity. In March 2016 UHS Hospitals (which applied on behalf of CCN) received a CRFP award of up to $14,332,500 for development of the PPS IT Infrastructure. Following this announcement the PPS hired an Interim CIO to bolster planning around these efforts which will likely include EMR, RHIO, Care Coordination, and Population Health platforms.
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.	For the Care Compass Network 2ai project plan there are only a few reported steps within Milestone 9 due in DY1, Q4. As a result we have provided a general project update for the remaining Milestones. Building the IDS Network: The PPS continued to make progress through DY1Q4 with regards to executing contracts with Providers in the PPS, of note having fully achieved speed and scale targets for 2bvii. Additionally, we have engaged with the KPMG MAX team with a hot spot location which will be contracting with the PPS for 3ai model 1 (integration of primary care and behavioral health). As of DY1, Q4 this location is actively doing the work associated with speed and scale for which numbers will be reported commencing DY2, Q1. Work performed in DY1, Q4 at this site could not be reported due to incomplete contracting status – the site is a part of a national Catholic Health System for which the contract is currently pending national review. This pilot site continues to learn lessons which will be leveraged with additional sites for 3ai models 1 and 2. The site continues to work on process improvement workflows to improve the coordination of care between the primary care physician and the behavioral health specialist. The site has also has adopted best practices such as (1) inclusion of behavioral health specialist embedded at the primary care practice on a full-time basis, (2) integration of PHQ-9 screening with successful referrals, and (3) warm hand-offs between the primary care and behavioral health provider for patients who have a positive screening for the brief intervention and the development of their treatment plan. PCMH Development: The PPS has developed a timeline for PCMH certification and distributed an RFP (March 2016) to vendors to help provide PCMH consulting, site plan

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	development, and application reviews to assist practice sites with PCMH readiness towards PCMH Level 3 2014 certification. IT Strategies: The PPS has engaged with KPMG for the IT Target Operating Model program ("IT TOM") with a specific focus on 2ai. As of DY1, Q4 we have defined the clinical workflows (or Business Requirement Definitions) for all three presented scenarios which is about half of the required work for IT TOM. From these workshops we have learned the following: 1) Our PPS is someone unique in that we have five major entities and three RHIOs as opposed to one lead hospital and one RHIO; we can present best practices to each system but they may need to alter slightly to accommodate their needs and workforce structure. 2) Full collaboration between major entities, CBOs, RHIOs and patient consent are all required to achieve an Integrated Delivery System. 3) It will be a significant effort to create an interface with the many existing EHRs in our PPS. 4) Workforce right-sizing and training will be critical to success and 5)The process improvement methodology can be replicated for any of our other ten projects. The results of these workshops have been included as standing items on the agendas to the IT sub-committees, the IT Informatics and Data Governance Committee as well as the Board of Directors. As part of the IT Systems and Processes Domain 1 Project, CCN distributed a survey to understand our partner's current and planned RHIO connectivity. In March 2016 UHS Hospitals (which applied on behalf of CCN) received a CRFP award of up to $14,332,500 for development of the PPS IT Infrastructure. Following this announcement the PPS hired an Interim CIO to bolster planning around these efforts which will likely include EMR, RHIO, Care Coordination, and Population Health platforms.
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	For the Care Compass Network 2ai project plan there are only a few reported steps within Milestone 9 due in DY1, Q4. As a result we have provided a general project update for the remaining Milestones. Building the IDS Network: The PPS continued to make progress through DY1Q4 with regards to executing contracts with Providers in the PPS, of note having fully achieved speed and scale targets for 2bvii. Additionally, we have engaged with the KPMG MAX team with a hot spot location which will be contracting with the PPS for 3ai model 1 (integration of primary care and behavioral health). As of DY1, Q4 this location is actively doing the work associated with speed and scale for which numbers will be reported commencing DY2, Q1. Work performed in DY1, Q4 at this site could not be reported due to incomplete contracting status – the site is a part of a national Catholic Health System for which the contract is currently pending national review. This pilot site continues to learn lessons which will be leveraged with additional sites for 3ai models 1 and 2. The site continues to work on process improvement workflows to improve the coordination of care between the primary care physician and the behavioral health specialist. The site has also has adopted best practices such as (1) inclusion of behavioral health specialist embedded at the primary care practice on a full-time basis, (2) integration of PHQ-9 screening with successful referrals, and (3) warm hand-offs between the primary care and behavioral health provider for patients who have a positive screening for the brief intervention and the development of their treatment plan. PCMH Development: The PPS has developed a timeline for PCMH certification and distributed an RFP (March 2016) to vendors to help provide PCMH consulting, site plan development, and application reviews to assist practice sites with PCMH readiness towards PCMH Level 3 2014 certification. IT Strategies: The PPS has engaged with KPMG for the IT Target Operating Model program ("IT TOM") with a specific focus on 2ai. As of DY1, Q4 we have defined the clinical workflows (or Business Requirement Definitions) for all three presented scenarios which is about half of the required work for IT TOM. From these workshops we have learned the following: 1) Our PPS is someone unique in that we have five major entities and three RHIOs as opposed to one lead hospital and one RHIO; we can present best practices to each system but they may need to alter slightly to accommodate their needs and workforce structure. 2) Full collaboration between major entities, CBOs, RHIOs and patient consent are all required to achieve an Integrated Delivery System. 3) It will be a significant effort to create an interface with the many existing EHRs in our PPS. 4) Workforce right-sizing and training will be critical to success and 5)The process improvement methodology can be replicated for any of our other ten projects. The results of these workshops have been included as standing items on the agendas to the IT sub-committees, the IT Informatics and Data Governance Committee as

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
	well as the Board of Directors. As part of the IT Systems and Processes Domain 1 Project, CCN distributed a survey to understand our partner's current and planned RHIO connectivity. In March 2016 UHS Hospitals (which applied on behalf of CCN) received a CRFP award of up to $14,332,500 for development of the PPS IT Infrastructure. Following this announcement the PPS hired an Interim CIO to bolster planning around these efforts which will likely include EMR, RHIO, Care Coordination, and Population Health platforms.
Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	For the Care Compass Network 2ai project plan there are only a few reported steps within Milestone 9 due in DY1, Q4. As a result we have provided a general project update for the remaining Milestones. Building the IDS Network: The PPS continued to make progress through DY1Q4 with regards to executing contracts with Providers in the PPS, of note having fully achieved speed and scale targets for 2bvii. Additionally, we have engaged with the KPMG MAX team with a hot spot location which will be contracting with the PPS for 3ai model 1 (integration of primary care and behavioral health). As of DY1, Q4 this location is actively doing the work associated with speed and scale for which numbers will be reported commencing DY2, Q1. Work performed in DY1, Q4 at this site could not be reported due to incomplete contracting status – the site is a part of a national Catholic Health System for which the contract is currently pending national review. This pilot site continues to learn lessons which will be leveraged with additional sites for 3ai models 1 and 2. The site continues to work on process improvement workflows to improve the coordination of care between the primary care physician and the behavioral health specialist. The site has also has adopted best practices such as (1) inclusion of behavioral health specialist embedded at the primary care practice on a full-time basis, (2) integration of PHQ-9 screening with successful referrals, and (3) warm hand-offs between the primary care and behavioral health provider for patients who have a positive screening for the brief intervention and the development of their treatment plan. PCMH Development: The PPS has developed a timeline for PCMH certification and distributed an RFP (March 2016) to vendors to help provide PCMH consulting, site plan development, and application reviews to assist practice sites with PCMH readiness towards PCMH Level 3 2014 certification. IT Strategies: The PPS has engaged with KPMG for the IT Target Operating Model program ("IT TOM") with a specific focus on 2ai. As of DY1, Q4 we have defined the clinical workflows (or Business Requirement Definitions) for all three presented scenarios which is about half of the required work for IT TOM. From these workshops we have learned the following: 1) Our PPS is someone unique in that we have five major entities and three RHIOs as opposed to one lead hospital and one RHIO; we can present best practices to each system but they may need to alter slightly to accommodate their needs and workforce structure. 2) Full collaboration between major entities, CBOs, RHIOs and patient consent are all required to achieve an Integrated Delivery System. 3) It will be a significant effort to create an interface with the many existing EHRs in our PPS. 4) Workforce right-sizing and training will be critical to success and 5)The process improvement methodology can be replicated for any of our other ten projects. The results of these workshops have been included as standing items on the agendas to the IT sub-committees, the IT Informatics and Data Governance Committee as well as the Board of Directors. As part of the IT Systems and Processes Domain 1 Project, CCN distributed a survey to understand our partner's current and planned RHIO connectivity. In March 2016 UHS Hospitals (which applied on behalf of CCN) received a CRFP award of up to $14,332,500 for development of the PPS IT Infrastructure. Following this announcement the PPS hired an Interim CIO to bolster planning around these efforts which will likely include EMR, RHIO, Care Coordination, and Population Health platforms.
Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	For the Care Compass Network 2ai project plan there are only a few reported steps within Milestone 9 due in DY1, Q4. As a result we have provided a general project update for the remaining Milestones. Building the IDS Network: The PPS continued to make progress through DY1Q4 with regards to executing contracts with Providers in the PPS, of note having fully achieved speed and scale targets for 2bvii. Additionally, we have engaged with the KPMG MAX team with a hot spot location which will be contracting with the PPS for 3ai model 1 (integration of primary care and behavioral health). As of DY1, Q4 this location is actively doing the work associated with speed and scale for which numbers will be reported commencing DY2, Q1. Work performed in DY1, Q4 at this site could not be reported due to incomplete contracting status – the site is a part of a national

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
	Catholic Health System for which the contract is currently pending national review. This pilot site continues to learn lessons which will be leveraged with additional sites for 3ai models 1 and 2. The site continues to work on process improvement workflows to improve the coordination of care between the primary care physician and the behavioral health specialist. The site has also has adopted best practices such as (1) inclusion of behavioral health specialist embedded at the primary care practice on a full-time basis, (2) integration of PHQ-9 screening with successful referrals, and (3) warm hand-offs between the primary care and behavioral health provider for patients who have a positive screening for the brief intervention and the development of their treatment plan. PCMH Development: The PPS has developed a timeline for PCMH certification and distributed an RFP (March 2016) to vendors to help provide PCMH consulting, site plan development, and application reviews to assist practice sites with PCMH readiness towards PCMH Level 3 2014 certification. IT Strategies: The PPS has engaged with KPMG for the IT Target Operating Model program ("IT TOM") with a specific focus on 2ai. As of DY1, Q4 we have defined the clinical workflows (or Business Requirement Definitions) for all three presented scenarios which is about half of the required work for IT TOM. From these workshops we have learned the following: 1) Our PPS is someone unique in that we have five major entities and three RHIOs as opposed to one lead hospital and one RHIO; we can present best practices to each system but they may need to alter slightly to accommodate their needs and workforce structure. 2) Full collaboration between major entities, CBOs, RHIOs and patient consent are all required to achieve an Integrated Delivery System. 3) It will be a significant effort to create an interface with the many existing EHRs in our PPS. 4) Workforce right-sizing and training will be critical to success and 5)The process improvement methodology can be replicated for any of our other ten projects. The results of these workshops have been included as standing items on the agendas to the IT sub-committees, the IT Informatics and Data Governance Committee as well as the Board of Directors. As part of the IT Systems and Processes Domain 1 Project, CCN distributed a survey to understand our partner's current and planned RHIO connectivity. In March 2016 UHS Hospitals (which applied on behalf of CCN) received a CRFP award of up to $14,332,500 for development of the PPS IT Infrastructure. Following this announcement the PPS hired an Interim CIO to bolster planning around these efforts which will likely include EMR, RHIO, Care Coordination, and Population Health platforms.
Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	There were 4 steps for Milestone 9 due in DY1 Q4 (Steps 9j-9m). As of 3/31/16 all 4 steps have been completed. Previously Completed Steps: The Finance Committee discussed the Value-Based Payment (VBP) planning efforts, including summary of items prepared by HANYS as well as Care Compass Network (CCN) commitment as outlined in the DSRIP application during the August 3, 2015 meeting. The Finance Committee agreed on August 3 to coordinate the establishment of the VBP subcommittee chaired by John Collett which was seated and met on August 10. The VBP subcommittee is comprised of membership representing hospitals, homecare agencies, skilled nursing homes, outpatient services, and CBOs (Step 9b-Q2 Complete.). As part of the DY1Q2 deliverables, the VBP Committee has cultivated pathways (Step 9c-Q2 Complete.) between the committee and the rest of the system in order to survey and educate the current landscape of existing VBP arrangements amongst providers within the PPS. An education and communication plan was created and reviewed at the VBP committee meeting on 09/14/2015 (Step 9d-Q2 Complete.) and approved by the VBP subcommittee on 09/14/2015, being based on the VBP roadmap as released on July 22nd, 2015 by NYS Department of Health. On September 30th, 2015 a contract was executed with a vendor who has a high level of expertise and experience in VBP arrangements, securing educational resources for the outreach endeavors with the anticipation of completing those endeavors by 12/31/2015 (Step 9e-Q2 Complete.). A VBP Overview was provided individually for each of the 4 RPUs during Q3 as well as at the December 11, 2015 Stakeholder meeting (Step 9f – Q3 Complete). The PAC presentation was a recorded and made available on the CCN website for those who were unable to attend an in-person presentation. The readiness self-assessment survey was reviewed by the VBP Committee on October 19, 2015 and was open for a comment period through October30, 2015 (Step 9g – Q3 Complete), after which the survey was sent to partner organizations on November 30th (Step 9h – Q3 Complete). The assessment was sent to 40 organizations, and as of 12/31/2015 25 of them had been returned (62.5% response rate). The Finance Manager had collected, assembled, and analyzed results of the VBP Assessments received through December of 2015 (Step 9i – Q3 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
	Steps Completed in DY1, Q4: Project 2ai Milestone 9 steps 9j through 9m were previously aligned with the CCN Financial Stability Milestone 4 to gain efficiencies and synergies between comparable efforts. For reference, 2ai Milestone 9 Steps 9j through 9m correlate to Financial Stability Milestone 4 Steps 9 through 12, respectively. The VBP Readiness Self-Assessment Survey was reviewed by the CCN VBP Committee on October 19th, 2015 and was open for a comment period through October 30th, 2015, after which the survey was sent to partner organizations on November 30th. The survey was sent to 40 organizations, and as of 03/31/2016 25 of them had been returned (62.5% response rate). The Finance Manager had collected, assembled, and analyzed results of the VBP Assessments received through December of 2015. The VBP baseline assessment was prepared based on the survey results (Step 9j – Q4 Complete) and shared with providers as well as the VBP Sub-Committee, Finance Committee, PAC, and Coordinating Council (Step 9k – Q4 Complete). All received feedback was incorporated into the baseline (Step 9l – Q4 Complete), and on 03/08/2016 the CCN Board of Directors approved a resolution regarding their preference for the role of the PPS in VBP contracting (Step 9m – Q4 Complete). Overall progress of the Milestone and remaining step are on track with no barriers identified which would prevent completion by the respective due dates.
Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	For the Care Compass Network 2ai project plan there are only a few reported steps within Milestone 9 due in DY1, Q4. As a result we have provided a general project update for the remaining Milestones. Building the IDS Network: The PPS continued to make progress through DY1Q4 with regards to executing contracts with Providers in the PPS, of note having fully achieved speed and scale targets for 2bvii. Additionally, we have engaged with the KPMG MAX team with a hot spot location which will be contracting with the PPS for 3ai model 1 (integration of primary care and behavioral health). As of DY1, Q4 this location is actively doing the work associated with speed and scale for which numbers will be reported commencing DY2, Q1. Work performed in DY1, Q4 at this site could not be reported due to incomplete contracting status – the site is a part of a national Catholic Health System for which the contract is currently pending national review. This pilot site continues to learn lessons which will be leveraged with additional sites for 3ai models 1 and 2. The site continues to work on process improvement workflows to improve the coordination of care between the primary care physician and the behavioral health specialist. The site has also has adopted best practices such as (1) inclusion of behavioral health specialist embedded at the primary care practice on a full-time basis, (2) integration of PHQ-9 screening with successful referrals, and (3) warm hand-offs between the primary care and behavioral health provider for patients who have a positive screening for the brief intervention and the development of their treatment plan. PCMH Development: The PPS has developed a timeline for PCMH certification and distributed an RFP (March 2016) to vendors to help provide PCMH consulting, site plan development, and application reviews to assist practice sites with PCMH readiness towards PCMH Level 3 2014 certification. IT Strategies: The PPS has engaged with KPMG for the IT Target Operating Model program ("IT TOM") with a specific focus on 2ai. As of DY1, Q4 we have defined the clinical workflows (or Business Requirement Definitions) for all three presented scenarios which is about half of the required work for IT TOM. From these workshops we have learned the following: 1) Our PPS is someone unique in that we have five major entities and three RHIOs as opposed to one lead hospital and one RHIO; we can present best practices to each system but they may need to alter slightly to accommodate their needs and workforce structure. 2) Full collaboration between major entities, CBOs, RHIOs and patient consent are all required to achieve an Integrated Delivery System. 3) It will be a significant effort to create an interface with the many existing EHRs in our PPS. 4) Workforce right-sizing and training will be critical to success and 5)The process improvement methodology can be replicated for any of our other ten projects. The results of these workshops have been included as standing items on the agendas to the IT sub-committees, the IT Informatics and Data Governance Committee as well as the Board of Directors. As part of the IT Systems and Processes Domain 1 Project, CCN distributed a survey to understand our partner's current and planned RHIO connectivity. In March 2016 UHS Hospitals (which applied on behalf of CCN) received a CRFP award of up to $14,332,500 for development of the PPS IT Infrastructure. Following this announcement the PPS hired an Interim CIO to bolster planning around these efforts which will likely include EMR, RHIO, Care Coordination, and Population Health platforms.
Engage patients in the integrated delivery system through outreach and	For the Care Compass Network 2ai project plan there are only a few reported steps within Milestone 9 due in DY1, Q4. As a result we have provided a general project

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	update for the remaining Milestones. Building the IDS Network: The PPS continued to make progress through DY1Q4 with regards to executing contracts with Providers in the PPS, of note having fully achieved speed and scale targets for 2bvii. Additionally, we have engaged with the KPMG MAX team with a hot spot location which will be contracting with the PPS for 3ai model 1 (integration of primary care and behavioral health). As of DY1, Q4 this location is actively doing the work associated with speed and scale for which numbers will be reported commencing DY2, Q1. Work performed in DY1, Q4 at this site could not be reported due to incomplete contracting status – the site is a part of a national Catholic Health System for which the contract is currently pending national review. This pilot site continues to learn lessons which will be leveraged with additional sites for 3ai models 1 and 2. The site continues to work on process improvement workflows to improve the coordination of care between the primary care physician and the behavioral health specialist. The site has also has adopted best practices such as (1) inclusion of behavioral health specialist embedded at the primary care practice on a full-time basis, (2) integration of PHQ-9 screening with successful referrals, and (3) warm hand-offs between the primary care and behavioral health provider for patients who have a positive screening for the brief intervention and the development of their treatment plan. PCMH Development: The PPS has developed a timeline for PCMH certification and distributed an RFP (March 2016) to vendors to help provide PCMH consulting, site plan development, and application reviews to assist practice sites with PCMH readiness towards PCMH Level 3 2014 certification. IT Strategies: The PPS has engaged with KPMG for the IT Target Operating Model program ("IT TOM") with a specific focus on 2ai. As of DY1, Q4 we have defined the clinical workflows (or Business Requirement Definitions) for all three presented scenarios which is about half of the required work for IT TOM. From these workshops we have learned the following: 1) Our PPS is someone unique in that we have five major entities and three RHIOs as opposed to one lead hospital and one RHIO; we can present best practices to each system but they may need to alter slightly to accommodate their needs and workforce structure. 2) Full collaboration between major entities, CBOs, RHIOs and patient consent are all required to achieve an Integrated Delivery System. 3) It will be a significant effort to create an interface with the many existing EHRs in our PPS. 4) Workforce right-sizing and training will be critical to success and 5)The process improvement methodology can be replicated for any of our other ten projects. The results of these workshops have been included as standing items on the agendas to the IT sub-committees, the IT Informatics and Data Governance Committee as well as the Board of Directors. As part of the IT Systems and Processes Domain 1 Project, CCN distributed a survey to understand our partner's current and planned RHIO connectivity. In March 2016 UHS Hospitals (which applied on behalf of CCN) received a CRFP award of up to $14,332,500 for development of the PPS IT Infrastructure. Following this announcement the PPS hired an Interim CIO to bolster planning around these efforts which will likely include EMR, RHIO, Care Coordination, and Population Health platforms.

Milestone Review Status

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

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

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 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 DY1 Q4 should include patients previously reported in DY1 Q3 plus new patients engaged in DY1 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	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4
PPS Reported	Baseline Commitment	0	1,530	1,800	3,773
	Quarterly Update	0	0	0	0
	Percent(%) of Commitment		0.00%	0.00%	0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment		0.00%	0.00%	0.00%

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
Fail	The PPS failed to meet at least 80% of its actively engaged commitments for DY1 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.b.iv.3 - Prescribed Milestones

Instructions :

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

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1b. The 2biv Project Team, through the Clinical Governance Committee and Board of Directors will identify and adopt evidence-based Care Transition Intervention Models appropriate for implementation and adoption by the Performing Provider System (PPS).		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 1c. Using the approved Care Transition Protocols, the 2biv Project Team and Project Champion from each of the nine PPS hospitals will perform a facility gap analysis to identify differences between the hospital care transition operating model versus the PPS Care Transition Plan. Following the assessment, the PPS will engage with hospitals who meet the criteria of the PPS Care Transition Protocol for Care Transitions Work. Organizations who do not meet the criteria, if any, would have training provided on use of the standardized protocol.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1d. The PPS will leverage the Regional Performing Unit (RPU) model to ensure consistency as well as customizability throughout PPS. RPU-specific Clinical Governance subcommittees (e.g., quality committees) will be used to determine strategies at the RPU level as well as perform oversight of adherence to established Care Transition Protocols.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will	DY2 Q4	Project	N/A	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
ensure appropriate post-discharge protocols are followed.										
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 2d. The 2biv Project Team and PMO will collaborate with the Medicaid Managed Care organizations and Health Homes, with focus on strategy development with MCOs and Health Homes to: i) improve care coordination, access, and delivery, ii) strengthen the community and safety-net infrastructure, and iii) prevent illness and reduce disparities. Risk assessment will begin at admission. Within 24 hours of admission, the Care Transition RN will identify what each beneficiary requires for a smooth and safe transition from the acute care hospital. As part of this assessment, the team will leverage tools (e.g., screening tool) to identify whether the patient is i) Not Eligible for Health Home (HH) Services, ii) Eligible for HH and connected to a HH, or iii) Eligible for HH and not connected to a HH. The use of a standardized Care Transition Protocol (CTP) will identify the root cause for admission, assess/address clinical, functional, behavioral, available/lack of available resources and social determinants for each beneficiary. Data analytic and population health technologies will provide a foundation for quality improvement and enable beneficiaries to be effectively risk stratified. A longitudinal plan of care will be developed in concert with appropriate service and community based organizations including Health Homes. In an attempt to break down the barriers between systems (e.g., with MCOs) of mental health and long term care, and in		Project		In Progress	04/01/2015	06/30/2016	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
recognition of the complex psycho-social needs of Medicaid beneficiaries as identified in the Care Compass Network community needs assessment, the CTP program will work to facilitate linkages with programs across systems. With the beneficiary's consent, the CTP program will refer to Health Homes within the PPS for ongoing care management services. A Health Home care manager will assist in coordinating the ongoing medical, mental health, substance abuse and social service needs of qualifying beneficiaries. Wherever appropriate, beneficiaries will be referred for additional long term care services such as home delivered meals and personal emergency response services. Beneficiaries will also be referred to outpatient services offered through CBOs where appropriate.										
Task 2e. Collaboratively use claims data to identify gaps in care.		Project		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		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2i. Payer agreements will be reviewed for Managed Care Organizations (MCOs) with patients in the PPS region.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 2j. Leverage telehealth strategies. (Beneficiaries suffering from 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.		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
Telemonitoring promotes self-care behaviors and a sense of control for beneficiaries.)										
Milestone #3 Ensure required social services participate in the project.	DY2 Q4	Project	N/A	Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Required network social services, including medically tailored home food services, are provided in care transitions.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3b. Identify required social service agencies using feedback from the CBO Engagement Council.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3c. Identify required social service agencies using responses to the PPS' readiness assessment.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3d. Collaborate with the local social services department as well as other CBOs to identify beneficiaries. Community based organizations have been actively engaged since PPS inception. To further identify and cultivate the breadth of services required to deliver project interventions, a CBO Council has been established and meets weekly. The nine county PPS has been divided into four Regional Performance Units (RPUs) to better understand the resources at the community level, foster the relationships among CBOs, and target providers to support outreach, patient activation and care coordination. An Academic Detailing approach will be used to educate and engage providers on Care Transitions as well as other PPS DSRIP projects. Goals of academic modeling include, but are not limited to: improving clinician knowledge of new clinical guidelines or health threats, selecting treatments to increase effectiveness and safety or to decrease overuse, improving patient education by helping clinicians communicate vital information to patients, increasing diagnosis or screening for overlooked conditions, and increasing utilization of complimentary resources such as community-based public health programs.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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
planned discharges.										
Task Policies and procedures are in place for early notification of planned discharges.		Provider	Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.		Provider	Hospital	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4e. Through the Clinical Governance Committee and the IT Committee as needed, identify methods of early notification of planned discharges and case manager patient visits.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4f. Establish protocols regarding early notification of planned discharges and case manager patient visits through the Clinical Governance Committee.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4g. Leverage RPU model to ensure consistency as well as customizability throughout PPS. RPU-specific Clinical Governance subcommittees will be used to determine strategies and effectiveness of implementation at the RPU level.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	DY2 Q4	Project	N/A	In Progress	04/01/2015	06/30/2016	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		In Progress	04/01/2015	06/30/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5b. Create a Cross Continuum Team made up of representatives from hospitals, discharge planning staff, ED staff, behavioral health staff, home care services, and medical directors and administrators from skilled nursing facilities. Members of the Cross Continuum Team can be selected to engage 2-3 beneficiaries in meetings to solicit feedback.		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
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	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6c. Through the Clinical Governance Committee, identify appropriate policies and procedures to ensure a 30-day transition of care period with consideration of the following nine elements: 1. Outreach and Engagement - Prior to discharge the Care Transition nurse will identify what each beneficiary requires for a smooth and safe transition from the acute care hospital. This includes but is not limited to: gain knowledge of social and physical factors that affect functional status at discharge (transportation, medication, specialized medical equipment, financial ability to sustain independent living and their feasibility to acquire what is needed). 2. Health Literacy - Assessment of the beneficiary's and caregiver's level of engagement and empowerment is key to developing a safe discharge to home. Assessment of the beneficiary and caregiver's knowledge of the disease process must take place during the hospital stay as limited health literacy has been shown to undermine beneficiary follow up with primary care provider, decreased adherence to treatment protocols, and their own engagement in their care. 3. Meet Patients Physically Where They Are - The Care Transition		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
nurse or appropriate healthcare representative (e.g. Community Health Advocate, Home Care agencies, etc.) will visit beneficiary while in inpatient setting and then visit the patient at home. Home visit(s) will emphasize best practices in care transitions including: medication reconciliation, follow-up with primary care physician and/or mental health clinician, awareness of worsening symptoms of a person's health condition, home safety, and connections to home and community-based supports. 4. Family/Caregiver Involvement - Family caregivers play a significant role in keeping loved ones living at home and in the community. The Care Transition nurse will engage with caregivers wherever possible and appropriate. Following the wishes of the beneficiary, family caregivers will be included in education about symptom management and medication management. Caregivers will be informed about support services and respite care to enable them to care for themselves while providing care. 5. Create Warm Hand Offs/ Minimize Hand Offs - Wherever possible, beneficiaries will be connected with CBOs where they have a preexisting relationship. 6. Community Navigation - Identified as a vital component of an effective 30 day transition of care plan, all beneficiaries will be introduced to the array of Community Navigation services within the PPS tailored to each beneficiary's unique profile. 7. Provide Incentives - Care Compass Network will develop guidelines and policy to incentivize beneficiaries for engagement and achievement of personal milestones. The Care Transition nurse will work within this framework. 8. Create Virtual Support Groups/ RMS Panel - Beneficiaries will be offered the option to participate with their peers in diagnosis specific, social support groups, or as a member on the CHNA Panel. 9. Maximize Physician Support - Physician recommendation is a key contributor to patient's acceptance as well as the initial presentation of the programs to beneficiaries and caregivers. Discuss all standards of care being utilized to insure understanding.										
Task 6d. Leverage RPU model to ensure consistency as well as customizability throughout PPS. RPU-specific Clinical Governance subcommittees will be used to determine strategies at the RPU level.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task		Project		Completed	04/01/2015	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
6e. Cross continuum team to meet (e.g., monthly or as needed) to monitor performance of participating organizations. QA Plan reviewed by the cross continuum team would include PPS use claims and lab reporting and related data fields and be reported to the associated RPU Quality Committee as required.										
Task 6f. Adjust procedures and protocols accordingly, informed by provider performance.		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	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7b. Leverage telehealth platforms. (Beneficiaries suffering from chronic disease and are at an increased risk of re-hospitalization are candidates for the use of telehealth. Telemonitoring services have proven to be effective among Medicaid beneficiaries for managing such conditions as hypertension, CHF, COPD, and diabetes, with improved health outcomes and reductions in hospital admissions and emergency department usage. Telemonitoring promotes self-care behaviors and a sense of control for beneficiaries.)		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7c. Care Transitions will utilize existing and new referral management technologies to enhance the patient referral process. A care management system will support the development of patient care plans across various care settings with alerts and automated follow-up reminders and Telehealth will be used to monitor patients in the community through a required and developing robust broadband/Wi-Fi network. The Care Management System will connect to the RHIOs to provide a foundation in support of the PPS Integrated Delivery System. Investment in IT is a baseline requirement for successful care coordination. Utilization of care coordination software and an integrated electronic health record with connectivity to the RHIO are essential to creating capacity within the provider network. Utilization of Office Based Case Managers, RNs and Allied Health Professionals will also be an important factor. Technology such as Telehealth and telemedicine will connect patients to		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

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
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
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.	rachaelm	Quarterly Report (no attachment necessary)	44_PMDL2803_1_4_20160427163432_Narrative.docx	Quarterly report narrative (exceeded character limits)	04/27/2016 04:34 PM
Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	rachaelm	Quarterly Report (no attachment necessary)	44_PMDL2803_1_4_20160427164050_Narrative.docx	Quarterly report narrative for Milestone 5 (exceeded character limits)	04/27/2016 04:40 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	Neither Milestones 1, 4, 6, or 7, nor the respective tasks are due for reporting in Q4. However, each remains on target for completion by their associated due dates. As reported in the Q3 report, Clinical Governance Committee endorsed an Eric Coleman-like model for the project, which was approved by the BOD on October 13, 2015. This model uses an evidence-based process and includes four pillars for coordinated care. The four components or pillars of coordinated care are as follows: 1. Medication reconciliation and teaching using tools from an Eric Coleman like model 2. Ensuring follow up appointment with PCP after hospital discharge 3. Disease/condition-specific teaching as well as recognition of signs and symptoms of worsening disease and how to appropriately respond 4. Personal Health Record is created with the patient to improve communication with providers During Q4, the Clinical Governance Committee, at the request of the Care Transition Project Team, reviewed and endorsed modifications to the previously approved care transition protocol model to better serve the Medicaid populations. The modification was approved by the BOD March 8, 2016. The Health Coach would be trained in the Care Transition Intervention Model (Eric Coleman like model) as well as being trained in the guidelines for 30 Days Care Transitions and motivational interviewing. 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
	Health Coach would not be required to have any specific certification or license. The approved modified Protocol with the four pillars for coordinated care is: • Medication self-management • Primary care provider or specialist follow-up • Patient understanding of "red flag" indicators of worsening condition and appropriate next steps • Use of a patient-centered health record that helps guide patients through the care process. The modifications in the model allow non-clinicians to conduct health coaching thereby allowing partnerships with community based organizations to fill gaps from hospital discharge to ambulatory follow-up care. In addition, the nine guidelines to ensure a 30-day transition of care drafted by the Care Transition project team were endorsed at the February 25, 2016 Clinical Governance Committee and approved by the Board of Directors on March 8, 2016.
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.	See attached document for narrative.
Ensure required social services participate in the project.	As of 12/31/15 CCN has completed the requirements for this milestone. No changes to report for DY1-Q4.
Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	Neither Milestones 1, 4, 6, or 7, nor the respective tasks are due for reporting in Q4. However, each remains on target for completion by their associated due dates. As reported in the Q3 report, Clinical Governance Committee endorsed an Eric Coleman-like model for the project, which was approved by the BOD on October 13, 2015. This model uses an evidence-based process and includes four pillars for coordinated care. The four components or pillars of coordinated care are as follows: 1. Medication reconciliation and teaching using tools from an Eric Coleman like model 2. Ensuring follow up appointment with PCP after hospital discharge 3. Disease/condition-specific teaching as well as recognition of signs and symptoms of worsening disease and how to appropriately respond 4. Personal Health Record is created with the patient to improve communication with providers During Q4, the Clinical Governance Committee, at the request of the Care Transition Project Team, reviewed and endorsed modifications to the previously approved care transition protocol model to better serve the Medicaid populations. The modification was approved by the BOD March 8, 2016. The Health Coach would be trained in the Care Transition Intervention Model (Eric Coleman like model) as well as being trained in the guidelines for 30 Days Care Transitions and motivational interviewing. The Health Coach would not be required to have any specific certification or license. The approved modified Protocol with the four pillars for coordinated care is: • Medication self-management • Primary care provider or specialist follow-up • Patient understanding of "red flag" indicators of worsening condition and appropriate next steps • Use of a patient-centered health record that helps guide patients through the care process. The modifications in the model allow non-clinicians to conduct health coaching thereby allowing partnerships with community based organizations to fill gaps from hospital discharge to ambulatory follow-up care. In addition, the nine guidelines to ensure a 30-day transition of care drafted by the Care Transition project team were endorsed 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
	the February 25, 2016 Clinical Governance Committee and approved by the Board of Directors on March 8, 2016.
Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	See attached document for quarterly report narrative.
Ensure that a 30-day transition of care period is established.	Neither Milestones 1, 4, 6, or 7, nor the respective tasks are due for reporting in Q4. However, each remains on target for completion by their associated due dates. As reported in the Q3 report, Clinical Governance Committee endorsed an Eric Coleman-like model for the project, which was approved by the BOD on October 13, 2015. This model uses an evidence-based process and includes four pillars for coordinated care. The four components or pillars of coordinated care are as follows: 1. Medication reconciliation and teaching using tools from an Eric Coleman like model 2. Ensuring follow up appointment with PCP after hospital discharge 3. Disease/condition-specific teaching as well as recognition of signs and symptoms of worsening disease and how to appropriately respond 4. Personal Health Record is created with the patient to improve communication with providers During Q4, the Clinical Governance Committee, at the request of the Care Transition Project Team, reviewed and endorsed modifications to the previously approved care transition protocol model to better serve the Medicaid populations. The modification was approved by the BOD March 8, 2016. The Health Coach would be trained in the Care Transition Intervention Model (Eric Coleman like model) as well as being trained in the guidelines for 30 Days Care Transitions and motivational interviewing. The Health Coach would not be required to have any specific certification or license. The approved modified Protocol with the four pillars for coordinated care is: • Medication self-management • Primary care provider or specialist follow-up • Patient understanding of "red flag" indicators of worsening condition and appropriate next steps • Use of a patient-centered health record that helps guide patients through the care process. The modifications in the model allow non-clinicians to conduct health coaching thereby allowing partnerships with community based organizations to fill gaps from hospital discharge to ambulatory follow-up care. In addition, the nine guidelines to ensure a 30-day transition of care drafted by the Care Transition project team were endorsed at the February 25, 2016 Clinical Governance Committee and approved by the Board of Directors on March 8, 2016.
Use EHRs and other technical platforms to track all patients engaged in the project.	Neither Milestones 1, 4, 6, or 7, nor the respective tasks are due for reporting in Q4. However, each remains on target for completion by their associated due dates. As reported in the Q3 report, Clinical Governance Committee endorsed an Eric Coleman-like model for the project, which was approved by the BOD on October 13, 2015. This model uses an evidence-based process and includes four pillars for coordinated care. The four components or pillars of coordinated care are as follows: 1. Medication reconciliation and teaching using tools from an Eric Coleman like model 2. Ensuring follow up appointment with PCP after hospital discharge 3. Disease/condition-specific teaching as well as recognition of signs and symptoms of worsening disease and how to appropriately respond 4. Personal Health Record is created with the patient to improve communication with providers During Q4, the Clinical Governance Committee, at the request of the Care Transition Project Team, reviewed and endorsed modifications to the previously approved care transition protocol model to better serve the Medicaid populations. The modification was approved by the BOD March 8, 2016. The Health Coach would be trained in 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
	Care Transition Intervention Model (Eric Coleman like model) as well as being trained in the guidelines for 30 Days Care Transitions and motivational interviewing. The Health Coach would not be required to have any specific certification or license. The approved modified Protocol with the four pillars for coordinated care is: • Medication self-management • Primary care provider or specialist follow-up • Patient understanding of "red flag" indicators of worsening condition and appropriate next steps • Use of a patient-centered health record that helps guide patients through the care process. The modifications in the model allow non-clinicians to conduct health coaching thereby allowing partnerships with community based organizations to fill gaps from hospital discharge to ambulatory follow-up care. In addition, the nine guidelines to ensure a 30-day transition of care drafted by the Care Transition project team were endorsed at the February 25, 2016 Clinical Governance Committee and approved by the Board of Directors on March 8, 2016.

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Complete	
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	
Milestone #7	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.4 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

IPQR Module 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 DY1 Q4 should include patients previously reported in DY1 Q3 plus new patients engaged in DY1 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	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4
PPS Reported	Baseline Commitment	0	68	68	171
	Quarterly Update	0	0	0	240
	Percent(%) of Commitment		0.00%	0.00%	140.35%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment		0.00%	0.00%	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
sculley	Rosters	44_PMDL3215_1_4_20160427150240_CCN_2bvii_DY1Q4_-_Patient_Registry.xlsx	Patient Registry file for INTERACT Project pertaining to DY1Q4.	04/27/2016 03:03 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task INTERACT principles implemented at each participating SNF.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Nursing home to hospital transfers reduced.		Provider	Nursing Home	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task INTERACT 3.0 Toolkit used at each SNF.		Provider	Nursing Home	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1d. SNF INTERACT Project Champion to perform a baseline assessment of staff to identify existing INTERACT expertise within their facility and work with the Workforce Development and Transition Team (WDTT) to determine staffing needs .		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	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	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1f. The PPS INTERACT Project team, PMO, and Finance Manager will incorporate the core components of the 2bvii project to the PPS budget and funds flow model. Once finalized and approved by the Finance Committee and Board of Directors the PPS will negotiate INTERACT implementation contracts with the associated SNFs.		Project		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		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
the project as well as benefits available for collaborating in these efforts with the PPS. If facility/provider is unable to continue the commitment required, PMO will conduct a root cause analysis to assist the affected facility(s) to determine provider specific risks and mitigation factors.										
Task 1h. INTERACT Champion at each contracted SNF facility to ensure INTERACT principles are incorporated into the facilities' Quality Assurance and Process Improvement (QAPI) process and report to PMO.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #2 Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	DY2 Q4	Project	N/A	In Progress	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	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2b. Identify an INTERACT champion per facility.		Project		In Progress	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		In Progress	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		In Progress	04/02/2015	09/30/2016	04/02/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #3 Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	DY2 Q4	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3c. Project team and Project Management Office to assess existing care pathways and other clinical tools for monitoring chronically ill patients. The project team and PMO will identify the common care paths and create educational tools and present for review by the Clinical Governance Committee for review and adoption.		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 3d. The educational tools created in Step 3c will be distributed to the SNFs and hospitals by the Provider Relations to be used as guidance in evaluating and monitoring patients. As needed additional education can be provided by the project lead and/or the trainor from the Workforce team.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3e. Workforce team and Provider Relations will educate hospital representatives on care pathways and preventive protocols created in step 3c in effort to align these throughout the PPS.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3f. Incorporate care pathway tools into SNF daily procedures. Staff within the SNF to provide feedback as necessary to the INTERACT champion & co-champion within the SNF.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3g. The INTERACT champion, co-champions and project team will meet at a minimum of once a year to review INTERACT care paths and related practice guidelines. The project team will adjust as needed using the Clinical Governance Committee.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #4 Educate all staff on care pathways and INTERACT principles.	DY3 Q4	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Training program for all SNF staff established encompassing care pathways and INTERACT principles.		Provider	Nursing Home	In Progress	04/01/2015	09/30/2016	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4b. Use INTERACT Champions in each facility to provide training sessions encompassing care pathways and INTERACT principles (e.g., annually or as seen appropriate by related parties) to all key staff including MD, FNP, PA etc. Record SNF training dates along with the number of staff trained. Review the content of the training annually with the Clinical Governance Committee and evaluate for adjustments needed.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4c. Each SNF will incorporate training of care pathways and INTERACT principles into new clinical staff orientation.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	DY2 Q4	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Advance Care Planning tools incorporated into program (as		Project		In Progress	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
evidenced by policies and procedures).										
Task 5b. Social Services Departments within each participating SNF to evaluate current Advance Care Planning tools and validate that usage is reflected in policies and procedures.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5c. Social Services Departments within each participating SNF and facility INTERACT champion to ensure Advance Care Planning tools meet the requirements of the INTERACT program. The Social Services Department and SNF Interact Champion/Co-Champion will adjust tools as needed working with the PMO and advised by the Clinical Governance Committee. The entire Interdisciplinary Team within the SNF will be educated on any changes to the Care Planning Tools within the month following the updates.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5d. The facility INTERACT champion and/or co-champion will audit use of advance care planning tools within the SNF and provide audit results to the PMO for review with the Clinical Governance Committee. The audits must be performed annually at a minimum.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5e. Social Services Department within each participating SNF to conduct meetings with residents and family members using the facility established Advance Care Planning tools.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5f. The facility INTERACT champion and/or co-champion and Social Services Department within the SNF will reassess Advance Care Planning tools annually at a minimum. The INTERACT champion, co-champion and Social Services Department within the SNF will update the tools as required. The entire Interdisciplinary team within the SNF will be educated on any changes to the Care Planning Tools within the month following the updates.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #6 Create coaching program to facilitate and support implementation.	DY2 Q4	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task INTERACT coaching program established at each SNF.		Provider	Nursing Home	In Progress	04/01/2015	06/30/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 6b. Identify an INTERACT Champion located within each SNF.		Project		In Progress	04/01/2015	03/31/2016	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
This Champion will be used for train-the-trainer programs within each respective organization to facilitate sustainability.										
Task 6c. Leverage Champions and facility Co-Champions in order to ensure continuity of training programs across units (facilities and RPUs).		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 6d. Integrate training efforts and needs with existing Performing Provider System (PPS) resources, such as the Workforce Strategy team and relationships built through the Provider Relations team.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 6e. Each SNF will prepare standardized progress reports (e.g., monthly) to the Care Compass Network PMO. The progress reports will include overview of key metrics, deliverables, as well as areas of success and implementation challenges at a minimum in order to assist the SNF during the implementation process.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	DY2 Q4	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Patients and families educated and involved in planning of care using INTERACT principles.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 7b. The Project Team, in conjunction with the PMO and Workforce Team (as needed) will create an educational strategy which will be leveraged for patient and family/caretakers distribution to supplement information found on INTERACT website regarding care planning. The strategy will outline the materials to be distributed, methods for refreshing materials for pertinence, as well as what the delivery method(s) will be for distribution. The plan will, at minimum, incorporate concepts as further outlined in the steps outlined in this plan.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
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		In Progress	04/01/2015	03/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 7d. The PPS will facilitate the achievement of interdisciplinary meetings focused on advanced care planning for the PPS		Project		In Progress	04/01/2015	03/31/2016	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
community of related providers.										
Task 7e. Identify Stop and Watch tool in SNF admissions packet and discuss with family members.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 7f. The comprehensive training strategy, materials, and distribution methods (as well as targeted audiences) will be delivered on at minimum an annual basis beginning in DSRIP year 2.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
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	09/30/2016	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	09/30/2016	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	09/30/2016	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	09/30/2016	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	09/30/2016	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 8e. SNF facilities are to receive education to inform them tracking/trending improvements in quality of care can be achieved most efficiently with an electronic health record that allows increased accessibility, sharing of data and analysis of data. Proof of education from each participating facility shall be reported to the PMO.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task		Project		In Progress	04/02/2015	09/30/2016	04/02/2015	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
8f. Each participating SNF to create and communicate a Nursing Home Capabilities List to local hospital emergency room staff, local hospital discharge planners and local hospital physicians at a minimum.										
Milestone #9 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2016	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	03/31/2016	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.		Project		In Progress	04/01/2015	03/31/2016	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	03/31/2016	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	03/31/2016	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	03/31/2016	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 9g. The project team and PMO to identify metrics to be used (such as Attachment J metrics) through the Clinical Governance Committee. Additionally, alternative or substitutive interventions as identified during the root cause analysis process will be		Project		In Progress	04/01/2015	03/31/2016	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
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	In Progress	04/01/2015	03/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2016	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		In Progress	04/01/2015	03/31/2016	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		In Progress	04/01/2015	03/31/2016	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		In Progress	04/01/2015	03/31/2016	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		In Progress	04/01/2015	03/31/2016	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

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at	Narrative: There is one task scheduled to be completed for the INTERACT project Milestone 1 in DY1, Q4 (Step 1d). Care Compass Network (CCN) seeks to defer this Milestone to a future quarter (DY2,Q2) to allow CCN to complete the contracting process with each of the PPS Skilled Nursing Facilities (23 in total) as well as to 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
http://interact2.net.	the INTERACT training tentatively planned for June/July 2016. This will also align this step with the correlated tasks associated with Milestone 2 and not impact the overall due date for Milestone 1. As of DY1, Q4 CCN has completed phase I of INTERACT contracting by targeting the three facilities that have already implemented the INTERACT toolkit and completed the requisite training with their staff. As a result CCN was able to report 240 engaged members for speed and scale, versus the planned year one target of 180. Moving into DY2 CCN has met one on one with 15 of the 23 SNFs, three of which have fully executed contracts and INTERACT implementation completed. Continued discussions are in process. CCN is also seeking engagement of SNFs in the region who have not previously attested with CCN predominantly due to engagement with overlapping PPSs in dissimilar SNF DSRIP projects.
Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	There are no steps due in the DY1Q4 reporting period for INTERACT Milestone 2 however Care Compass Network (CCN) continues to make progress in regards to completing this milestone and four associated steps. Through the end of March the INTERACT Project Manager and regional Provider Relations staff have met individually with 15 of the 23 SNF's in the PPS with 3 of those signing contracts to participate in the INTERACT project. There are several additional pre-contracting meetings on schedule for April 2016. After a CCN Partner executes the contract to participate in the INTERACT project, the CCN 2bvii Project Manager and regional Provider Relations team member meets with the Partner to gather the Facility Champion, INTERACT Champion and INTERACT Co-Champion for each facility(steps 2a, 2b and 2c). Once the INTERACT training is scheduled the SNF's who have signed contracts or have attested but not yet signed will be invited to send their identified Champion and Co-Champion to the 2 day INTERACT training sessions to be hosted by Interact TEAM Strategies, LLC (step 2d). We are in contract discussions with Interact TEAM Strategies, LLC for provision of these training services and via hosting regional training forums in June/July of 2016. CCN will offer the INTERACT 2-day training session in each of the 4 Regional Performing Units (RPUs) in an effort to maximize participation from across the PPS. Initial interest from engaged SNFs has been high as the training not only provides good overview of the toolkit but also allows for any licensed health care professional attending the training to become a Certified INTERACT Champion 4.0.
Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	There is one task scheduled to be completed for the INTERACT project Milestone 3 in DY1, Q4 (Step 3c). As of 3/31/16 this step is being reported as Complete. At the October 8, 2015 Clinical Governance Committee meeting the 10 INTERACT Care Paths (from the INTERACT Decision Support Toolkit) were successfully accepted and recommended for approval for use by the PPS. Following review by the Clinical Governance Committee the 10 INTERACT Care Paths were presented to and approved by the Board of Directors at the November 10, 2015 Board meeting. As the SNF's sign contracts to participate in the INTERACT project with Care Compass Network we will be providing them the 10 Care Paths. These tools are also available publically on the PPS publically available SharePoint. Formal training of the Care Paths for the SNF INTERACT Champion and Co-Champion will be included as part of the 2 day INTERACT training to be given by Interact TEAM Strategies, LLC during a series of dates to be determined in June/July of 2016. The 2 day INTERACT training sessions can also be attended by regional hospital staff. As an alternative, appropriate regional hospital staff will be invited to attend a 2 hour INTERACT leadership program that provides an overview of INTERACT. Interact TEAM Strategies, LLC will be providing the 2 hour training and we expect that session to be scheduled in July 2016. Since steps 3d and 3e require training of these 10 Care Paths to the SNF's and to hospital staff we are deferring steps 3d and 3e to the end of DY2, Q2 for completion.
Educate all staff on care pathways and INTERACT principles.	There are no steps due in the DY1Q4 reporting period for INTERACT Milestone 4 however Care Compass Network (CCN) continues to make progress in regards to completing this milestone and associated steps. SNF's who have signed contracts or have attested but not yet signed will be invited to send their identified Champion and Co-Champion to the 2 day INTERACT training sessions to be hosted by Interact TEAM Strategies, LLC. We are currently reviewing the Letter of Agreement from Interact TEAM Strategies, LLC and once complete the training sessions will be scheduled. Tentatively we are looking at hosting the sessions in the June/July timeframe. The PPS will be offering the INTERACT 2 day training session in each of the 4 Regional Performing Units (RPU) in an effort to maximize participation from across the PPS. Once the INTERACT Champion and Co-Champion have been trained in INTERACT a train-the-trainer model will be used to roll out training in each of the Skilled Nursing Facilities. The monthly reporting templates that have been distributed to SNF's includes information regarding training that will be reported monthly to Care Compass Network. Since the INTERACT training is tentatively scheduled for June/July 2016 we are deferring this milestone and three associated steps (4a-4c) to DY2, Q4 to allow the SNF's time to complete the INTERACT training for all staff in each facility.
Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	There are no steps due in the DY1Q4 reporting period for INTERACT Milestone 5 however Care Compass Network (CCN) continues to make progress in regards to completing this milestone and associated steps. Training in INTERACT is a pre-requisite for Social Service Departments within each SNF to evaluate the Advance Care Planning tools they have and compare to the INTERACT toolkit. The INTERACT training has yet to be scheduled but is tentatively scheduled for June/July 2016. SNF's who have signed contracts or have attested but not yet signed will be invited to send their identified Champion and Co-Champion to the 2 day INTERACT training sessions

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 be hosted by Interact TEAM Strategies, LLC. After the INTERACT training has been completed we feel the SNF will have the necessary information required to complete step 5b. As a result we are deferring step 5b to DY2, Q2.
Create coaching program to facilitate and support implementation.	There are four tasks scheduled to be completed for the INTERACT project Milestone 6 in DY1, Q4 (Steps 6b-6e). We are deferring all four of these steps to a future quarter (DY2,Q3) to allow Care Compass Network to complete the requisite INTERACT training for the Skilled Nursing Facilities in the PPS, as well as the contracting required as part of a step in Milestone 1 (due DY2, Q2). SNF's who have signed contracts or have attested but not yet signed will be invited to send their identified Champion and Co-Champion to the 2 day INTERACT training sessions to be hosted by Interact TEAM Strategies, LLC. Tentatively we are looking at hosting the sessions in the June/July timeframe. The PPS will be offering the INTERACT 2 day training session in each of the 4 Regional Performing Units (RPU) in an effort to maximize participation from across the PPS. Once the INTERACT Champion and Co-Champion have been trained in INTERACT a train-the-trainer model will be used to roll out training in each of the Skilled Nursing Facilities (steps 6a – 6d). The monthly reporting templates that have been distributed to SNF's includes information regarding training that will be reported monthly to Care Compass Network (step 6e). Since the INTERACT training is scheduled for June/July 2016 we are deferring steps 6a-6e to be completed by DY2,Q3.
Educate patient and family/caretakers, to facilitate participation in planning of care.	There are three tasks scheduled to be completed for the INTERACT project Milestone 7 in DY1, Q4 (Steps 7b-7d). We are deferring all three of these steps to a future quarter (DY2,Q3) to allow Care Compass Network to fully align the associated 2bvii tasks/milestones with the upcoming PPS-wide INTERACT training for the Skilled Nursing Facilities across the PPS. Training in INTERACT is a pre-requisite for educating families/caretakers relative to the INTERACT toolkit. The INTERACT training is being scheduled for the June/July timeframe in 2016. SNF's who have signed contracts or have attested but not yet signed will be invited to send their identified Champion and Co-Champion to the 2 day INTERACT training sessions to be hosted by Interact TEAM Strategies, LLC. After the INTERACT training has been completed and training performed within each facility we feel the SNF will have the necessary information required to complete the milestone and associated steps. As a result we are deferring this milestone and all six associated steps to DY2, Q3.
Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	There are no steps due in the DY1Q4 reporting period for INTERACT Milestone 8. As part of the pre-contracting meetings with the SNF's and the Safety Net Hospitals we are collecting information on the EHR systems currently in use along with RHIO Connectivity that is in use already. Additionally, as part of the IT Systems & Processes Domain Project Milestone 4, the Care Compass Network has developed a plan for engaging attributed members in Qualifying Entities. This milestone and associated steps correlate directly to deliverables in other Domain 2 & 3 projects. INTERACT Milestone 8 is the same as Project 2ai Milestone 4 and Project 3aii Milestone 8 due by DY3, Q4. Step 8a is the same as Project 3bi Milestone 3, step 3a which is due DY3, Q4. Step 8b is the same as Project 2ai Milestone 4 step 4c and Project 3aii Milestone 8 step 8d both due DY3, Q4. Step 8c is the same as Project 2ai Milestone 5, step 5e due in DY3, Q4. Steps 8d and 8e are also being deferred to DY3, Q4 to align with the other steps associated with this milestone. In summary we are deferring this milestone and five of the six associated steps to DY3, Q4.
Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	This milestone and remaining six tasks were scheduled to be completed in DY1, Q4 (Steps 9a-9d, 9f-9g). We are deferring the milestone and six steps to a future quarter to allow Care Compass Network (CCN) to schedule INTERACT training for the Skilled Nursing Facilities in the PPS, to roll out the INTERACT training in each of the facilities and then to allow time to evaluate use of INTERACT in order to identify additional interventions. It is important to note the INTERACT project co-leads are both Administrators at SNFs within the PPS and are involved in a SNF Administrator meeting in the South Regional Performing Unit (RPU) where information is shared with other SNF management. In the other RPUs Care Compass Network is looking to build a SNF Coalition group to formalize regional collaboration among the SNFs. The PPS has created the infrastructure for this milestone by seeding the quality committees in each RPU with representation from Skilled Nursing Facilities in the PPS. In conjunction with the contracting process a monthly reporting template was created for each of the 11 projects. This template will be used to report data to CCN on a monthly basis. In the appendix C for the INTERACT project the SNFs are required to provide feedback at least twice a year regarding program efficacy, best practices, and areas which have opportunity for improvement. Once the SNFs execute contracts they will be (if not already) measuring and sharing outcomes with CCN. This information is a key component to completing this milestone so the milestone and six steps will be deferred to be completed by DY3, Q3 so that training, implementation, data gathering, Quality Committee review, and implementation reports can be completed and results of them reported. Additionally, CCN has begun to familiarize various stakeholders to quality metrics by means of reviewing (1) documentation submission requirements associated with each project and (2) reviewing MAPP DSRIP dashboards. This overview of metric information has been presented to the Coordinating council, RPU Leads, PAC Executive Council and the RPU Operating Committees.
Use EHRs and other technical platforms to track all patients engaged in the project.	This milestone and five tasks were scheduled to be completed in DY1, Q4 (Steps 10a-10e). We are deferring the milestone and five steps to a future quarter (DY2, Q3) to allow Care Compass Network to schedule INTERACT training for the Skilled Nursing Facilities in the PPS since INTERACT training is required for facilities to count

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
	Medicaid members as actively engaged. The PPS has created the infrastructure for this milestone by creating and distributing a monthly reporting template for each of the 11 projects. This template will be used to report and track actively engaged members to CCN on a quarterly basis. Organizations that have EHR systems (so far 12 of the 15 SNFs we have met with are already using an EHR) can use their existing system to report actively engaged to CCN if they have a similar report in their EHR. As far as being ready to report actively engaged, we have 3 SNFs in the PPS that have had training in INTERACT already, one of which has signed a contract to participate in the INTERACT project. Many of the SNFs use subsets of the INTERACT toolkit but have not had any kind of INTERACT training. The INTERACT training has yet to be scheduled but is tentatively scheduled for June/July 2016. SNFs who have signed contracts or have attested but not yet signed will be invited to send their identified Champion and Co-Champion to the 2 day INTERACT training sessions to be hosted by Interact TEAM Strategies, LLC. After the INTERACT training has been completed and training performed within each facility we feel the remaining SNFs will have the necessary information required to complete the milestone and associated steps. As a result we are deferring this milestone and all five associated steps to DY2, Q3.

Milestone Review Status

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

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

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 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 DY1 Q4 should include patients previously reported in DY1 Q3 plus new patients engaged in DY1 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	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4
PPS Reported	Baseline Commitment	0	0	1,900	5,700
	Quarterly Update	0	0	0	0
	Percent(%) of Commitment			0.00%	0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment			0.00%	0.00%

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
Fail	The PPS failed to meet at least 80% of its actively engaged commitments for DY1 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.c.i.3 - Prescribed Milestones

Instructions :

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

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2016	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task Community-based health navigation services established.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
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		Project		In Progress	04/01/2015	03/31/2016	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
Workforce Team and the Project 2ci Team will work in conjunction with the contracted organizations providing navigation services to develop a robust training program/resource guide. An initial training will be mandatory for organizations who contract with the PPS to perform Project 2ci related navigation services, supplemented by a community related resource guide. An ongoing, regular training schedule will be established for quality improvement and efficiency. Inherent to ongoing training will be the cross-pollination of Community Health Advocates from across the PPS. Best practices will be discussed and assessed by CHAs from adjacent RPUs and neighboring PPSs as they are able to participate. Once this role's competencies and services provided have been approved and contracts have been executed between CCN and participating organizations, related training will delivered.										
Task 1e. Navigation Collaboration - The PPS will develop forums to assist Navigators in the identification and adoption of leading practices, lessons learned, overview of results (e.g., metrics to highlight whether navigated services resulted in reduced ED and IP admissions) and general 'tricks of the trade' which have been learned through first hand navigation experiences. Through these forums feedback on the PPS training and resources will be solicited to determine efficacy of materials, which in tandem with program metrics and results will allow the 2ci Project Team and PMO to gather suggestions to the Workforce team for plan modification (as needed).		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
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	DY2 Q4	Project	N/A	In Progress	04/01/2015	06/30/2016	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
services providers.										
Task Resource guide completed, detailing medical/behavioral/social community resources and care protocols developed by program oversight committee.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2b. The 2ci Project Team will develop a Program Oversight Group to develop a Community Care Resource Guide. The Program Oversight Group will be comprised of members from the 2ci Project Team, PMO, Workforce Development Team, as well as representatives from medical/behavioral health, 211 centers, community nursing, and social services providers (including faith based organizations that provide support for chronic illness, etc.). Once developed the Resource Guide will be approved by the Clinical Governance Committee and be used to supplement PPS navigation related training efforts (as outlined in Milestone 1). Review of this resource will occur annually at a minimum for any potential alterations.		Project		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	03/31/2016	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		Project		In Progress			01/01/2016	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	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
will be offered in a variety of mediums such as training documents available to augment organizations existing training materials, one on one in person training when applicable for agencies new to navigation services or requesting this level of training. As the Community Resource Guide will provide information regarding the Managed Care Organizations websites training will include some navigation of those systems to better engage the non-insured and non or low utilizing members. An ongoing, regular training will be established for quality improvement and efficiency.										
Milestone #3 Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Navigators recruited by residents in the targeted area, where possible.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3b. The PPS will leverage the Workforce Development Team to provide oversight to the creation/review of community navigator job descriptions, roles/responsibilities, with consideration for regional needs of the nine county PPS (as appropriate).		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3c. The Workforce Development Team will work with the Project Management Office to provide PPS partner organizations support related to their recruitment of Community Health Advocates/Community Navigators with consideration for how to obtain input from the local community talent pool.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3d. The Workforce Development Team and Provider Relations Team will collaborate with PPS Partners to confirm they have available tools and resources, including PPS developed resource guides to facilitate the training of new community navigators. As required by the PPS partner organization contract the existing and newly hired community navigators will receive and certify completion of PPS training materials.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Resource appropriately for the community navigators, evaluating placement and service type.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Navigator placement implemented based upon opportunity assessment.		Project		In Progress	04/01/2015	03/31/2016	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
Task Telephonic and web-based health navigator services implemented by type.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
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	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Navigators have partnerships with transportation, housing, and other social services benefitting target population.		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5b. Project Management Office will assess existing non-clinical resources and their relationships to CBOs providing navigation services in order to utilize and maximize current resource base.		Project		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		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5d. Project Management Office will ensure delivery of training and orient all community navigators to non-clinical resources by partnering with the eight participating providers using existing curriculums which will be reviewed and modified to create standard protocols then used to train navigators using classroom techniques, small groups, 1-on-1 training, modeling, and shadowing. Additionally, Industry on line training through associations or contractors will be included to provide additional		Project		On Hold	04/01/2015	12/31/2016	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
support and reinforcement to understand vital concepts.										
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		In Progress			01/01/2016	09/30/2016	09/30/2016	DY2 Q2
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	In Progress	04/01/2015	06/30/2016	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		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6b. The 2ci Project Team and PMO will collaborate with the Program Oversight Group to identify hot spotting opportunities/approaches for where navigators are needed within the PPS. Following initial assessments, the Program Oversight Group will help to monitor the optimal patient-to-community health advocate ratio by comparing previous ratios and workflows and what is needed for meeting established Speed and Scale needs.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	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		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6d. The 2ci Project Team, PMO, and participating CBOs will develop discharge processes for patients who receive navigation services. Triggers for discharge, proper follow up post-discharge, and other methodological considerations will be borrowed from existing dicharge processes, synthesized with current and future needs, and/or created anew. These processes will be assessed and approved by the Clinical Governance Committee.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6e. As required, the IT & Data Governance Committee will be		Project		In Progress	04/01/2015	06/30/2016	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
solicited to identify tools/resources required for the tracking of patient flows, databases, and/or reporting.										
Milestone #7 Market the availability of community-based navigation services.	DY2 Q4	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Health navigator personnel and services marketed within designated communities.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
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	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 8b. The 2ci Project Team, in collaboration with the PMO and IT Workgroup will develop a set of standard Electronic Health Record (EHR) or other technical platform core requirements for organizations participating in the 2ci project to confirm navigated patient related services are properly documented and recorded and aligned with DSRIP needs.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 8c. As required, the PPS will provide technical assistance and training to CHA organizations to assure appropriate utilization and implementation of EMRs and/or other technical platforms to		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

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
track all patients engaged in the 2ci project.										

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.	rachaelm	Quarterly Report (no attachment necessary)	44_PMDL3403_1_4_20160428165328_Narrative_M1.docx	Quarterly report narrative (exceeded character limits)	04/28/2016 04:53 PM

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.	See attached document for quarterly report narrative.
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.	For DY1Q4 the step 2c and 2d are due. The PPS is requesting to defer the training efforts outlines in 2d by placing step 2d on hold and replacing with step 2e which better addresses training geared towards the community resource guide itself. Along with this change in steps we are requesting to defer Milestone 2. Currently a mockup has been completed of the Community resource guide which was presented to each Regional Performing Unit within the PPS and brought forth to Clinical Governance on March 24th for their endorsement (Step 2c-Complete) This version of the Community Resource Guide is being added to and will be available for use, PPS wide for the public and navigators, by June of 2016 (original MS2 due date), but, the training documentation and training schedule will be created as we complete the resource guide and place in use. The training documentation is actively being created as all members of the PPS have given feedback regarding the mockup of the Community Resource Guide. This guide will at first be searchable through direct links listed for area organizations but the 2.c.i project team is working to obtain quotes on the iCarol system currently used to search the existing 211 databases. The idea resource guide will be a searchable website that links the existing known databases across the PPS, as well as any identified past the boundaries of the PPS that are relevant to the attributed members. So we wish to defer the milestone until we can complete the training documentation as well as initial training of navigators for the PPS.
Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.	There are no Milestone 3 steps due for completion for DY1Q4. This Milestone remains in process and all steps and the milestone are due for completion on time. As the PPS continues to contract for this service and project the PMO will then be able to analyze placement and outcomes as detailed in 2ci Milestone 4. This analysis will aid the workforce development group and 2ci Project Team in collaborating with where new navigation services should be developed and then on region specific recruitment of navigators from the specified region in need of services.
Resource appropriately for the community navigators, evaluating placement and service type.	The overall milestone and related steps listed as in process (steps 4a and 4b) were initially scheduled for completion in DY1,Q4 and are now being deferred to DY2, Q2. Milestone 4 has strong dependencies on other 2ci Project Milestones as well as Workforce implementation efforts, in particular with regards to resourcing services and placement appropriately. The correlated Workforce Milestone 1 ("Define target workforce state") was deferred from DY1, Q4 to DY2, Q1 as per guidance from the DOH in December 2015. For many organizations the adaptation of web and telephonic services to achieve the goals of this Milestone are new concepts. Based on our initial work we expect to need to customize approach and/or content on a case by case basis, however the overall program itself will retain a PPS level of coordination and roll-out to allow for proper achievement of community needs.
Provide community navigators with access to non-clinical resources, such as transportation and housing services.	For DY1,Q4 step 5b is due for completion and is being submitted as complete. Step 5d is also due for completion, however, the PPS is requesting to re-define and clarify the requirements by creating a new step, 5e. Step 5e has been assigned a due date of DY2, Q2, 9/30/16.

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
	In the creation of the Community Resource Guide under milestone 2 non-clinical services such as transportation, housing and the like are identified for inclusion within the guide and are listed, by county, for use in helping navigators appropriately resource for a potential needed service outside the scope of their present agency . (step 5b – Complete) Once live, The Community Resource Guide will be used in conjunction with trainings and reports to analyze any gaps not listed within the guide for use for community based navigation services. This will, overall, help to more robustly identify these non-clinical services to navigators (milestone 5 – in process) Step 5d we are placing on hold and resubmitting as step 5e to better align and clarify the training for this portion with these non-clinical services, availability and correct use given the social determinate of health as identified for each member. Additionally, this training will also be provided by more than the original eight listed organizations. This training will eventually be encapsulated within Milestone 1 training of a community navigator. (Step 5e – In Process)
Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.	No milestones or steps are due in DY1,Q4 for Milestone 6. However, in assessing the implementation plan the PPS would like to defer the milestone and step 6b and e to better align efforts with the work in progress In conjunction with the 2.d.i work group on Milestone 3 due in DY2Q2 and Milestone 16 due in DY4Q2 which both directly correlate to the efforts in 2.c.i milestone 6. The IT, Informatics, & Data Governance committee has completed assessment of the PPS for IT needs and integration with a timeline available. The 2.c.i project team is working in conjunction with this committee to identify the needs of the partnering organizations within the PPS and will continue to work with the committee on the proposed timeline and role out of the integration initiative. System racking of case loads, management and members will be a unique to each community based organization depending on level of care and number of attributed lives touched. The 2.c.i project team in conjunction with the oversight committee is currently working on the discharge process, post-discharge and follow up protocols. Along with the 2.d.i project team work continues on hot spotting for the noninsured and non or low utilizing members which will also be incorporated into the entire access to navigation services and subsequently discharge process. Step 6c and 6d are currently in progress and expected to be completed on time.
Market the availability of community-based navigation services.	There are currently no milestones or steps due for DY1Q4, however, the marketing strategy is being reviewed and developed by the 2.c.i project team. Additionally, the PPS hired a Marketing Manager in DY1, Q4 who will help coordinate the PPS-wide communication strategy associated with this Milestone. Upcoming priorities of the 2ci Project Team will include the awareness and reinforcement of existing services within the community to help shine a light on under-utilized services. Two priority needs identified include the marketing of the existing 2-1-1 infrastructure, what navigation services are and can do to benefit a member as well as how navigation services can augment clinical care for primary care and hospitalization. Through this strategy the existing services are still utilized and reinforced within the communities while allowing room for new services to be easily added as gaps are identified.
Use EHRs and other technical platforms to track all patients engaged in the project.	Neither the milestone nor any steps are due in DY1,Q4. The 2.c.i group has been actively working with the CCN IT team throughout the IT plan development, including frequent one-on-one meetings with the IT consultants from WeiserMazars to discuss technical requirements of the 2ci project as well as factors for implementation such as timing and existing partner capabilities. Once finalized training will be created around the individualized EHR and process for tracking actively engaged patients within each system.

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	
Milestone #3	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 #4	Pass & Ongoing	
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 2.c.i.4 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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 DY1 Q4 should include patients previously reported in DY1 Q3 plus new patients engaged in DY1 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	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4
PPS Reported	Baseline Commitment	0	0	1,296	3,240
	Quarterly Update	0	0	0	0
	Percent(%) of Commitment			0.00%	0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment			0.00%	0.00%

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
Fail	The PPS failed to meet at least 80% of its actively engaged commitments for DY1 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		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
2c. Leverage the Project 11 Planning team to identify and solicit organizations and/or individuals to join the PAM Survey Training Team. In this effort the project planning team will leverage local expertise at the RPU level (through RPU Leads in the CBO Engagement Council) to educate and gauge partner interest and expertise for the initial round of Insignia training. In addition, the 2di Project Team will collaborate with the PPS Provider Relations team to identify CBOs for PAM survey training team/administration based on results from the PPS Pre-engagement Assessment (e.g., organizations with indicated skillsets/expertise in outreach/patient activation). Organizations attending the initial Insignia training session on 9/29/2015 will participate on the PAM training team.										
Task 2d. Members of the Care Compass Network PAM Training Team (e.g., those trained by Insignia on 9/29) will be contracted with the PPS, starting in October 2015, to receive payment for subsequently training either (a) their internal organization, or (b) training other PPS 2di participating organizations, in the utilization of the PAM Survey system. The Care Compass Network Project Management Office will centrally coordinate future training efforts, a process which will be aligned with the execution of partner contracts. The Care Compass Network Project Management team will subsequently track training and refresher course participation on an ongoing basis using a roster for individuals trained and monthly reports from partners/Trainers.		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	In Progress	04/01/2015	03/31/2016	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		In Progress	04/01/2015	03/31/2016	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		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
Emergency Departments that serve a high percentage of the uninsured by zip code as tracked by hospitals.										
Task 3d. Identify "hot spots" by analyzing the utilization low-utilizing and/or non-utilizing Medicaid enrollee Salient related data and reports. Leveraging the local expertise from each of the four Regional Performance Unit members, the 2di Project Team will also assess non-healthcare resource use for both non-utilizing and low-utilizing Medicaid enrollees.		Project		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		In Progress	04/01/2015	03/31/2016	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	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
health literacy, and cultural competency.										
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	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

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 to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.										
Task Procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6b. Care Compass Network will develop a focus team to align the steps and deliverables associated with this milestone with HIPAA and legal requirements to receive MCO enrollee lists.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6c. Non Utilizing - The PPS project team will develop a procedure/protocol for connecting non-utilizing enrollees with PCPs. The focus will aim to identify the intial PCP (if any) previously identified by the patient, from where the CCN care coordination or navigation services will attempt to consent the patient and educate them regarding the benefits of collaboration with a PCP and utilization of other PPS benefits.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6d. Low Utilizing - The PPS project team will develop a procedure/protocol for connecting low-utilizing patients with PCPs. The focus will aim to identify the patients corresponding PCP (if any) and utilize PPS care coordinationg or navigation services to re-establish patient connectivity to PCP resources already available to the member. As appropriate available claims data on recent encounters may be utilized to promote the re-engagement process with the PCP.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

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
6e. As required, obtain input at the RPU/PPS level through the Clinical Governance Committee for related procedures and protocols.										
Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	DY3 Q4	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 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,		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
including the utilization of the RMS vendor.										
Task 8c. Consult with RMS on tactics to engage beneficiaries in a manner that will result in their participation.		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	06/30/2016	04/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation		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 patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement										
Task 9b. Once the contract with Insignia is finalized, obtain Insignia delivered training to identify and determine the utilization of PAM components.		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		In Progress	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		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 10d. Increase access and availability for non-emergent care for the target populations.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	DY3 Q4	Project	N/A	Completed	04/01/2015	12/31/2015	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	12/31/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task		Provider	PAM(R) Providers	Completed	04/01/2015	12/31/2015	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
Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.										
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	09/30/2015	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	09/30/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 13b. Get patient activation training for the CHAs and 211 staff (if needed)		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 13c. Organize regular meetings between community navigators and PAM surveyers for best practices and ongoing dialogue.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Milestone #14 Ensure direct hand-offs to navigators who are prominently placed	DY3 Q4	Project	N/A	In Progress	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
at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.										
Task Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.		Provider	PAM(R) Providers	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
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		In Progress	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	In Progress	04/01/2015	06/30/2016	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		In Progress	04/01/2015	06/30/2016	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 providing services specifically to these populations for education and informative purposes.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 15e. Obtain and/or develop training for navigators on insurance options and healthcare resources specific to UI, NU, and LU populations. Execution of training for navigators related to the 2di project will be incorporated to training also provided as a result of the 2ci project. Through the Project Management Office, Care Compass Network will track training and refresher course participation on an ongoing basis using a roster for individuals trained and monthly reports from partners.		Project		In Progress	04/01/2015	06/30/2016	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 15f. At a minimum, PPS protocols will be reviewed on an annual basis. During this time, the 2di Project team will also review the current insurance options landscape and adjust the impacted training strategies accordingly.		Project		In Progress	04/01/2015	06/30/2016	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	06/30/2016	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Timely access for navigator when connecting members to services.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 16b. Develop a priority matrix to assist with referring patients to necessary primary and preventative services in conjunction with the Clinical Governance Committee.		Project		On Hold	04/01/2015	03/31/2016	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	06/30/2016	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #17 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	DY2 Q4	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
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		In Progress	04/01/2015	06/30/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task		Project		In Progress	04/01/2015	06/30/2016	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
17c. Collaborate among project participants to determine whether or not a patient has taken the PAM by both screening participants as well as coding appropriately for LUs, NUs, and the uninsured by using a shared IT resource.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
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.	rachaelm	Contracts and Agreements	44_PMDL3603_1_4_20160427130418_Executed_RHN_Appendix_C_2di.pdf	Contract documentation with Rural Health Network of South Central New York	04/27/2016 01:04 PM
	rachaelm	Contracts and Agreements	44_PMDL3603_1_4_20160427130347_Executed_FamilyChildren's_Appendix_C_2di.pdf	Contract documentation with Family & Children's Society	04/27/2016 01:03 PM
	rachaelm	Contracts and Agreements	44_PMDL3603_1_4_20160427130249_Executed_CHN_Appendix_C_2di.pdf	Contract documentation with Chenango Health Network	04/27/2016 01:02 PM
Survey the targeted population about healthcare needs in the PPS' region.	rachaelm	Other	44_PMDL3603_1_4_20160427131048_List_of_Community_Forums.xlsx	List of community forums held	04/27/2016 01:10 PM
	rachaelm	Other	44_PMDL3603_1_4_20160427131004_Feb_2016_Accessing_Healthcare_Survey_Report.pdf	Documentation of surveys from RMS Panel	04/27/2016 01:10 PM
	rachaelm	Other	44_PMDL3603_1_4_20160427130912_Cultural_Competency_Survey_Report.pdf	Documentation of surveys from RMS Panel	04/27/2016 01:09 PM
Include beneficiaries in development team to promote preventive care.	rachaelm	Other	44_PMDL3603_1_4_20160427131826_RMS_Group_1_List.xlsx	List of contributing patient members participating in program development and awareness efforts	04/27/2016 01:18 PM
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.	rachaelm	Other	44_PMDL3603_1_4_20160429192743_Training_Schedule_Navigators_2di.xlsx	Uploaded in previous quarterly report upon changing milestone to complete - error saving and continuing without file upload	04/29/2016 07:27 PM
	rachaelm	Other	44_PMDL3603_1_4_20160429192633_Navigator_Training_Roster_+_Credentials.xlsx	Uploaded in previous quarterly report upon changing milestone complete - error saving and continuing without file upload	04/29/2016 07:26 PM
Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	rachaelm	Other	44_PMDL3603_1_4_20160429192947_Navigator_Training_Roster.xlsx	Uploaded in previous quarterly report upon changing milestone to complete - error saving and continuing without file upload	04/29/2016 07:29 PM
	rachaelm	Other	44_PMDL3603_1_4_20160429192921_Insignia_Training_Roster.pdf	Uploaded in previous quarterly report upon changing milestone to complete - error saving and continuing without file upload	04/29/2016 07:29 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 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 reported as Complete in DY1, Q3. During the DY1, Q4 reporting period the PPS has engaged four additional organizations with executed contracts for 2di including three CBOs which are as follows: -Rural Health Network of South Central New York -Chenango Health Network -Family & Children's Society of Broome County Each of these organizations have previously been engaged as Care Compass Network (CCN) Master Trainers and will be responsible for training their internal staff as well as other CCN partner organizations as they require PAM® training. These contracts have been included in this report. Consistent with the statewide approach for the PAM® survey, completed survey information from these organizations is being uploaded to Flourish® and will be reported for speed and scale purposes in the upcoming DY2, Q1 timeframe. Additional contracts are in draft and will be reported through this Milestone for future quarterly reports.
Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	This Milestone was reported as Complete in DY1, Q3. During the DY1, Q4 report, there are no changes to report at this time.
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.	Using a mixed methodology, the Care Compass Network (CCN) 2di Project Manager, in conjunction with multiple work groups (Complete – Step 3b.), performed an analysis to identify potential "hot spot" areas for the uninsured, non-utilizing, and low-utilizing target populations. As a starting point, the team used SPARCS (Statewide Planning and Research Cooperative System) "self-pay" category data to identify the uninsured's ER utilization by zip code within the PPS. Instances greater than 500 were flagged as potential hot spots and noted on a map by zip code with red circles indicating greater than 1000 instances (7 zip codes total) and yellow indicating between 500 and 1000 instances (6 zip codes total) (Complete – Step 3c.). In summary, this data indicated seven locations as hot spots for the uninsured, including UHS Binghamton General Hospital, UHS Wilson Medical Center, Our Lady of Lourdes, Cayuga Medical Center, Cortland Regional Medical Center, UHS Chenango Memorial Hospital, and Corning Hospital. This hot spot model assumes that the uninsured population remains local to the point of service. Of note, each of these locations are PPS attested partners and have executed or are in process of executing 2di contracts with CCN. Salient data can be used to determine by zip code where the underutilizing populations of Medicaid Members are with some limits which are described later in this narrative. This can be sorted by ER utilization and compared with uninsured data or can indicate the member's zip of residence. For the target populations, input was solicited from the local CCN operating units called Regional Performing Units (RPUs) as well as the 2di Project Team to identify non-healthcare resources used to expand on the initial hot spots identified via SPARCS data (Complete – Step 3d.). Salient reports proved of little use in terms of locating this population due to most services provided by non-healthcare sources being non-billable for Medicaid. As a claims database, many non-healthcare resources provided to Medicaid members are not captured. Furthermore, low and non-utilizing members are estimated using filtering capabilities for a very limited definition. This complication in identifying the populations for this project is only compounded by the fact that the uninsured are not included in the Salient database at all. Care Compass Network's Pre-Engagement Assessment was also used to make note of CBOs aligned to reach this population. Following this logic, CCN identified and removed organizations who provide qualifying services. CBOs that self-identified as seeing uninsured, non-utilizing, and low-utilizing individuals were noted and compiled in addition to those collected through the aforementioned methods in a map and organized by region according to the four CCN RPUs (Complete – Step 3e.). The overall 2di heat map by zip for the uninsured, non-utilizers, and low-utilizers is anticipated to be completed in DY2, Q1. The remaining step to completion for this Milestone has been deferred as well as the Milestone itself to DY2, Q2. While hot spots have been identified, contracting continues to occur on a rolling basis. To account for the need for organizations to begin surveying in their immediate location before gaining confidence to perform outreach otherwise (assuming this is primarily gaining momentum in DY2, Q1), a DY2, Q2 target for completion is more appropriate.
Survey the targeted population about healthcare needs in the PPS' region.	This Milestone was reported as Complete in DY1, Q3. During the DY1, Q4 reporting period, additional surveys have been completed using the RMS Panel by the Medicaid member & uninsured panel as well as the healthcare provider, community organization, and community member panels completed during the DY1, Q4 timeframe 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
	been included in the documentation in order to substantiate the continual effort to engage the target population regarding healthcare needs in the PPS' region. As of Q4, the total Medicaid or uninsured members engaged in the survey included 203 members. The panel topics and dates of collection are as follows: Cultural Competency Survey: 01/06/15-01/26/15. Response rate: 29% Accessing Healthcare Survey: 02/24/15-03/09/15. Response rate: 32% Compared to industry the Care Compass Network (CCN) panel continues to participate at above average levels. RMS' panel management trends would indicate a response rate of between 25% and 35%, which CCN continues to yield response rates on the higher end of the range throughout Q4. CCN has engaged a multi-year engagement with RMS for the continued engagement of the panel members and will continue reporting panel engagement progress in future quarters.
Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	This Milestone was reported as Complete in DY1, Q3. During the DY1, Q4 report, there are no changes to report. Additional providers should be listed in the DY2, Q1 report as partner organizations train their staff following contract execution.
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.	This Milestone continues to be an outstanding item discussed between 2di project managers across the NY PPSs as they grapple with strategies to engage MCOs and compliantly share the type of information described in the prescribed language.
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.	This Milestone was previously due in DY1, Q3, however was placed on hold until the State develops the associated cohort methodology. As of the filing of the DY1, Q4 report, the methodology has not yet been prepared, as such the Milestone remains On Hold.
Include beneficiaries in development team to promote preventive care.	This Milestone was reported as Complete in DY1, Q3. During the DY1, Q4 report, the RMS panel is comprised of 203 Medicaid Members and uninsured individuals who reside in the PPS nine county region, 77 of which began participating in our surveys in the DY1, Q3 timeframe. Ongoing panel management continues to be an effort of the PPS in Q4 to account for variation and changes in Medicaid enrollment status. The RMS vendor has been engaged to continually look for new group participation from Medicaid members to ensure consistent participation levels are retained. In addition to existing efforts to recruit new members, in Q4 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 did Facebook boosts. CCN also printed panel card handouts with information and the link on the Care Compass Network which are provided to provider/practice sites and continue to attract new membership. These efforts have contributed to a large boost in engagement and have already

Care Compass Network (PPS ID:44)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	demonstrated success in DY1, Q4 as well. Lastly, the panel continues to be asked about their needs and access to preventative care.
Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.	While the PPS has established a screening tool to determine the status of patients (whether they are uninsured, non-utilizing, or low-utilizing), the hold on the baselining methodology (Milestone 7) and the deferment of Milestone 6 makes total completion unlikely by the original projected target date. In order to "average… to calculate a baseline measure for that year's cohort", a baseline methodology needs to be established. Additionally, in order to appropriately link the Medicaid Member to their PCP assigned by the MCO, the relationship described in Milestone 6 should requisitely be established. Nonetheless, the PPS will make efforts to begin to collect other reporting requirements such as screen status and PCP links established through the 2ci Navigation efforts. Therefore, the end date for this Milestone has been updated to DY2, Q4. The PPS anticipates a low-level report of PAM® components to be included in the DY2, Q1 report.
Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	With a projected DY3, Q4 end date, the strategies to increase the care for these populations is in its earliest stages with the primary and pressing need being a better understanding of the population eligible to participate in the 2di project. In the meantime, Salient data has been mined to develop our understanding as best as possible before survey results are received. In future quarters, the results in Flourish® and numbers Care Compass Network partners report can begin to inform our understanding of the NU, LU, and UI populations with the aid of our data analytics team, the 2di project team, and the Clinical Governance Onboarding Quality Subcommittees in each of the Regional Performing Units (RPUs).
Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	This Milestone was reported as Complete in DY1, Q3. During the DY1, Q4 reporting period, there are no changes or updates to report at this time. As more navigators are trained, the list originally submitted in the DY1, Q3 report will be updated and uploaded with future quarter submissions. During the DY1, Q4 quarterly report, an error occurred requiring the Milestone and task, "list of community navigators formally trained in the PAM(R)", to be placed "In Progress" and then reported as "Complete" once more to allow the PPS to upload the PIT providers. The was required in order to "Save and Continue" in order to attest. Additionally, the Human Services Coalition also would be listed here but is not currently in the PIT (to be added to PIT at future date).

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 a process for Medicaid recipients and project participants to report complaints and receive customer service.	This Milestone was reported as Complete in DY1, Q2. During the DY1, Q4 reporting period, there are no Changes to Report, the CCN process for complaint reports and customer service was developed and reported as complete in DY1, Q2. There have been no modifications or revisions to this document since. Additionally, there have been no complaints.
Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	This Milestone was reported as Complete in DY1, Q2. During the DY1, Q4 reporting period, there are no Changes to Report, the CCN Master Trainer team was reported as complete in DY1, Q2. Care Compass Network anticipates providing updated documentation in DY2, Q1 as partner organizations with executed contract train their staff and report. During the DY1, Q4 quarterly report, an error occurred requiring the Milestone and task, "list of community navigators formally trained in the PAM(R)", to be placed "In Progress" and then reported as "Complete" once more to allow the PPS to upload the PIT providers. The was required in order to "Save and Continue" in order to attest. Additionally, the Human Services Coalition also would be listed here but is not currently in the PIT (to be added to PIT at future date).
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.	Using a mixed methodology, the Care Compass Network (CCN) 2di Project Manager, in conjunction with multiple work groups (Complete – Step 3b.), performed an analysis to identify potential "hot spot" areas for the uninsured, non-utilizing, and low-utilizing target populations. As a starting point, the team used SPARCS (Statewide Planning and Research Cooperative System) "self-pay" category data to identify the uninsured's ER utilization by zip code within the PPS. Instances greater than 500 were flagged as potential hot spots and noted on a map by zip code with red circles indicating greater than 1000 instances (7 zip codes total) and yellow indicating between 500 and 1000 instances (6 zip codes total) (Complete – Step 3c.). In summary, this data indicated seven locations as hot spots for the uninsured, including UHS Binghamton General Hospital, UHS Wilson Medical Center, Our Lady of Lourdes, Cayuga Medical Center, Cortland Regional Medical Center, UHS Chenango Memorial Hospital, and Corning Hospital. This hot spot model assumes that the uninsured population remains local to the point of service. Of note, each of these locations are PPS attested partners and have executed or are in process of executing 2di contracts with CCN. Salient data can be used to determine by zip code where the underutilizing populations of Medicaid Members are with some limits which are described later in this narrative. This can be sorted by ER utilization and compared with uninsured data or can indicate the member's zip of residence. For the target populations, input was solicited from the local CCN operating units called Regional Performing Units (RPUs) as well as the 2di Project Team to identify non-healthcare resources used to expand on the initial hot spots identified via SPARCS data (Complete – Step 3d.). Salient reports proved of little use in terms of locating this population due to most services provided by non-healthcare sources being non-billable for Medicaid. As a claims database, many non-healthcare resources provided to Medicaid members are not captured. Furthermore, low and non-utilizing members are estimated using filtering capabilities for a very limited definition. This complication in identifying the populations for this project is only compounded by the fact that the uninsured are not included in the Salient database at all. Care Compass Network's Pre-Engagement Assessment was also used to make note of CBOs aligned to reach this population. Following this logic, CCN identified and removed organizations who provide qualifying services. CBOs that self-identified as seeing uninsured, non-utilizing, and low-utilizing individuals were noted and compiled in addition to those collected through the aforementioned methods in a map and organized by region according to the four CCN RPUs (Complete – Step 3e.). Care Compass Network initiated its contracting process and has three community navigator (Project 2ci) contracts executed in DY1, Q4. Placement of these organizations' employees (and others to follow) within other organizations at hot spot locations is aimed to line up with Milestone 4 of the 2ci project, "Resource appropriately for the community navigators, evaluating placement and service type" due DY2, Q2.
Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	In DY1, Q3, Care Compass Network researched the current landscape of insurance through the NYS Health Exchange with the help of its partners, compiling a list of Qualified Health Plans by county as a resource (Complete – Step 15b.). Additionally, Care Compass Network's Pre-Engagement Assessment was used to make note of CBOs aligned to reach the target population. After eliminating organizations who provide qualifying services, CBOs that self-identified as seeing uninsured, non-utilizing, and low-utilizing individuals were noted and compiled in addition to those

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
	collected based on RPU input (Complete – Step 15c.). The remaining steps for completion should align with the 2ci Community Navigator deliverable, the completion of the community resource guide (Milestone 2 of the 2ci project plan), in order to streamline training. This would allow for the opportunity to educate navigators on insurance options, healthcare resources, and other community resources available to the uninsured, non-utilizing and low utilizing Medicaid Members. Therefore, the projected date of completion has been updated as such to DY2, Q3.
Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	With the help of the 2di project team, CBOs with expertise in social determinants of health and intake staff assisted in analyzing the social determinants of health to inform and guide the processes developed to facilitate intake or scheduling staff receipt of navigator calls. Conversations with these and Onboarding Quality Subcommittees across the regional performing units (RPUs) suggested that an appropriate strategy might be to initially develop a mutual understanding between navigators and intake staff, with the social determinants of health and their effect on health outcomes as link between the two functions, establishing shared goals. This shared understanding can inform a change of culture where currently, there is a perception of non-compliance when, in all likelihood, individuals who are "no shows" for their appointments are facing social barriers and are in greater need for services yet, symptomatically, are barred from receiving them. This approach was brought before the Clinical Governance Committee in February 2016 and the aforementioned conclusions were echoed. Therefore, the social determinants of health will be a focus of training and inform any procedure to come. Once these are developed, they will be vetted through the Clinical Governance Committee with implementation and training to follow. The first step in this plan (Step 16b.) has been permanently placed "On Hold". The initial intent of the step was to create a priority matrix for preventative and primary care, however through detailed stakeholder analysis and review we've determined this will imply a greater amount of risk bore by navigators than would be appropriate, requiring a level of clinical expertise best reserved for the primary care office. An analysis of this step reveals limited usefulness in that it is inappropriate for navigators to stratify this way and already the job of the PCP to do so. The remaining step (Step 16d.) and Milestone is deferred to a DY2, Q4 end date in order to align with the 2ci implementation plan, which will allow for caseloads and discharge processes to be established for health navigators following patients longitudinally for the 2ci project through the steps to implementation for Milestone 6, facilitating timely access for the 2di project.
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	Milestone 17 and its associated steps are projected to be completed in a similar timeframe to other EHR-related milestones in the PPS' project plans and, therefore, are deferred to DY2, Q3. The PPS-wide IT Strategic Plan was approved by the Board of Directors in March 2016 (Complete – Step 17b.). Furthermore, Flourish®, Insignia's database tracking tool, is anticipated to assist in tracking patients and informing population health management. Furthermore, a screening tool has been developed to assist partners in determining an individual's eligibility to take the PAM®. Flourish® and the Department of Health have dictated the use of unique identifiers which can assist in distinguishing Medicaid beneficiaries from the uninsured for this project.

Milestone Review Status

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

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Complete	
Milestone #9	Pass & Ongoing	
Milestone #10	Pass & Ongoing	
Milestone #11	Pass & Complete	
Milestone #12	Pass & Complete	
Milestone #13	Pass & Complete	
Milestone #14	Pass & Ongoing	
Milestone #15	Pass & Ongoing	
Milestone #16	Pass & Ongoing	
Milestone #17	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.d.i.4 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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 :

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

DSRIP Implementation Plan Project

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 DY1 Q4 should include patients previously reported in DY1 Q3 plus new patients engaged in DY1 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	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4
PPS Reported	Baseline Commitment	0	0	1,619	6,860
	Quarterly Update	0	0	0	0
	Percent(%) of Commitment			0.00%	0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment			0.00%	0.00%

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
Fail	The PPS failed to meet at least 80% of its actively engaged commitments for DY1 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

Instructions :

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

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	DY3 Q4	Model 1	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.			Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Behavioral health services are co-located within PCMH/APC practices and are available.			Provider	Mental Health	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1c. The 3ai Project Team will perform a review of PPS partners to understand the number of Medicaid recipients, facility PCMH status, and overall readiness/interest level of the site to participate in project 3ai. Following the assessment, a series of primary care (PC) pilot sites will be identified for project 3ai.			Project		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 Management Subcommittee of the IT Committee). The 3ai Project Team and associated Behavioral Health Quality Committees will develop and monitor			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
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		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1f. The 3ai Project Team and CCN will confirm and document each integrated site has negotiated contracts with Managed Care Organizations (as required) to reflect delivery of on site behavioral health (BH) services.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1g. The CCN PMO will promote the integration of differing cultures in primary and Behavioral Health (BH) care by developing and disseminating training, and encouraging cross specialty shadowing and collaboration. (Risk #5) The PMO will leverage the training functionality developed by the Workforce Development team as well as the Provider Relations team to assist with program development and program dissemination.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1h. The 3ai Project Team and CCN PMO to develop a strategy to engage partner Emergency Departments and Walk-In Clinics in project plans in order to address patients not being captured due to seeking primary care in ED or Walk-In clinics (Risk #2). Implement strategies to address this issue, as appropriate.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	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
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			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	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
Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.											
Task 2c. Develop collaborative care protocols for integrating evidence based Behavioral Health screening tools into PC sites. Protocols will be approved by the Clinical Governance Committee and recertified on an annual basis.			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 At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).			Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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

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 3i. The Care Compass Network PMO will perform implementation related reviews and/or reporting requirements to confirm and document PC sites incorporate into policies the implementation of BH screenings for clients.			Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	DY2 Q4	Model 1	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4c. The Care Compass Network PMO and PC sites will develop timelines for waiver approval to integrate BH and PC Medical Record.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4d. The 3ai Project Team, in collaboration with the Workforce Development and PMO teams will develop training material to educate PC staff regarding elements of a BH Medical Record with approval from the Clinical Governance Committee. Workforce Committee and Provider Relations teams will subsequently implement training.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4e. CCN will engage with the PC site to develop efficient flow of clinical information between providers using CQI principals.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4f. CCN engages with PC site to track actively engaged patients by reporting on frequency of screening, referral, and follow up for milestone reporting using the EHR.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Co-locate primary care services at behavioral health	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

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
sites.											
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.			Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
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		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 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		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	DY2 Q4	Model 2	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6c. CCN PMO/Provider Relations will reach out to partners to gather information regarding existing practice protocols for care engagement, screening, assessment, medication management, and treatment.			Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 6d. RPU Behavioral Health Subcommittees to adopt/develop protocols for care engagement, screening, assessment, crisis/high risk response plan, medication management and treatment including development of an integrated care plan, follow - up,			Project		In Progress	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		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	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 screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).			Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.			Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 7e. The 3ai Project Team and Care Compass Network PMO/Provider Relations to survey PPS Partners to identify existing evidence-based screening tools leveraged by participating providers. The 3ai Project			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	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
Team will propose a minimum level of screening required of PPS Partners, for approval and annual recertification by the CCN Clinical Governance Committee and PPS-wide adoption.											
Task 7f. Client facing staff will complete training on chronic illness management including common physical health medications, preventive care, and chronic conditions. PMO will coordinate development of training material with approval from the Clinical Governance Committee. Workforce Project Manager and Provider Relations will facilitate the delivery and tracking of training.			Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 7g. The Care Compass Network PMO will perform implementation related reviews and/or reporting requirements to confirm and document BH sites have incorporated into policies the implementation of U.S. Preventive Task Force recommended screenings for all clients.			Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 7h. Client-facing staff receives training on Preventive screening tool(s), how to integrate screening into patient work flow, add information to patient chart, referral and follow up. PMO will coordinate development of training material with approval from the Clinical Governance Committee. Workforce Project Manager and Provider Relations will facilitate the delivery and tracking of training.			Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	DY2 Q4	Model 2	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.			Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.			Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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 8c. The 3ai Project Team and CCN PMO will work with PC sites to confirm BH sites have obtained necessary waivers to be able to integrate BH and PC Medical Record.			Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 8d. CCN PMO to develop educational tools for BH staff regarding elements of a PC Medical Record with approval from the Clinical Governance Committee. Workforce Project Manager and Provider Relations will facilitate the delivery and tracking of training.			Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 8e. CCN will engage with the PC site to develop efficient flow of clinical information between providers using CQI principals.			Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 8f. CCN engages with PC site to track actively engaged patients by reporting on frequency of screening, referral, and follow up for milestone reporting using the EHR.			Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #9 Implement IMPACT Model at Primary Care Sites.	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.			Provider	Practitioner - Primary Care Provider (PCP)	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	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	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

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
requirements of the IMPACT model.											
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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			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
PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.											

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Care Compass Network (CCN) is reporting step 1d as complete and is on track to meet the provider-level milestone of co-locating behavioral health services in primary care sites which have achieved NCQA 2014 Level 3 Patient-Centered Medical Home recognition. CCN is also making an administrative update to the timeframe, as DY2, Q4 was erroneously entered when DY3, Q4 was the intended date (as reflected by the Milestone requirements). CCN has engaged the partner base through extensive contracting discussions, identifying practices which have already achieved 2014 PCMH Level 3, or have a roadmap for achievement, or need supplemental help or guidance. The PPS has also developed financial assistance for co-locating services where they are not already in place, as approved by the Finance Committee and Board of Directors. Additionally, CCN established a PCMH Committee to support PCMH achievement in our North Regional Performance Unit (RPU). Whereas the rest of the CCN service area is dominated by hospital-owned and operated primary care practices, the North RPU is comprised mainly of independent practices. CCN recognized early on that additional resources and support for PCMH achievement would be required. CCN has also approved substantial PCMH consulting to aid these support these partners in their achievement of PCMH Level 3. Second, we created additional funding via establishment of RPU Budgets, to promote a grassroots level innovation and community support. These budgets will layer on top of existing PPS/3ai Project Team level efforts. For upcoming items, the 3ai Project Team is hosting a summer 2016 provider engagement event with Cornell University's Gannett Health Services clinical team to overview their implementation, work flow processes, and best practices for co-located PCP/BH services. Finally, CCN is tracking PCMH achievement as part of our overall project performance monitoring. The goal of the CCN Analytics Team is to track attainment and performance results by practice, county, RPU, and at the PPS level. This will be continually achieved and monitored through standardized monthly partner invoice submissions (Step 1d – Complete). The PCMH tracking is relevant for several projects including 2ai, 3ai, 3bi, and 3gi. We will also be tracking specific care coordination functions against patient outcomes such as avoidable hospitalizations, use of the Emergency Departments, and patient compliance. The purpose of this performance monitoring is to be able to demonstrate the importance of care coordination and facets of the PCMH model in improving the overall delivery of health care service to Medicaid members while avoiding costly and potentially unnecessary hospitalization and avoidable Emergency Department utilization. CCN is also participating in MAX Program offered via the DOH. MAX is an 8 month intensive learning collaborative focusing on the development of an efficient process towards a patient centered care. CCN is one of 8 PPS participating in this pilot program to integrate behavioral health in primary care setting. Early successes from MAX to date include: (1) The team embedded a behavioral health consultant on site 1 day a week and was able to successfully complete 69 PHQ-9 screenings in a 30 day

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
	timeframe. (2) The screenings allow the team to subsequently refer patients for appropriate treatment and intervention (3) The team will be tracking 5 core performance metrics to evaluate their progress and outcomes. (4) The team will be embedding a behavioral health consultant on a fulltime basis starting in May 2016.
Develop collaborative evidence-based standards of care including medication management and care engagement process.	Care Compass Network is on track for completing all other milestones related to Model 1 of this project. We have completed the Milestone 2 (Develop collaborative evidence-based standards of care including medication management and care engagement process). The 3ai Project Team is currently developing a workshop/conference with primary care physicians who have successfully integrated behavioral health services into primary care settings. The target audience of this will be physicians, practice managers, and nurses from primary care practices with an interest in the Care Compass Network 3ai Project. The Project Team is on track to meet the milestone implementing behavioral health screening in practices (Milestone 3). We have already a set of approved screens, an approved screening protocol (requiring storage of results in the EMR, communication of results to the clinical staff, etc), and a follow up protocol for the PHQ-9 which specifies when the behavioral health consultant should be engaged ("warm handoff"). We are currently in the contracting process for partners and are engaged in the MAX series for this topic, which is piloting the screening tools and the Behavioral Health consultant at a primary care practice. Care Compass Network contracts specify requirement for EMRs (integrating medical and behavioral health information, storage of the behavioral health screening results, and indication of the "warm handoff") and the ability of partners to track actively engaged Medicaid members (Milestones 3 and 4).
Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Care Compass Network is on track for completing all other milestones related to Model 1 of this project. We have completed the Milestone 2 (Develop collaborative evidence-based standards of care including medication management and care engagement process). The 3ai Project Team is currently developing a workshop/conference with primary care physicians who have successfully integrated behavioral health services into primary care settings. The target audience of this will be physicians, practice managers, and nurses from primary care practices with an interest in the Care Compass Network 3ai Project. The Project Team is on track to meet the milestone implementing behavioral health screening in practices (Milestone 3). We have already a set of approved screens, an approved screening protocol (requiring storage of results in the EMR, communication of results to the clinical staff, etc), and a follow up protocol for the PHQ-9 which specifies when the behavioral health consultant should be engaged ("warm handoff"). We are currently in the contracting process for partners and are engaged in the MAX series for this topic, which is piloting the screening tools and the Behavioral Health consultant at a primary care practice. Care Compass Network contracts specify requirement for EMRs (integrating medical and behavioral health information, storage of the behavioral health screening results, and indication of the "warm handoff") and the ability of partners to track actively engaged Medicaid members (Milestones 3 and 4).
Use EHRs or other technical platforms to track all patients engaged in this project.	Care Compass Network is on track for completing all other milestones related to Model 1 of this project. We have completed the Milestone 2 (Develop collaborative evidence-based standards of care including medication management and care engagement process). The 3ai Project Team is currently developing a workshop/conference with primary care physicians who have successfully integrated behavioral health services into primary care settings. The target audience of this will be physicians, practice managers, and nurses from primary care practices with an interest in the Care Compass Network 3ai Project. The Project Team is on track to meet the milestone implementing behavioral health screening in practices (Milestone 3). We have already a set of approved screens, an approved screening protocol (requiring storage of results in the EMR, communication of results to the clinical staff, etc), and a follow up protocol for the PHQ-9 which specifies when the behavioral health consultant should be engaged ("warm handoff"). We are currently in the contracting process for partners and are engaged in the MAX series for this topic, which is piloting the screening tools and the Behavioral Health consultant at a primary care practice. Care Compass Network contracts specify requirement for EMRs (integrating medical and behavioral health information, storage of the behavioral health screening results, and indication of the "warm handoff") and the ability of partners to track actively engaged Medicaid members (Milestones 3 and 4).
Co-locate primary care services at behavioral health sites.	Care Compass Network is on track to complete all milestones related to Model 2 of the Integrating Behavioral Health and Primary Care Project on time. CCN has begun the contracting process with organizations which have expressed interest in the 3ai model; there are roughly eight behavioral health sites interested in the project, with two contracts that are currently in process. CCN has recommended that organizations use the increase in licensure thresholds to offer primary care in their organization (Milestone 5- In progress). The 3ai Project Team, in conjunction with the Behavioral Health Subcommittees in each of Care Compass Network's four Regional Performance Units (RPU), has finalized collaborative care guidelines including medication management and care engagement processes (Milestone 6 – In progress). We will complete this milestone by developing and implementing training for behavioral health site staff members on common medical needs and how to identify them. In addition, the Project Team will facilitate cross training opportunities between behavioral health sites and primary care sites. As part of our work on Milestone 7, the 3ai Project Team has identified primary-care related screening processes currently in place in behavioral health sites. The Team, in conjunction with the Behavioral Health Quality Committees,

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
	added several primary care screenings to that list, including screening for the metabolic syndrome (which includes Diabetes, Cardiovascular Disease, and Obesity), HIV, Hepatitis C, Chronic Obstructive Pulmonary Disease, Pain Assessments, and a Health History and Current Needs Assessment. These items are directly related to DSRIP Performance Metrics and Care Compass Network's population health strategies and goals. We will complete this milestone through the dissemination of training (developed under Milestone 6) and through our contracting process. The Project Team does not foresee any obstacles to completing this milestone. Care Compass Network contracts specify all project related requirements for EMRs (integrating medical and behavioral health information, storage of the preventive health screening results, and indication of the "warm handoff") and the ability of partners to track actively engaged Medicaid members (Milestones 7 and 8). Once we have executed contracts and have collected required information from our first partners on this project, we plan to mark these milestones as complete. Additional partners' information will be submitted as updates to these milestones.
Develop collaborative evidence-based standards of care including medication management and care engagement process.	Care Compass Network is on track to complete all milestones related to Model 2 of the Integrating Behavioral Health and Primary Care Project on time. CCN has begun the contracting process with organizations which have expressed interest in the 3ai model; there are roughly eight behavioral health sites interested in the project, with two contracts that are currently in process. CCN has recommended that organizations use the increase in licensure thresholds to offer primary care in their organization (Milestone 5- In progress). The 3ai Project Team, in conjunction with the Behavioral Health Subcommittees in each of Care Compass Network's four Regional Performance Units (RPU), has finalized collaborative care guidelines including medication management and care engagement processes (Milestone 6 – In progress). We will complete this milestone by developing and implementing training for behavioral health site staff members on common medical needs and how to identify them. In addition, the Project Team will facilitate cross training opportunities between behavioral health sites and primary care sites. As part of our work on Milestone 7, the 3ai Project Team has identified primary-care related screening processes currently in place in behavioral health sites. The Team, in conjunction with the Behavioral Health Quality Committees, added several primary care screenings to that list, including screening for the metabolic syndrome (which includes Diabetes, Cardiovascular Disease, and Obesity), HIV, Hepatitis C, Chronic Obstructive Pulmonary Disease, Pain Assessments, and a Health History and Current Needs Assessment. These items are directly related to DSRIP Performance Metrics and Care Compass Network's population health strategies and goals. We will complete this milestone through the dissemination of training (developed under Milestone 6) and through our contracting process. The Project Team does not foresee any obstacles to completing this milestone. Care Compass Network contracts specify all project related requirements for EMRs (integrating medical and behavioral health information, storage of the preventive health screening results, and indication of the "warm handoff") and the ability of partners to track actively engaged Medicaid members (Milestones 7 and 8). Once we have executed contracts and have collected required information from our first partners on this project, we plan to mark these milestones as complete. Additional partners' information will be submitted as updates to these milestones.
Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Care Compass Network is on track to complete all milestones related to Model 2 of the Integrating Behavioral Health and Primary Care Project on time. CCN has begun the contracting process with organizations which have expressed interest in the 3ai model; there are roughly eight behavioral health sites interested in the project, with two contracts that are currently in process. CCN has recommended that organizations use the increase in licensure thresholds to offer primary care in their organization (Milestone 5- In progress). The 3ai Project Team, in conjunction with the Behavioral Health Subcommittees in each of Care Compass Network's four Regional Performance Units (RPU), has finalized collaborative care guidelines including medication management and care engagement processes (Milestone 6 – In progress). We will complete this milestone by developing and implementing training for behavioral health site staff members on common medical needs and how to identify them. In addition, the Project Team will facilitate cross training opportunities between behavioral health sites and primary care sites. As part of our work on Milestone 7, the 3ai Project Team has identified primary-care related screening processes currently in place in behavioral health sites. The Team, in conjunction with the Behavioral Health Quality Committees, added several primary care screenings to that list, including screening for the metabolic syndrome (which includes Diabetes, Cardiovascular Disease, and Obesity), HIV, Hepatitis C, Chronic Obstructive Pulmonary Disease, Pain Assessments, and a Health History and Current Needs Assessment. These items are directly related to DSRIP Performance Metrics and Care Compass Network's population health strategies and goals. We will complete this milestone through the dissemination of training (developed under Milestone 6) and through our contracting process. The Project Team does not foresee any obstacles to completing this milestone. Care Compass Network contracts specify all project related requirements for EMRs (integrating medical and behavioral health information, storage of the preventive health screening results, and indication of the "warm handoff") and the ability of partners to track actively engaged Medicaid members (Milestones 7 and 8). Once we have executed contracts and have collected required information from our first partners on this project, we plan to mark these milestones as complete. Additional partners' information will be submitted as updates to these milestones.

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
Use EHRs or other technical platforms to track all patients engaged in this project.	Care Compass Network is on track to complete all milestones related to Model 2 of the Integrating Behavioral Health and Primary Care Project on time. CCN has begun the contracting process with organizations which have expressed interest in the 3ai model; there are roughly eight behavioral health sites interested in the project, with two contracts that are currently in process. CCN has recommended that organizations use the increase in licensure thresholds to offer primary care in their organization (Milestone 5- In progress). The 3ai Project Team, in conjunction with the Behavioral Health Subcommittees in each of Care Compass Network's four Regional Performance Units (RPU), has finalized collaborative care guidelines including medication management and care engagement processes (Milestone 6 – In progress). We will complete this milestone by developing and implementing training for behavioral health site staff members on common medical needs and how to identify them. In addition, the Project Team will facilitate cross training opportunities between behavioral health sites and primary care sites. As part of our work on Milestone 7, the 3ai Project Team has identified primary-care related screening processes currently in place in behavioral health sites. The Team, in conjunction with the Behavioral Health Quality Committees, added several primary care screenings to that list, including screening for the metabolic syndrome (which includes Diabetes, Cardiovascular Disease, and Obesity), HIV, Hepatitis C, Chronic Obstructive Pulmonary Disease, Pain Assessments, and a Health History and Current Needs Assessment. These items are directly related to DSRIP Performance Metrics and Care Compass Network's population health strategies and goals. We will complete this milestone through the dissemination of training (developed under Milestone 6) and through our contracting process. The Project Team does not foresee any obstacles to completing this milestone. Care Compass Network contracts specify all project related requirements for EMRs (integrating medical and behavioral health information, storage of the preventive health screening results, and indication of the "warm handoff") and the ability of partners to track actively engaged Medicaid members (Milestones 7 and 8). Once we have executed contracts and have collected required information from our first partners on this project, we plan to mark these milestones as complete. Additional partners' information will be submitted as updates to these milestones.
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 & 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 #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Ongoing	
Milestone #9	Pass & Ongoing	
Milestone #10	Pass & Ongoing	
Milestone #11	Pass & Ongoing	
Milestone #12	Pass & Ongoing	
Milestone #13	Pass & Ongoing	
Milestone #14	Pass & Ongoing	
Milestone #15	Pass & Ongoing	

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

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.a.i.5 - IA Monitoring

Instructions :

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 DY1 Q4 should include patients previously reported in DY1 Q3 plus new patients engaged in DY1 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	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4
PPS Reported	Baseline Commitment	0	144	180	288
	Quarterly Update	0	0	0	0
	Percent(%) of Commitment		0.00%	0.00%	0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment		0.00%	0.00%	0.00%

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
Fail	The PPS failed to meet at least 80% of its actively engaged commitments for DY1 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.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	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS has established a crisis intervention program that includes outreach, mobile crisis, and intensive crisis services.		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1b. 3aii Team will develop a crisis intervention program and perform an assessment to determine, for each Regional Performance Unit (RPU) as well as overlapping PPSs, which agencies (including the respective local governance units "LGUs" for each of the nine counties) or individual provider(s) can best meet the project needs. Project components will include mobile crisis intervention, phone triage, observation beds, and community respite services. Engaged agencies/individuals are expected to include county mental health agencies, Directors of Community Services, law enforcement, and CBOs offering behavioral health and respite services. Program will create alternative ways (compared to ED admission) for patients and families to seek out crisis stabilization services, especially in cases when patient does not require intensive inpatient care. Program approaches for each RPU are listed in steps 1c-1f within this milestone.		Project		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		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1e. Repeat model for the West RPU by identifying available resources, readiness, and adjusting plan as necessary for local needs. CCN PMO will coordinate services with PPSs with overlapping coverage to identify economies of scale.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1f. Repeat model for the East RPU by identifying available resources, readiness, and adjusting plan as necessary for local needs. CCN PMO will coordinate services with PPSs with overlapping coverage to identify economies of scale.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #2 Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.	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	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS has engaged MCO in negotiating coverage of services under this project and/or MCO provides coverage for services in project.		Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 3b. The PPS would have an initial conversation with the MCOs to discuss the approach on how to include services not currently covered today. The discussion will outline a framework which will include a summary whereby the the CCN PMO will conduct a quantitative and qualitative needs assessment of the affected population to understand service array utilization of the continuum of care, the organizations providing them, and corresponding expected level of effort. In addition, the PPS will seek to understand needed services to address related issues of the affected population not currently covered by Medicaid. For example, this will help to understand what services in the community would effectively help to avoid utilization of more expensive services.		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3c. With an understanding on the approach, the PPS PMO and Analytics team will perform a review of available data to identify trends and understand the continuum of care to develop a prototype model for crisis management whose intent is to reduce hospital leverage / ED use. Other key stakeholders to include in this review include police departments, EMT transports, etc. Upon completion the PPS will meet with MCOs to share the data and analysis and work together to develop a payment methodology to include currently uncovered services that are found to be essential in avoiding hopsital use for this population.		Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Milestone #4 Develop written treatment protocols with consensus from participating providers and facilities.	DY2 Q4	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

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		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4c. Develop written Crisis Stabilization protocols in tandem with the 3aii Project Team, participating agencies, providers, CBOs, and collaboration with other PPSs. Once developed, the protocols will be submitted to the Clinical Governance Committee (CGC) and Board of Directors for approval. Each year, the CGC will approve and recertify previously adopted protocols. (Risk #3) On an ongoing basis, the respective regional performance unit Behavioral Health Subcommittee will provide oversight and monitoring for adherence and efficacy of plans. Provider remediation or protocol amendment (e.g., based on regional customization or alignment with new leading practices) will be made available to the Clinical Governance Committee.		Project		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	06/30/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #5 Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS includes at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services in provider network		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS evaluates access to psychiatric services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.		Provider	Safety Net Hospital	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5c. The 3aii Project Team and CCN PMO will pursue contracting with identified hospitals within the PPS based off evaluation of implementation criteria such as offering of specialty psychiatric services/crisis oriented-psychiatric services, and overall readiness/willingness to engage in 3aii related work. Based on the initial assessments, the 3aii Project Team expects to engage		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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
with United Health Services, Inc., Cayuga Medical Center, and Cortland Regional Medical Center for this project.										
Task 5d. On at least an annual basis, the 3aii Project Team and PMO will present to each regional performance unit Behavioral Health Subcommittee (e.g., 3aii Quality Committee) an evaluation and report of crisis-oriented psychiatric services availability, geographic access, wait times, etc. to identify areas for improved access. As required and advised by the BH Quality Committee, the PMO will implement improvement plans (e.g., such as improvement efforts or program expansion efforts).		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS includes hospitals with observation unit or off campus crisis residence locations for crisis monitoring.		Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.		Provider	Safety Net Hospital	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.		Provider	Safety Net Clinic	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.		Provider	Safety Net Mental Health	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 6e. Using the review performed of 3aii related health care linkages and workflows, the Project 3aii Team and PMO will pursue contracts (as necessary) with PPS health care providers to offer observation beds in Safety Net Hospitals. Team has initially identified a Phase I approach for collaboration with Cortland Regional Medical Center and Cayuga Medical Center for the expansion of access to observation units. In Phase II the		Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 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
3aii Project Team will identify strategies for the remaining regions/providers.										
Task 6f. CCN PMO to contract with PPS CBOs to maintain community-based respite beds (safety net clinics and/or safety net behavioral health providers) that offer crisis intervention and observation services within the community for those individuals who can be stabilized outside of hospital setting.		Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 6g. Annually, PMO will present to RPU Behavioral Health Subcommittees an evaluation of off-campus residence service availability, geographic access, wait times, etc. to identify areas for improved access. PMO implements improvement plans.		Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Milestone #7 Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS includes mobile crisis teams to help meet crisis stabilization needs of the community.		Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Coordinated evidence-based care protocols for mobile crisis teams are in place.		Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 7c. The 3aii Project Team to perform an assessment of PPS needs (e.g., based on community needs assessment, Salient data, etc.) as well as PPS Partner service offerings, capabilities, and readiness/ability to partner with CCN in the deployment of mobile crisis teams to provide crisis stabilization services using 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		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 7d. The PPS, in collaboration with existing leading practices and partner protocols will develop/adopt evidence-based protocols for mobile intervention for use by mobile intervention teams. Identified protocol(s) will be endorsed by the Clinical Governance Committee, approved by the Board of Directors, and subsequently recertified on, at minimum, an annual basis by the Clinical Governance Committee.		Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4

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 7e. The 3aii Project Team will identify strategies to provide/deliver mobile crisis teams/services throughout the PPS as needs exist (e.g., by RPU.)		Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 7f. Annually, the PMO will present to RPU Behavioral Health Subcommittees (e.g., 3aii Quality Committees by region) an evaluation of mobile crisis service availability, geographic access, wait times, etc. to identify areas for improved access. The PMO will collaborate with partners to implement improvement plans identified by the quality committees (as required by PPS partner contracts).		Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Milestone #8 Ensure that all PPS safety net providers have actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Hospital	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Alerts and secure messaging functionality are used to facilitate crisis intervention services.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 8g. 3aii Team to identify EHR or other IT platform(s) for behavioral health screening/assessment tool, collection, sharing and storage of data. EHR or other IT platform(s) to meets several		Project		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
requirements which facilitate intervention services (for example, integrated medical/behavioral health record, ability to track patients, ability to report agency-level performance metrics, RHIO/SHIN-NY connectivity, alerts and secure messaging). CCN PMO to coordinate review and approval of IT solutions with the IT Committee (and the associated review processes) and align vendor solutions with project needs as well as the broader IT Vision of the PPS.										
Task 8h. The PPS will execute a contract with the selected vendor for the delivery of services. The CCN PMO/Provider Relations to oversee roll out of EHR or other IT platform to contracted agencies, providers, and CBOs offering crisis stabilization services. Rollout includes readiness assessment, training, workflow optimization, and go live. (Risk #3) As part of the implementation process, PPS Partners will be required to submit documentation such as certifications, training attestations/rosters, or system reports to confirm achievement of key implementation/integration milestones.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #9 Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.	DY3 Q4	Project	N/A	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has implemented central triage service among psychiatrists and behavioral health providers.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 9b. The PPS (through collaboration by the project team as well as stakeholders) will identify potential providers of a central triage service crisis stabilization services, as outlined by the PPS and/or by the respective regional performance unit. As part of this process, the 3aii Project Team will perform an assessment to align project requirements with the availability and needs of the community (e.g., central triage service). A strategy will be developed to connect triage service provider(s) identified with participating providers of behavioral health services, mobile intervention, inpatient observation, and community respite services. The finalized plans will serve as a baseline for operating/contractual agreements with PPS members participating in project 3aii.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 9c. As part of the Care Compass Network contract, the centralized phone triage provider(s) will be required to use a standard assessment tool, approved by the Clinical Governance Committee and recertified annually.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Milestone #10 Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.	DY2 Q4	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task PPS has created an active quality subcommittee that reports to PPS quality committee that is representative of medical and behavioral health staff and is specifically focused on integration of primary care and behavioral health services within practice sites and other behavioral health project initiatives. Note: Only one quality sub-committee is required for medical and behavioral health integration projects in Domain 3a.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics listed in Attachment J Domain 3 Behavioral Health Metrics.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task PPS quality subcommittee conducts and/or reviews self-audits to ensure compliance with processes and procedures developed for this project.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Service and quality outcome measures are reported to all stakeholders including PPS quality committee.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 10f. CCN to seat Regional Performance Unit Behavioral Health Subcommittees. Each committee will be comprised of local medical and behavioral health experts who can evaluate the crisis stabilization program and integration of primary care and behavioral health services.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 10g. CCN PMO regularly reports key quality metrics (including Appendix J metrics Domain 3 Behavioral Health metrics) to RPU		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.	Care Compass Network has made significant progress on the Crisis Stabilization project to create a community-wide network of providers to de-escalate behavioral health crises in the community, as opposed to using more traditional, hospital based services (either Emergency Departments or inpatient psychiatric services). The Care Compass Network program includes phone triage, mobile outreach, community-based respite services, and hospital-based observation; the project is developing community-based providers of crisis stabilization services so that, where appropriate, individuals experiencing a behavioral health crisis can remain in the community. The first step in building this program across the PPS (Step 1b) is to assess the current availability of these services in each of Care Compass Network's nine counties. For a complete understanding of the relevant services already available in our service area, we identified for each county any existing mobile outreach services, potential providers of that service, existing crisis phone services, housing providers(as potential for community-based respite care providers), and hospitals and compiled them in a matrix (one column for each service; one row for each county). In several of our counties, some of the core services are currently offered, albeit in a limited ways. For example, mobile teams exist in Delaware, Chenango, Chemung, and Schuyler counties. One area for improvement is that many of the existing services operate only during regular business hours; we are seeking to expand these services to times of the day when the traditional means of crisis de-escalation are usually called upon (Step 1b--Complete). To complete Step 1c, the 3aii Project Team initially sought to build the first network of crisis service providers for Broome County and then replicate this model throughout the PPS. In Broome County, we are in contract conversation with the Mental Health Association of the Southern Tier (MHAST) to provide the mobile services for the project. MHAST is already working closely with the Crisis Intervention Team (CIT) in the Broome County Sheriff's Department. As the mobile team, MHAST will build on this relationship to provide a licensed clinician to assist on police calls for behavioral health crises and provide follow up services where appropriate. The mobile team may also be activated by our central phone triage service, provided by Suicide Prevention and Crisis Service. This organization is part of the National Lifeline Network and serves the entire 607 area code which covers all but a small portion of the Care Compass Network service area. The 3aii Project Team is simultaneously pursuing contracting for services in other counties as well. We have had contracting discussions for various services in the following counties: Cortland, Tompkins, Schuyler, Tioga, Chenango, Delaware, and Chemung counties. We are preparing to release a Request for Proposals for the Community-Based Respite services for each of our service counties (Step 1c—Complete). Care Compass Network is on target for meeting this milestone on time.
Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.	Care Compass Network is on track to complete the milestone establishing clear linkages between our network of crisis stabilization services and existing health homes, emergency department and hospital services. To complete Step2b, we have identified health home providers, hospital emergency rooms, and Law Enforcement efforts aligned with Crisis Stabilization in each of the nine Care Compass Network counties. The Behavioral Health Subcommittees (subcommittees of the Clinical Governance Committee) in each of our four Regional Performance Units (RPUs) represent behavioral health providers in our community, including Health Homes, CPEP service, Mental Health clinics, and hospitals. The committees have contributed to 3aii project planning by helping to identify the existing linkages and gaps in connecting patients to appropriate resources. One specific development out of the South Behavioral Health Committee was to identify behavioral health providers who could serve as a Health Coach for patients following their inpatient psychiatric hospitalization under the Care Transitions program (a program which is not strictly a behavioral health project). This development is important as it can address an existing gap in the Crisis Stabilization program, which aims to keep Medicaid members out of the Emergency Department when community-based services can be used instead, but does not address providing support to Medicaid members who are, in fact, admitted to a psychiatric unit and are at high risk for hospital readmission. Care Compass Network seeks to address this need across the PPS (Step 2b—Complete). To address Step 2c, the Project Team has developed a Crisis Stabilization Definition and Guidelines Policy which 1) defines a low, medium and high level acuity of behavioral health crises, 2) outlines the key

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
	deliverable components of core stabilization services, 3) recommends specific assessment tools, and 4) establishes guidelines for follow up after a crisis is diverted from the emergency room. Each of the four Behavioral Health Quality Committees reviewed the policy and provided valuable feedback and suggestions. The Clinical Governance Committee has endorsed the policy (March 24, 2016) and it was approved by the Board of Directors April 12, 2016. In addition, the 3aii Project Team has been working with law enforcement units which are currently focusing on behavioral health issues. For example, the Mental Health Association of the Southern Tier (MHAST) will be the Mobile Team for Broome County; MHAST is currently working with the Crisis Intervention Team within the Broome County Sherriff's Department to train officers to be able to address behavioral health-related calls with sensitivity. The 3aii Project Team is similarly building on the relationships between behavioral health providers and law enforcement in Cortland, Tompkins, Schuyler, and Chemung counties. As the project is implemented, communication to the existing behavioral health providers about the project and patient services will be critical to its success (Step 2c—Complete).
Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.	In addition to the milestones we are reporting to have completed Implementation Steps, Care Compass Network has made significant progress on the Crisis Stabilization project. We have had contracting discussions for services for eight of our nine counties, with various providers of crisis phone lines, mobile outreach, community-based respite, and hospital observation (Milestones 5, 6, 7, and 9). The Project 3aii, along with the Behavioral Health Quality Subcommittees, has finalized the Crisis Stabilization Definition and Guideline which serves as a diversionary treatment protocol (Milestone 4). We will use this policy as a basis for each county network of providers. We envision that the various providers (along with county mental health, law enforcement) will meet on a periodic basis (monthly, perhaps) to discuss cases, the treatment protocols, what is working, and what is not working, to be able to shape the project around community needs. Care Compass Network has begun to engage Managed Care Organizations (MCOs) in a PPS--wide strategy to establish relationships (Milestone 3). Care Compass Network intends to evaluate the Crisis Stabilization project in terms of its ability to reduce the number of unnecessary Emergency Room Visits and Hospitalizations and lobby MCOs for coverage of services (mobile outreach, crisis respite, etc.) when not covered by Medicaid. Care Compass Network is aligning the program with the Home and Community-Based Service (HCBS) waiver where possible; but even this will not guarantee coverage for all Medicaid members. Finally, Care Compass Network is working with our partners on the IT-related requirements of their EMR systems to ensure these requirements can be met (Milestones 8 and 11). Care Compass Network is on track for completion of all Milestones in this project. Care Compass Network has made significant progress on the 3aii Crisis Stabilization project. Beyond the progress reported on the milestones where specific implementation steps have been completed, there has been progress in the areas of written protocols—our Crisis Stabilization Definition and Guideline Policy (Milestone 4), contracting for services in our counties (Milestones 5, 6, 7, and 9), EMR development and information sharing (Milestone 9 and 11).
Develop written treatment protocols with consensus from participating providers and facilities.	To address Step 4c, the Project Team has developed a Crisis Stabilization Definition and Guidelines Policy which 1) defines a low, medium and high level acuity of behavioral health crises, 2) outlines the key deliverable components of core stabilization services, 3) recommends specific assessment tools, and 4) establishes guidelines for follow up after a crisis is diverted from the emergency room. Each of the four Behavioral Health Quality Committees reviewed the policy and provided valuable feedback and suggestions. The Clinical Governance Committee has endorsed the policy (March 24, 2016) and it was approved by the Board of Directors April 12, 2016. These policies will be reviewed and recertified annually (Step 4c –Complete). As partners of Care Compass Network, the organizations who provider the various crisis stabilization services will be contractually required to follow the policies. Of course, their input on the policies is important and the 3aii Project Team will use periodic meetings to make adjustment to the project and policies (with approval from the Clinical Governance Committee required) (Step 4d—Complete). Care Compass Network expects to be able to complete this milestone after the contracting process is complete with multiple providers.
Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.	In addition to the milestones we are reporting to have completed Implementation Steps, Care Compass Network has made significant progress on the Crisis Stabilization project. We have had contracting discussions for services for eight of our nine counties, with various providers of crisis phone lines, mobile outreach, community-based respite, and hospital observation (Milestones 5, 6, 7, and 9). The Project 3aii, along with the Behavioral Health Quality Subcommittees, has finalized the Crisis Stabilization Definition and Guideline which serves as a diversionary treatment protocol (Milestone 4). We will use this policy as a basis for each county network of providers. We envision that the various providers (along with county mental health, law enforcement) will meet on a periodic basis (monthly, perhaps) to discuss cases, the treatment protocols, what is working, and what is not working, to be able to shape the project around community needs. Care Compass Network has begun to engage Managed Care Organizations (MCOs) in a PPS--wide strategy to establish relationships (Milestone 3). Care Compass Network intends to evaluate the Crisis Stabilization project in terms of its ability to reduce the number of unnecessary Emergency Room Visits and Hospitalizations and lobby MCOs for coverage of services (mobile outreach, crisis respite,

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
	etc.) when not covered by Medicaid. Care Compass Network is aligning the program with the Home and Community-Based Service (HCBS) waiver where possible; but even this will not guarantee coverage for all Medicaid members. Finally, Care Compass Network is working with our partners on the IT-related requirements of their EMR systems to ensure these requirements can be met (Milestones 8 and 11). Care Compass Network is on track for completion of all Milestones in this project. Care Compass Network has made significant progress on the 3aii Crisis Stabilization project. Beyond the progress reported on the milestones where specific implementation steps have been completed, there has been progress in the areas of written protocols—our Crisis Stabilization Definition and Guideline Policy (Milestone 4), contracting for services in our counties (Milestones 5, 6, 7, and 9), EMR development and information sharing (Milestone 9 and 11).
Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).	In addition to the milestones we are reporting to have completed Implementation Steps, Care Compass Network has made significant progress on the Crisis Stabilization project. We have had contracting discussions for services for eight of our nine counties, with various providers of crisis phone lines, mobile outreach, community-based respite, and hospital observation (Milestones 5, 6, 7, and 9). The Project 3aii, along with the Behavioral Health Quality Subcommittees, has finalized the Crisis Stabilization Definition and Guideline which serves as a diversionary treatment protocol (Milestone 4). We will use this policy as a basis for each county network of providers. We envision that the various providers (along with county mental health, law enforcement) will meet on a periodic basis (monthly, perhaps) to discuss cases, the treatment protocols, what is working, and what is not working, to be able to shape the project around community needs. Care Compass Network has begun to engage Managed Care Organizations (MCOs) in a PPS--wide strategy to establish relationships (Milestone 3). Care Compass Network intends to evaluate the Crisis Stabilization project in terms of its ability to reduce the number of unnecessary Emergency Room Visits and Hospitalizations and lobby MCOs for coverage of services (mobile outreach, crisis respite, etc.) when not covered by Medicaid. Care Compass Network is aligning the program with the Home and Community-Based Service (HCBS) waiver where possible; but even this will not guarantee coverage for all Medicaid members. Finally, Care Compass Network is working with our partners on the IT-related requirements of their EMR systems to ensure these requirements can be met (Milestones 8 and 11). Care Compass Network is on track for completion of all Milestones in this project. Care Compass Network has made significant progress on the 3aii Crisis Stabilization project. Beyond the progress reported on the milestones where specific implementation steps have been completed, there has been progress in the areas of written protocols—our Crisis Stabilization Definition and Guideline Policy (Milestone 4), contracting for services in our counties (Milestones 5, 6, 7, and 9), EMR development and information sharing (Milestone 9 and 11).
Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.	In addition to the milestones we are reporting to have completed Implementation Steps, Care Compass Network has made significant progress on the Crisis Stabilization project. We have had contracting discussions for services for eight of our nine counties, with various providers of crisis phone lines, mobile outreach, community-based respite, and hospital observation (Milestones 5, 6, 7, and 9). The Project 3aii, along with the Behavioral Health Quality Subcommittees, has finalized the Crisis Stabilization Definition and Guideline which serves as a diversionary treatment protocol (Milestone 4). We will use this policy as a basis for each county network of providers. We envision that the various providers (along with county mental health, law enforcement) will meet on a periodic basis (monthly, perhaps) to discuss cases, the treatment protocols, what is working, and what is not working, to be able to shape the project around community needs. Care Compass Network has begun to engage Managed Care Organizations (MCOs) in a PPS--wide strategy to establish relationships (Milestone 3). Care Compass Network intends to evaluate the Crisis Stabilization project in terms of its ability to reduce the number of unnecessary Emergency Room Visits and Hospitalizations and lobby MCOs for coverage of services (mobile outreach, crisis respite, etc.) when not covered by Medicaid. Care Compass Network is aligning the program with the Home and Community-Based Service (HCBS) waiver where possible; but even this will not guarantee coverage for all Medicaid members. Finally, Care Compass Network is working with our partners on the IT-related requirements of their EMR systems to ensure these requirements can be met (Milestones 8 and 11). Care Compass Network is on track for completion of all Milestones in this project. Care Compass Network has made significant progress on the 3aii Crisis Stabilization project. Beyond the progress reported on the milestones where specific implementation steps have been completed, there has been progress in the areas of written protocols—our Crisis Stabilization Definition and Guideline Policy (Milestone 4), contracting for services in our counties (Milestones 5, 6, 7, and 9), EMR development and information sharing (Milestone 9 and 11).
Ensure that all PPS safety net providers have actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and	In addition to the milestones we are reporting to have completed Implementation Steps, Care Compass Network has made significant progress on the Crisis Stabilization project. We have had contracting discussions for services for eight of our nine counties, with various providers of crisis phone lines, mobile outreach, community-based

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
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.	respite, and hospital observation (Milestones 5, 6, 7, and 9). The Project 3aii, along with the Behavioral Health Quality Subcommittees, has finalized the Crisis Stabilization Definition and Guideline which serves as a diversionary treatment protocol (Milestone 4). We will use this policy as a basis for each county network of providers. We envision that the various providers (along with county mental health, law enforcement) will meet on a periodic basis (monthly, perhaps) to discuss cases, the treatment protocols, what is working, and what is not working, to be able to shape the project around community needs. Care Compass Network has begun to engage Managed Care Organizations (MCOs) in a PPS--wide strategy to establish relationships (Milestone 3). Care Compass Network intends to evaluate the Crisis Stabilization project in terms of its ability to reduce the number of unnecessary Emergency Room Visits and Hospitalizations and lobby MCOs for coverage of services (mobile outreach, crisis respite, etc.) when not covered by Medicaid. Care Compass Network is aligning the program with the Home and Community-Based Service (HCBS) waiver where possible; but even this will not guarantee coverage for all Medicaid members. Finally, Care Compass Network is working with our partners on the IT-related requirements of their EMR systems to ensure these requirements can be met (Milestones 8 and 11). Care Compass Network is on track for completion of all Milestones in this project. Care Compass Network has made significant progress on the 3aii Crisis Stabilization project. Beyond the progress reported on the milestones where specific implementation steps have been completed, there has been progress in the areas of written protocols—our Crisis Stabilization Definition and Guideline Policy (Milestone 4), contracting for services in our counties (Milestones 5, 6, 7, and 9), EMR development and information sharing (Milestone 9 and 11).
Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.	In addition to the milestones we are reporting to have completed Implementation Steps, Care Compass Network has made significant progress on the Crisis Stabilization project. We have had contracting discussions for services for eight of our nine counties, with various providers of crisis phone lines, mobile outreach, community-based respite, and hospital observation (Milestones 5, 6, 7, and 9). The Project 3aii, along with the Behavioral Health Quality Subcommittees, has finalized the Crisis Stabilization Definition and Guideline which serves as a diversionary treatment protocol (Milestone 4). We will use this policy as a basis for each county network of providers. We envision that the various providers (along with county mental health, law enforcement) will meet on a periodic basis (monthly, perhaps) to discuss cases, the treatment protocols, what is working, and what is not working, to be able to shape the project around community needs. Care Compass Network has begun to engage Managed Care Organizations (MCOs) in a PPS--wide strategy to establish relationships (Milestone 3). Care Compass Network intends to evaluate the Crisis Stabilization project in terms of its ability to reduce the number of unnecessary Emergency Room Visits and Hospitalizations and lobby MCOs for coverage of services (mobile outreach, crisis respite, etc.) when not covered by Medicaid. Care Compass Network is aligning the program with the Home and Community-Based Service (HCBS) waiver where possible; but even this will not guarantee coverage for all Medicaid members. Finally, Care Compass Network is working with our partners on the IT-related requirements of their EMR systems to ensure these requirements can be met (Milestones 8 and 11). Care Compass Network is on track for completion of all Milestones in this project. Care Compass Network has made significant progress on the 3aii Crisis Stabilization project. Beyond the progress reported on the milestones where specific implementation steps have been completed, there has been progress in the areas of written protocols—our Crisis Stabilization Definition and Guideline Policy (Milestone 4), contracting for services in our counties (Milestones 5, 6, 7, and 9), EMR development and information sharing (Milestone 9 and 11).
Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.	Care Compass Network is on track to complete Milestone 10 on time. The first step (Step 10f) in this milestone is to seat our Behavioral Health Quality Committees in each of our four Regional Performance Units. These committees have been slated since early Fall 2015 and are very active. Each committee is comprised of local behavioral health providers, including for example, licensed social workers, psychiatrists, nurses with behavioral health experience, mental health clinic directors, directors of community services, substance abuse clinic directors, health home managers, and primary care physicians. These committees have been very active since their formation and have provided significant input into policies surrounding the Crisis Stabilization project and the Integration of Primary Care and Behavioral Health project (3ai). This milestone will be completed on time without any issue.
Use EHRs or other technical platforms to track all patients engaged in this project.	In addition to the milestones we are reporting to have completed Implementation Steps, Care Compass Network has made significant progress on the Crisis Stabilization project. We have had contracting discussions for services for eight of our nine counties, with various providers of crisis phone lines, mobile outreach, community-based respite, and hospital observation (Milestones 5, 6, 7, and 9). The Project 3aii, along with the Behavioral Health Quality Subcommittees, has finalized the Crisis Stabilization Definition and Guideline which serves as a diversionary treatment protocol (Milestone 4). We will use this policy as a basis for each county network of providers. We envision that the various providers (along with county mental health, law enforcement) will meet on a periodic basis (monthly, perhaps) to discuss cases, the treatment protocols, what is working, and what is not working, to be able to shape the project around community needs. Care Compass Network has begun to engage Managed Care

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
	Organizations (MCOs) in a PPS--wide strategy to establish relationships (Milestone 3). Care Compass Network intends to evaluate the Crisis Stabilization project in terms of its ability to reduce the number of unnecessary Emergency Room Visits and Hospitalizations and lobby MCOs for coverage of services (mobile outreach, crisis respite, etc.) when not covered by Medicaid. Care Compass Network is aligning the program with the Home and Community-Based Service (HCBS) waiver where possible; but even this will not guarantee coverage for all Medicaid members. Finally, Care Compass Network is working with our partners on the IT-related requirements of their EMR systems to ensure these requirements can be met (Milestones 8 and 11). Care Compass Network is on track for completion of all Milestones in this project. Care Compass Network has made significant progress on the 3aii Crisis Stabilization project. Beyond the progress reported on the milestones where specific implementation steps have been completed, there has been progress in the areas of written protocols—our Crisis Stabilization Definition and Guideline Policy (Milestone 4), contracting for services in our counties (Milestones 5, 6, 7, and 9), EMR development and information sharing (Milestone 9 and 11).

Milestone Review Status

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

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

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.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 DY1 Q4 should include patients previously reported in DY1 Q3 plus new patients engaged in DY1 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	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4
PPS Reported	Baseline Commitment	0	0	0	620
	Quarterly Update	0	0	0	0
	Percent(%) of Commitment				0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment				0.00%

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
Fail	

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		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1c. Data Analytics - The PPS Salient team will work in conjunction with the Population Health workgroup in order to identify patients with cardiovascular disease within our PPS region. The associated methodologies, assumptions, and results will be presented to the respective Disease Management subcommittees of the Clinical Governance Committee for review and identification of potential gaps in the analysis.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1d. Interventions - The PPS will adopt and/or develop evidence based strategies - such as the Million Hearts Campaign, JNC-8, AHA 2013, ACC - for implementation based on benficiary risk in conjunction with the 3bi Project Team and the Clinical Governance Committee. These interventions will be used in tandem with other industry standards such as blood pressure checks, lipids, smoking and other health assessment screenings at primary care provider visits to determine criteria for patient risk stratification.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task		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
1e. Identify process to risk stratify beneficiaries with cardiovascular disease for intervention. An acuity score will be developed by the Project 3bi Team working with the Project Management Office. This acuity score will determine a level of risk and the subsequent health management interventions needed, i.e. preventive services, lifestyle coaching, transitional care, complex care management, and/or palliative care. The acuity score and subsequent interventions will be presented to the Disease Management subcommittee and Clinical Governance Committee for review, alterations, and approval. Reassessment of acuity score and interventions will occur annually at a minimum.										
Task 1f. Patient Supports - The Project Leaders and PMO representation from Projects 3bi and Project 2ci will work together to identify community-based organizations (e.g., Social Services) offering the necessary patient supports for medicaid beneficiaries with cardiovascular disease. The PPS Community Navigation Team will leverage the Community Health Advocates (CHAs) and defined care management protocols to further promote navigation of cardiovascular disease patients through the healthcare system.		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		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
Office. The Project Chamption will then conduct training at their respective facility to the related support staff, including topics such as care coordination processes, blood pressure measurement, protocol regarding patients with repeated elevated blood pressure, patient self-management, follow-up procedures, home blood pressure monitoring, and Million Lives Campaign strategies. As required by partner contract agreements the champion will also be responsible for the provision of training date(s), attendees, and written materials (as well as Q/A items) to the PMO.										
Task 1i. IT Tools and Support - The Project 3bi Team will collaborate with the IT Workgroup to develop necessary IT Tools and support such as provider alerts and patient reminders as per defined care management goals within EHRs. These metrics will be created to align with 2014 PCMH Level 3 standards and/or Meaningful Use requirements.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	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

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 2f. Develop plan to connect all providers- begin with high volume / well engaged providers.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 2g. Develop outreach plans and a PPS consent for patients to participate in the exchange.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 2h. Develop standards for provider alerts in the EMR in conjunction with the Clinical Governance and IT & Data Governance Committees .		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	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	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 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		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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
4c. The Project Management Office will work with partners and/or alongside EHR vendors to acquire required validation of EHR connectivity and capabilities, including formal documentation/retention of certification related documents and EHR reminder functionality. The PPS IT Project Manager will review and monitor the IT environment to confirm EHR system capabilities are in place and used and functioning as designed, ensuring access to real-time data to improve interoperability. Periodic reviews will be performed and include evidence of alerts/secure messaging, availability of training materials, and status of prior review remediation status. The status of these reviews will be reported to the IT & Data Governance Committee and/or Clinical Governance Committee as appropriate.										
Task 4d. As required and appropriate, partners will be contracted with for achievement of specific tasks (e.g., build and maintenance of EMR modification to provide reminders), which will be monitored for completion as reported to the project team and PMO. Upon completion, validity of system enhancements will be reviewed and validated as described in step 4c.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate tobacco control protocols.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5c. Educate providers and office staff on the "5A's" - Ask, Assess, Advise, Assist, and Arrange.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5d. Develop 5As assessment tool in the EMRs including hard stop prompts.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5e. Develop process for smoking cessation referrals through EMR secure messaging .		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5f. Develop process for provider feedback.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #6	DY2 Q4	Project	N/A	In Progress	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
Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.										
Task Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 6b. Obtain PPS approval for hypertension protocol from the Clinical Governance Committee - suggest existing guidance such as "JNC8".		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6c. Obtain PPS approval for cholesterol protocol from the Clinical Governance Committee- suggest existing guidance such as "AHA 2013" guidelines.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6d. Educate providers on these protocols .		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination processes are in place.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7d. The 3bi Project Team and PMO will develop care coordination teams by achieving four core foundational requirements: assessing available resources, assessing the patient demographics, providing education where required, and adopting applicable standards.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7e. Assess Resources - The 3bi Project Team and PMO will work in tandem with the Population Health workgroup to assess availability of current care coordination and disease management resources in the PPS.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

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
Assess Patients - The 3bi Project Team, in conjunction with the PPS Analytics Team will develop a process to risk stratify beneficiaries for connection with care coordination based on the results of the Population Health data results and risk stratification review.										
Task 7f. Education - The Workforce team along with the Project Management Office will create Care Coordination teams within each office/practice and will include nurses, pharmacists, dieticians, community health workers, health home care managers, and others where applicable. Once established, the Workforce team will oversee the education to providers on these resources and create referral processes through the EMR to connect with providers of care coordination.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7g. Standards - Adopt/develop standards for cardiovascular disease management / care coordination in conjunction with the Clinical Governance Committee and, more specificly, disease management subcommittees.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	DY3 Q4	Project	N/A	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 8b. Assess availability of current practice for blood pressure checks with no copay or appointment required .		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 8c. Develop PPS protocol for the provision of this service as a standard of care in conjunction with the Clinical Governance Committee.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 8d. Identify the support needed for practices to offer this service and document in the EMRs.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	DY2 Q4	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS has protocols in place to ensure blood pressure		Project		In Progress	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
measurements are taken correctly with the correct equipment.										
Task 9b. Identify evidence based practice for blood pressure measurement in conjunction with the Clinical Governance Committee and, more specifically, the disease management subcommittees.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 9c. Create the competency for staff training and annual assessment.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 9d. Create PPS protocol to require all staff taking blood pressures take/pass an annual competency test.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	DY3 Q4	Project	N/A	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 10d. Create risk stratification tool to identify beneficiaries in need of follow-up appointments for BP management.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 10e. Develop alert in the EMR for beneficiaries with repeat elevated blood pressure readings.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 10f. Utilize "measure up, pressure down" for BP management (Million Hearts Campaign).		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

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
significant non-differentiating factors.										
Task 11b. Establish alert in the EMRs as reminders for once daily regimens.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11c. Engage pharmacists in recommending once daily regimens as substitutions for other regimens.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11d. Engage managed care payers in offering once daily regimens as formulary options.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Self-management goals are documented in the clinical record.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 12c. The education of staff on the development of self management goals with beneficiaries will be done by the collaborative efforts of the Project Management Office, the Provider Relations team, and the Communications Team. Forums will be held within each RPU for the participating providers.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 12d. The 3bi Project Team will collaborate with the PPS IT Committee and/or Clinical Governance Committee to develop standards of data elements to identify partner EMR capability of reaching the required elements of the standard of care (e.g., documentation of benficiary self management goals.)		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 12e. Once approved, the 3bi Project Team and PMO will conduct a survey/assessment with partners to understand current system capabilities. As identified, system functionality deficiencies or gaps will be reported to the IT Committee and PPS partner 3bi Project Champion for identification of remediation solutions.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 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		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
patient driven self-management goals in the medical record and review of said goals.										
Task 12g. PPS Partner status reports will be reported to the PPS Disease Management Quality Committee for review and any necessary improvements to be pursued as appropriate.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	DY3 Q4	Project	N/A	In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task PPS has developed referral and follow-up process and adheres to process.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task PPS provides periodic training to staff on warm referral and follow-up process.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 13d. Identify resources to provide beneficiary support for lifestyle changes- CDSMP.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 13e. Develop a 2 way referral process from the EMR: provider to CBO and CBO feedback to provider.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 13f. Train staff on the referral process including appropriate beneficiaries for referral.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	DY2 Q4	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS has developed and implemented protocols for home blood pressure monitoring.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS provides periodic training to staff on warm referral and		Project		In Progress	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
follow-up process.										
Task 14d. Develop protocols for home BP monitoring based on risk (self monitor vs telehealth) in conjunction with the Clinical Governance Committee and, more specifically, the disease management subcommittees.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 14e. Identify resource for home BP cuffs if needed to support compliance .		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 14f. Develop method for beneficiary follow up reporting- phone, web program, telehealth, etc.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 15b. Identify benficiaries through EMR functionality and/or claims data.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 15c. Develop process for scheduling patients for office visit.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 15d. Develop process for BP screening outside of office setting in a community "hot spot".		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed referral and follow-up process and adheres to process.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 16b. Develop process for referral to quitline preferably through EMR.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 16c. Develop process for provider feedback on referral.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 16d. Educate providers and office staff on referral process and beneficiary education.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #17 Perform additional actions including "hot spotting" strategies in	DY3 Q4	Project	N/A	In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 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
high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.										
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task If applicable, PPS has established linkages to health homes for targeted patient populations.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 17d. Identification of high risk neighborhoods and development of strategies to engage beneficiaries.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 17e. Develop processes to link with patients through Medicaid health home relationships.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 17f. Utilize CDSMP for beneficiary engagement in lifestyle changes .		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Milestone #18 Adopt strategies from the Million Hearts Campaign.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.		Provider	Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.		Provider	Mental Health	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 18d. Develop methods to risk stratify the population with CV or potential CV disease.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

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

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 #20 Engage a majority (at least 80%) of primary care providers in this project.	DY2 Q4	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS has engaged at least 80% of their PCPs in this activity.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 20b. Identify PCPs and evaluate their ability to meet the project requirements.		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 20c. Educate providers on the projects and seek their input on implementation.		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	There are 20 milestones in project 3.b.i with 0 due for submission in DY1, Q4. The project team has continued to meet on a monthly basis with bi-weekly telephonic touch points to ensure all members are actively working towards quarterly goals. During DY1, Q4 the team met with clinical leaders from local physician practice groups to establish clinical competencies for taking a manual blood pressure, general hypertension guidelines, as well as home blood pressure monitoring guidelines (Milestones 6, 9, 14). These guidelines will be brought to the Clinical Governance Committee and the Board of Directors for approval in DY2, Q1. On February 9th the team participated in multi-PPS Tobacco Cessation Planning meetings with Bassett and Alliance PPSs. This allowed sharing of best practices as well as various tobacco cessation models. Additionally, the PPS has continued to work with the CNY Regional Center for Tobacco Systems and will be participating in a Tobacco Cessation Education Seminar on April 8th. The project team held an in-person meeting with the CNY Regional Center for Tobacco Systems on February 9th and focused on patient focused tobacco cessation strategies rather than provider driven strategies. Additionally, the PPS is also facilitating monthly multi-PPS conference calls with PPSs across the state also participating in project 3.b.i. These discussions have been very beneficial to all involved, and the cross-PPS collaboration has helped the discussion group move forward with CDSMP strategy, which has remained a focal point of the conference call. Other continual discussion points have been implementation of Million Lives strategies, tobacco cessation hand offs, sharing of implementation plans, and best practices to date. The Multi-PPS Collaborative continues to meet the first Tuesday of the month for 1 hour. We do not anticipate any barriers or roadblocks to completing milestones at this time. The project team anticipates having multiple partner contracts signed for project 3bi by the close of DY2, Q1.
Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	There are 20 milestones in project 3.b.i with 0 due for submission in DY1, Q4. The project team has continued to meet on a monthly basis with bi-weekly telephonic touch points to ensure all members are actively working towards quarterly goals. During DY1, Q4 the team met with clinical leaders from local physician practice groups to establish clinical competencies for taking a manual blood pressure, general hypertension guidelines, as well as home blood pressure monitoring guidelines (Milestones 6, 9, 14). These guidelines will be brought to the Clinical Governance Committee and the Board of Directors for approval in DY2, Q1. On February 9th the team participated in multi-PPS Tobacco Cessation Planning meetings with Bassett and Alliance PPSs. This allowed sharing of best practices as well as various tobacco cessation models.

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
	Additionally, the PPS has continued to work with the CNY Regional Center for Tobacco Systems and will be participating in a Tobacco Cessation Education Seminar on April 8th. The project team held an in-person meeting with the CNY Regional Center for Tobacco Systems on February 9th and focused on patient focused tobacco cessation strategies rather than provider driven strategies. Additionally, the PPS is also facilitating monthly multi-PPS conference calls with PPSs across the state also participating in project 3.b.i. These discussions have been very beneficial to all involved, and the cross-PPS collaboration has helped the discussion group move forward with CDSMP strategy, which has remained a focal point of the conference call. Other continual discussion points have been implementation of Million Lives strategies, tobacco cessation hand offs, sharing of implementation plans, and best practices to date. The Multi-PPS Collaborative continues to meet the first Tuesday of the month for 1 hour. We do not anticipate any barriers or roadblocks to completing milestones at this time. The project team anticipates having multiple partner contracts signed for project 3bi by the close of DY2, Q1.
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	There are 20 milestones in project 3.b.i with 0 due for submission in DY1, Q4. The project team has continued to meet on a monthly basis with bi-weekly telephonic touch points to ensure all members are actively working towards quarterly goals. During DY1, Q4 the team met with clinical leaders from local physician practice groups to establish clinical competencies for taking a manual blood pressure, general hypertension guidelines, as well as home blood pressure monitoring guidelines (Milestones 6, 9, 14). These guidelines will be brought to the Clinical Governance Committee and the Board of Directors for approval in DY2, Q1. On February 9th the team participated in multi-PPS Tobacco Cessation Planning meetings with Bassett and Alliance PPSs. This allowed sharing of best practices as well as various tobacco cessation models. Additionally, the PPS has continued to work with the CNY Regional Center for Tobacco Systems and will be participating in a Tobacco Cessation Education Seminar on April 8th. The project team held an in-person meeting with the CNY Regional Center for Tobacco Systems on February 9th and focused on patient focused tobacco cessation strategies rather than provider driven strategies. Additionally, the PPS is also facilitating monthly multi-PPS conference calls with PPSs across the state also participating in project 3.b.i. These discussions have been very beneficial to all involved, and the cross-PPS collaboration has helped the discussion group move forward with CDSMP strategy, which has remained a focal point of the conference call. Other continual discussion points have been implementation of Million Lives strategies, tobacco cessation hand offs, sharing of implementation plans, and best practices to date. The Multi-PPS Collaborative continues to meet the first Tuesday of the month for 1 hour. We do not anticipate any barriers or roadblocks to completing milestones at this time. The project team anticipates having multiple partner contracts signed for project 3bi by the close of DY2, Q1.
Use EHRs or other technical platforms to track all patients engaged in this project.	There are 20 milestones in project 3.b.i with 0 due for submission in DY1, Q4. The project team has continued to meet on a monthly basis with bi-weekly telephonic touch points to ensure all members are actively working towards quarterly goals. During DY1, Q4 the team met with clinical leaders from local physician practice groups to establish clinical competencies for taking a manual blood pressure, general hypertension guidelines, as well as home blood pressure monitoring guidelines (Milestones 6, 9, 14). These guidelines will be brought to the Clinical Governance Committee and the Board of Directors for approval in DY2, Q1. On February 9th the team participated in multi-PPS Tobacco Cessation Planning meetings with Bassett and Alliance PPSs. This allowed sharing of best practices as well as various tobacco cessation models. Additionally, the PPS has continued to work with the CNY Regional Center for Tobacco Systems and will be participating in a Tobacco Cessation Education Seminar on April 8th. The project team held an in-person meeting with the CNY Regional Center for Tobacco Systems on February 9th and focused on patient focused tobacco cessation strategies rather than provider driven strategies. Additionally, the PPS is also facilitating monthly multi-PPS conference calls with PPSs across the state also participating in project 3.b.i. These discussions have been very beneficial to all involved, and the cross-PPS collaboration has helped the discussion group move forward with CDSMP strategy, which has remained a focal point of the conference call. Other continual discussion points have been implementation of Million Lives strategies, tobacco cessation hand offs, sharing of implementation plans, and best practices to date. The Multi-PPS Collaborative continues to meet the first Tuesday of the month for 1 hour. We do not anticipate any barriers or roadblocks to completing milestones at this time. The project team anticipates having multiple partner contracts signed for project 3bi by the close of DY2, Q1.
Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	There are 20 milestones in project 3.b.i with 0 due for submission in DY1, Q4. The project team has continued to meet on a monthly basis with bi-weekly telephonic touch points to ensure all members are actively working towards quarterly goals. During DY1, Q4 the team met with clinical leaders from local physician practice groups to establish clinical competencies for taking a manual blood pressure, general hypertension guidelines, as well as home blood pressure monitoring guidelines (Milestones 6, 9, 14). These guidelines will be brought to the Clinical Governance Committee and the Board of Directors for approval in DY2, Q1. On February 9th the team participated in multi-PPS Tobacco Cessation Planning meetings with Bassett and Alliance PPSs. This allowed sharing of best practices as well as various tobacco cessation models. Additionally, the PPS has continued to work with the CNY Regional Center for Tobacco Systems and will be participating in a Tobacco Cessation Education Seminar on

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
	April 8th. The project team held an in-person meeting with the CNY Regional Center for Tobacco Systems on February 9th and focused on patient focused tobacco cessation strategies rather than provider driven strategies. Additionally, the PPS is also facilitating monthly multi-PPS conference calls with PPSs across the state also participating in project 3.b.i. These discussions have been very beneficial to all involved, and the cross-PPS collaboration has helped the discussion group move forward with CDSMP strategy, which has remained a focal point of the conference call. Other continual discussion points have been implementation of Million Lives strategies, tobacco cessation hand offs, sharing of implementation plans, and best practices to date. The Multi-PPS Collaborative continues to meet the first Tuesday of the month for 1 hour. We do not anticipate any barriers or roadblocks to completing milestones at this time. The project team anticipates having multiple partner contracts signed for project 3bi by the close of DY2, Q1.
Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	There are 20 milestones in project 3.b.i with 0 due for submission in DY1, Q4. The project team has continued to meet on a monthly basis with bi-weekly telephonic touch points to ensure all members are actively working towards quarterly goals. During DY1, Q4 the team met with clinical leaders from local physician practice groups to establish clinical competencies for taking a manual blood pressure, general hypertension guidelines, as well as home blood pressure monitoring guidelines (Milestones 6, 9, 14). These guidelines will be brought to the Clinical Governance Committee and the Board of Directors for approval in DY2, Q1. On February 9th the team participated in multi-PPS Tobacco Cessation Planning meetings with Bassett and Alliance PPSs. This allowed sharing of best practices as well as various tobacco cessation models. Additionally, the PPS has continued to work with the CNY Regional Center for Tobacco Systems and will be participating in a Tobacco Cessation Education Seminar on April 8th. The project team held an in-person meeting with the CNY Regional Center for Tobacco Systems on February 9th and focused on patient focused tobacco cessation strategies rather than provider driven strategies. Additionally, the PPS is also facilitating monthly multi-PPS conference calls with PPSs across the state also participating in project 3.b.i. These discussions have been very beneficial to all involved, and the cross-PPS collaboration has helped the discussion group move forward with CDSMP strategy, which has remained a focal point of the conference call. Other continual discussion points have been implementation of Million Lives strategies, tobacco cessation hand offs, sharing of implementation plans, and best practices to date. The Multi-PPS Collaborative continues to meet the first Tuesday of the month for 1 hour. We do not anticipate any barriers or roadblocks to completing milestones at this time. The project team anticipates having multiple partner contracts signed for project 3bi by the close of DY2, Q1.
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.	There are 20 milestones in project 3.b.i with 0 due for submission in DY1, Q4. The project team has continued to meet on a monthly basis with bi-weekly telephonic touch points to ensure all members are actively working towards quarterly goals. During DY1, Q4 the team met with clinical leaders from local physician practice groups to establish clinical competencies for taking a manual blood pressure, general hypertension guidelines, as well as home blood pressure monitoring guidelines (Milestones 6, 9, 14). These guidelines will be brought to the Clinical Governance Committee and the Board of Directors for approval in DY2, Q1. On February 9th the team participated in multi-PPS Tobacco Cessation Planning meetings with Bassett and Alliance PPSs. This allowed sharing of best practices as well as various tobacco cessation models. Additionally, the PPS has continued to work with the CNY Regional Center for Tobacco Systems and will be participating in a Tobacco Cessation Education Seminar on April 8th. The project team held an in-person meeting with the CNY Regional Center for Tobacco Systems on February 9th and focused on patient focused tobacco cessation strategies rather than provider driven strategies. Additionally, the PPS is also facilitating monthly multi-PPS conference calls with PPSs across the state also participating in project 3.b.i. These discussions have been very beneficial to all involved, and the cross-PPS collaboration has helped the discussion group move forward with CDSMP strategy, which has remained a focal point of the conference call. Other continual discussion points have been implementation of Million Lives strategies, tobacco cessation hand offs, sharing of implementation plans, and best practices to date. The Multi-PPS Collaborative continues to meet the first Tuesday of the month for 1 hour. We do not anticipate any barriers or roadblocks to completing milestones at this time. The project team anticipates having multiple partner contracts signed for project 3bi by the close of DY2, Q1.
Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	There are 20 milestones in project 3.b.i with 0 due for submission in DY1, Q4. The project team has continued to meet on a monthly basis with bi-weekly telephonic touch points to ensure all members are actively working towards quarterly goals. During DY1, Q4 the team met with clinical leaders from local physician practice groups to establish clinical competencies for taking a manual blood pressure, general hypertension guidelines, as well as home blood pressure monitoring guidelines (Milestones 6, 9, 14). These guidelines will be brought to the Clinical Governance Committee and the Board of Directors for approval in DY2, Q1. On February 9th the team participated in multi-PPS Tobacco Cessation Planning meetings with Bassett and Alliance PPSs. This allowed sharing of best practices as well as various tobacco cessation models. Additionally, the PPS has continued to work with the CNY Regional Center for Tobacco Systems and will be participating in a Tobacco Cessation Education Seminar on April 8th. The project team held an in-person meeting with the CNY Regional Center for Tobacco Systems on February 9th and focused on patient focused tobacco

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
	cessation strategies rather than provider driven strategies. Additionally, the PPS is also facilitating monthly multi-PPS conference calls with PPSs across the state also participating in project 3.b.i. These discussions have been very beneficial to all involved, and the cross-PPS collaboration has helped the discussion group move forward with CDSMP strategy, which has remained a focal point of the conference call. Other continual discussion points have been implementation of Million Lives strategies, tobacco cessation hand offs, sharing of implementation plans, and best practices to date. The Multi-PPS Collaborative continues to meet the first Tuesday of the month for 1 hour. We do not anticipate any barriers or roadblocks to completing milestones at this time. The project team anticipates having multiple partner contracts signed for project 3bi by the close of DY2, Q1.
Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	There are 20 milestones in project 3.b.i with 0 due for submission in DY1, Q4. The project team has continued to meet on a monthly basis with bi-weekly telephonic touch points to ensure all members are actively working towards quarterly goals. During DY1, Q4 the team met with clinical leaders from local physician practice groups to establish clinical competencies for taking a manual blood pressure, general hypertension guidelines, as well as home blood pressure monitoring guidelines (Milestones 6, 9, 14). These guidelines will be brought to the Clinical Governance Committee and the Board of Directors for approval in DY2, Q1. On February 9th the team participated in multi-PPS Tobacco Cessation Planning meetings with Bassett and Alliance PPSs. This allowed sharing of best practices as well as various tobacco cessation models. Additionally, the PPS has continued to work with the CNY Regional Center for Tobacco Systems and will be participating in a Tobacco Cessation Education Seminar on April 8th. The project team held an in-person meeting with the CNY Regional Center for Tobacco Systems on February 9th and focused on patient focused tobacco cessation strategies rather than provider driven strategies. Additionally, the PPS is also facilitating monthly multi-PPS conference calls with PPSs across the state also participating in project 3.b.i. These discussions have been very beneficial to all involved, and the cross-PPS collaboration has helped the discussion group move forward with CDSMP strategy, which has remained a focal point of the conference call. Other continual discussion points have been implementation of Million Lives strategies, tobacco cessation hand offs, sharing of implementation plans, and best practices to date. The Multi-PPS Collaborative continues to meet the first Tuesday of the month for 1 hour. We do not anticipate any barriers or roadblocks to completing milestones at this time. The project team anticipates having multiple partner contracts signed for project 3bi by the close of DY2, Q1.
Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	There are 20 milestones in project 3.b.i with 0 due for submission in DY1, Q4. The project team has continued to meet on a monthly basis with bi-weekly telephonic touch points to ensure all members are actively working towards quarterly goals. During DY1, Q4 the team met with clinical leaders from local physician practice groups to establish clinical competencies for taking a manual blood pressure, general hypertension guidelines, as well as home blood pressure monitoring guidelines (Milestones 6, 9, 14). These guidelines will be brought to the Clinical Governance Committee and the Board of Directors for approval in DY2, Q1. On February 9th the team participated in multi-PPS Tobacco Cessation Planning meetings with Bassett and Alliance PPSs. This allowed sharing of best practices as well as various tobacco cessation models. Additionally, the PPS has continued to work with the CNY Regional Center for Tobacco Systems and will be participating in a Tobacco Cessation Education Seminar on April 8th. The project team held an in-person meeting with the CNY Regional Center for Tobacco Systems on February 9th and focused on patient focused tobacco cessation strategies rather than provider driven strategies. Additionally, the PPS is also facilitating monthly multi-PPS conference calls with PPSs across the state also participating in project 3.b.i. These discussions have been very beneficial to all involved, and the cross-PPS collaboration has helped the discussion group move forward with CDSMP strategy, which has remained a focal point of the conference call. Other continual discussion points have been implementation of Million Lives strategies, tobacco cessation hand offs, sharing of implementation plans, and best practices to date. The Multi-PPS Collaborative continues to meet the first Tuesday of the month for 1 hour. We do not anticipate any barriers or roadblocks to completing milestones at this time. The project team anticipates having multiple partner contracts signed for project 3bi by the close of DY2, Q1.
Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	There are 20 milestones in project 3.b.i with 0 due for submission in DY1, Q4. The project team has continued to meet on a monthly basis with bi-weekly telephonic touch points to ensure all members are actively working towards quarterly goals. During DY1, Q4 the team met with clinical leaders from local physician practice groups to establish clinical competencies for taking a manual blood pressure, general hypertension guidelines, as well as home blood pressure monitoring guidelines (Milestones 6, 9, 14). These guidelines will be brought to the Clinical Governance Committee and the Board of Directors for approval in DY2, Q1. On February 9th the team participated in multi-PPS Tobacco Cessation Planning meetings with Bassett and Alliance PPSs. This allowed sharing of best practices as well as various tobacco cessation models. Additionally, the PPS has continued to work with the CNY Regional Center for Tobacco Systems and will be participating in a Tobacco Cessation Education Seminar on April 8th. The project team held an in-person meeting with the CNY Regional Center for Tobacco Systems on February 9th and focused on patient focused tobacco cessation strategies rather than provider driven strategies. Additionally, the PPS is also facilitating monthly multi-PPS conference calls with PPSs across the state also

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
	participating in project 3.b.i. These discussions have been very beneficial to all involved, and the cross-PPS collaboration has helped the discussion group move forward with CDSMP strategy, which has remained a focal point of the conference call. Other continual discussion points have been implementation of Million Lives strategies, tobacco cessation hand offs, sharing of implementation plans, and best practices to date. The Multi-PPS Collaborative continues to meet the first Tuesday of the month for 1 hour. We do not anticipate any barriers or roadblocks to completing milestones at this time. The project team anticipates having multiple partner contracts signed for project 3bi by the close of DY2, Q1.
Document patient driven self-management goals in the medical record and review with patients at each visit.	There are 20 milestones in project 3.b.i with 0 due for submission in DY1, Q4. The project team has continued to meet on a monthly basis with bi-weekly telephonic touch points to ensure all members are actively working towards quarterly goals. During DY1, Q4 the team met with clinical leaders from local physician practice groups to establish clinical competencies for taking a manual blood pressure, general hypertension guidelines, as well as home blood pressure monitoring guidelines (Milestones 6, 9, 14). These guidelines will be brought to the Clinical Governance Committee and the Board of Directors for approval in DY2, Q1. On February 9th the team participated in multi-PPS Tobacco Cessation Planning meetings with Bassett and Alliance PPSs. This allowed sharing of best practices as well as various tobacco cessation models. Additionally, the PPS has continued to work with the CNY Regional Center for Tobacco Systems and will be participating in a Tobacco Cessation Education Seminar on April 8th. The project team held an in-person meeting with the CNY Regional Center for Tobacco Systems on February 9th and focused on patient focused tobacco cessation strategies rather than provider driven strategies. Additionally, the PPS is also facilitating monthly multi-PPS conference calls with PPSs across the state also participating in project 3.b.i. These discussions have been very beneficial to all involved, and the cross-PPS collaboration has helped the discussion group move forward with CDSMP strategy, which has remained a focal point of the conference call. Other continual discussion points have been implementation of Million Lives strategies, tobacco cessation hand offs, sharing of implementation plans, and best practices to date. The Multi-PPS Collaborative continues to meet the first Tuesday of the month for 1 hour. We do not anticipate any barriers or roadblocks to completing milestones at this time. The project team anticipates having multiple partner contracts signed for project 3bi by the close of DY2, Q1.
Follow up with referrals to community based programs to document participation and behavioral and health status changes.	There are 20 milestones in project 3.b.i with 0 due for submission in DY1, Q4. The project team has continued to meet on a monthly basis with bi-weekly telephonic touch points to ensure all members are actively working towards quarterly goals. During DY1, Q4 the team met with clinical leaders from local physician practice groups to establish clinical competencies for taking a manual blood pressure, general hypertension guidelines, as well as home blood pressure monitoring guidelines (Milestones 6, 9, 14). These guidelines will be brought to the Clinical Governance Committee and the Board of Directors for approval in DY2, Q1. On February 9th the team participated in multi-PPS Tobacco Cessation Planning meetings with Bassett and Alliance PPSs. This allowed sharing of best practices as well as various tobacco cessation models. Additionally, the PPS has continued to work with the CNY Regional Center for Tobacco Systems and will be participating in a Tobacco Cessation Education Seminar on April 8th. The project team held an in-person meeting with the CNY Regional Center for Tobacco Systems on February 9th and focused on patient focused tobacco cessation strategies rather than provider driven strategies. Additionally, the PPS is also facilitating monthly multi-PPS conference calls with PPSs across the state also participating in project 3.b.i. These discussions have been very beneficial to all involved, and the cross-PPS collaboration has helped the discussion group move forward with CDSMP strategy, which has remained a focal point of the conference call. Other continual discussion points have been implementation of Million Lives strategies, tobacco cessation hand offs, sharing of implementation plans, and best practices to date. The Multi-PPS Collaborative continues to meet the first Tuesday of the month for 1 hour. We do not anticipate any barriers or roadblocks to completing milestones at this time. The project team anticipates having multiple partner contracts signed for project 3bi by the close of DY2, Q1.
Develop and implement protocols for home blood pressure monitoring with follow up support.	There are 20 milestones in project 3.b.i with 0 due for submission in DY1, Q4. The project team has continued to meet on a monthly basis with bi-weekly telephonic touch points to ensure all members are actively working towards quarterly goals. During DY1, Q4 the team met with clinical leaders from local physician practice groups to establish clinical competencies for taking a manual blood pressure, general hypertension guidelines, as well as home blood pressure monitoring guidelines (Milestones 6, 9, 14). These guidelines will be brought to the Clinical Governance Committee and the Board of Directors for approval in DY2, Q1. On February 9th the team participated in multi-PPS Tobacco Cessation Planning meetings with Bassett and Alliance PPSs. This allowed sharing of best practices as well as various tobacco cessation models. Additionally, the PPS has continued to work with the CNY Regional Center for Tobacco Systems and will be participating in a Tobacco Cessation Education Seminar on April 8th. The project team held an in-person meeting with the CNY Regional Center for Tobacco Systems on February 9th and focused on patient focused tobacco cessation strategies rather than provider driven strategies. Additionally, the PPS is also facilitating monthly multi-PPS conference calls with PPSs across the state also participating in project 3.b.i. These discussions have been very beneficial to all involved, and the cross-PPS collaboration has helped the discussion group move forward

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 CDSMP strategy, which has remained a focal point of the conference call. Other continual discussion points have been implementation of Million Lives strategies, tobacco cessation hand offs, sharing of implementation plans, and best practices to date. The Multi-PPS Collaborative continues to meet the first Tuesday of the month for 1 hour. We do not anticipate any barriers or roadblocks to completing milestones at this time. The project team anticipates having multiple partner contracts signed for project 3bi by the close of DY2, Q1.
Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	There are 20 milestones in project 3.b.i with 0 due for submission in DY1, Q4. The project team has continued to meet on a monthly basis with bi-weekly telephonic touch points to ensure all members are actively working towards quarterly goals. During DY1, Q4 the team met with clinical leaders from local physician practice groups to establish clinical competencies for taking a manual blood pressure, general hypertension guidelines, as well as home blood pressure monitoring guidelines (Milestones 6, 9, 14). These guidelines will be brought to the Clinical Governance Committee and the Board of Directors for approval in DY2, Q1. On February 9th the team participated in multi-PPS Tobacco Cessation Planning meetings with Bassett and Alliance PPSs. This allowed sharing of best practices as well as various tobacco cessation models. Additionally, the PPS has continued to work with the CNY Regional Center for Tobacco Systems and will be participating in a Tobacco Cessation Education Seminar on April 8th. The project team held an in-person meeting with the CNY Regional Center for Tobacco Systems on February 9th and focused on patient focused tobacco cessation strategies rather than provider driven strategies. Additionally, the PPS is also facilitating monthly multi-PPS conference calls with PPSs across the state also participating in project 3.b.i. These discussions have been very beneficial to all involved, and the cross-PPS collaboration has helped the discussion group move forward with CDSMP strategy, which has remained a focal point of the conference call. Other continual discussion points have been implementation of Million Lives strategies, tobacco cessation hand offs, sharing of implementation plans, and best practices to date. The Multi-PPS Collaborative continues to meet the first Tuesday of the month for 1 hour. We do not anticipate any barriers or roadblocks to completing milestones at this time. The project team anticipates having multiple partner contracts signed for project 3bi by the close of DY2, Q1.
Facilitate referrals to NYS Smoker's Quitline.	There are 20 milestones in project 3.b.i with 0 due for submission in DY1, Q4. The project team has continued to meet on a monthly basis with bi-weekly telephonic touch points to ensure all members are actively working towards quarterly goals. During DY1, Q4 the team met with clinical leaders from local physician practice groups to establish clinical competencies for taking a manual blood pressure, general hypertension guidelines, as well as home blood pressure monitoring guidelines (Milestones 6, 9, 14). These guidelines will be brought to the Clinical Governance Committee and the Board of Directors for approval in DY2, Q1. On February 9th the team participated in multi-PPS Tobacco Cessation Planning meetings with Bassett and Alliance PPSs. This allowed sharing of best practices as well as various tobacco cessation models. Additionally, the PPS has continued to work with the CNY Regional Center for Tobacco Systems and will be participating in a Tobacco Cessation Education Seminar on April 8th. The project team held an in-person meeting with the CNY Regional Center for Tobacco Systems on February 9th and focused on patient focused tobacco cessation strategies rather than provider driven strategies. Additionally, the PPS is also facilitating monthly multi-PPS conference calls with PPSs across the state also participating in project 3.b.i. These discussions have been very beneficial to all involved, and the cross-PPS collaboration has helped the discussion group move forward with CDSMP strategy, which has remained a focal point of the conference call. Other continual discussion points have been implementation of Million Lives strategies, tobacco cessation hand offs, sharing of implementation plans, and best practices to date. The Multi-PPS Collaborative continues to meet the first Tuesday of the month for 1 hour. We do not anticipate any barriers or roadblocks to completing milestones at this time. The project team anticipates having multiple partner contracts signed for project 3bi by the close of DY2, Q1.
Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	There are 20 milestones in project 3.b.i with 0 due for submission in DY1, Q4. The project team has continued to meet on a monthly basis with bi-weekly telephonic touch points to ensure all members are actively working towards quarterly goals. During DY1, Q4 the team met with clinical leaders from local physician practice groups to establish clinical competencies for taking a manual blood pressure, general hypertension guidelines, as well as home blood pressure monitoring guidelines (Milestones 6, 9, 14). These guidelines will be brought to the Clinical Governance Committee and the Board of Directors for approval in DY2, Q1. On February 9th the team participated in multi-PPS Tobacco Cessation Planning meetings with Bassett and Alliance PPSs. This allowed sharing of best practices as well as various tobacco cessation models. Additionally, the PPS has continued to work with the CNY Regional Center for Tobacco Systems and will be participating in a Tobacco Cessation Education Seminar on April 8th. The project team held an in-person meeting with the CNY Regional Center for Tobacco Systems on February 9th and focused on patient focused tobacco cessation strategies rather than provider driven strategies. Additionally, the PPS is also facilitating monthly multi-PPS conference calls with PPSs across the state also participating in project 3.b.i. These discussions have been very beneficial to all involved, and the cross-PPS collaboration has helped the discussion group move forward with CDSMP strategy, which has remained a focal point of the conference call. Other continual discussion points have been implementation of Million Lives strategies,

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
	tobacco cessation hand offs, sharing of implementation plans, and best practices to date. The Multi-PPS Collaborative continues to meet the first Tuesday of the month for 1 hour. We do not anticipate any barriers or roadblocks to completing milestones at this time. The project team anticipates having multiple partner contracts signed for project 3bi by the close of DY2, Q1.
Adopt strategies from the Million Hearts Campaign.	There are 20 milestones in project 3.b.i with 0 due for submission in DY1, Q4. The project team has continued to meet on a monthly basis with bi-weekly telephonic touch points to ensure all members are actively working towards quarterly goals. During DY1, Q4 the team met with clinical leaders from local physician practice groups to establish clinical competencies for taking a manual blood pressure, general hypertension guidelines, as well as home blood pressure monitoring guidelines (Milestones 6, 9, 14). These guidelines will be brought to the Clinical Governance Committee and the Board of Directors for approval in DY2, Q1. On February 9th the team participated in multi-PPS Tobacco Cessation Planning meetings with Bassett and Alliance PPSs. This allowed sharing of best practices as well as various tobacco cessation models. Additionally, the PPS has continued to work with the CNY Regional Center for Tobacco Systems and will be participating in a Tobacco Cessation Education Seminar on April 8th. The project team held an in-person meeting with the CNY Regional Center for Tobacco Systems on February 9th and focused on patient focused tobacco cessation strategies rather than provider driven strategies. Additionally, the PPS is also facilitating monthly multi-PPS conference calls with PPSs across the state also participating in project 3.b.i. These discussions have been very beneficial to all involved, and the cross-PPS collaboration has helped the discussion group move forward with CDSMP strategy, which has remained a focal point of the conference call. Other continual discussion points have been implementation of Million Lives strategies, tobacco cessation hand offs, sharing of implementation plans, and best practices to date. The Multi-PPS Collaborative continues to meet the first Tuesday of the month for 1 hour. We do not anticipate any barriers or roadblocks to completing milestones at this time. The project team anticipates having multiple partner contracts signed for project 3bi by the close of DY2, Q1.
Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	There are 20 milestones in project 3.b.i with 0 due for submission in DY1, Q4. The project team has continued to meet on a monthly basis with bi-weekly telephonic touch points to ensure all members are actively working towards quarterly goals. During DY1, Q4 the team met with clinical leaders from local physician practice groups to establish clinical competencies for taking a manual blood pressure, general hypertension guidelines, as well as home blood pressure monitoring guidelines (Milestones 6, 9, 14). These guidelines will be brought to the Clinical Governance Committee and the Board of Directors for approval in DY2, Q1. On February 9th the team participated in multi-PPS Tobacco Cessation Planning meetings with Bassett and Alliance PPSs. This allowed sharing of best practices as well as various tobacco cessation models. Additionally, the PPS has continued to work with the CNY Regional Center for Tobacco Systems and will be participating in a Tobacco Cessation Education Seminar on April 8th. The project team held an in-person meeting with the CNY Regional Center for Tobacco Systems on February 9th and focused on patient focused tobacco cessation strategies rather than provider driven strategies. Additionally, the PPS is also facilitating monthly multi-PPS conference calls with PPSs across the state also participating in project 3.b.i. These discussions have been very beneficial to all involved, and the cross-PPS collaboration has helped the discussion group move forward with CDSMP strategy, which has remained a focal point of the conference call. Other continual discussion points have been implementation of Million Lives strategies, tobacco cessation hand offs, sharing of implementation plans, and best practices to date. The Multi-PPS Collaborative continues to meet the first Tuesday of the month for 1 hour. We do not anticipate any barriers or roadblocks to completing milestones at this time. The project team anticipates having multiple partner contracts signed for project 3bi by the close of DY2, Q1.
Engage a majority (at least 80%) of primary care providers in this project.	There are 20 milestones in project 3.b.i with 0 due for submission in DY1, Q4. The project team has continued to meet on a monthly basis with bi-weekly telephonic touch points to ensure all members are actively working towards quarterly goals. During DY1, Q4 the team met with clinical leaders from local physician practice groups to establish clinical competencies for taking a manual blood pressure, general hypertension guidelines, as well as home blood pressure monitoring guidelines (Milestones 6, 9, 14). These guidelines will be brought to the Clinical Governance Committee and the Board of Directors for approval in DY2, Q1. On February 9th the team participated in multi-PPS Tobacco Cessation Planning meetings with Bassett and Alliance PPSs. This allowed sharing of best practices as well as various tobacco cessation models. Additionally, the PPS has continued to work with the CNY Regional Center for Tobacco Systems and will be participating in a Tobacco Cessation Education Seminar on April 8th. The project team held an in-person meeting with the CNY Regional Center for Tobacco Systems on February 9th and focused on patient focused tobacco cessation strategies rather than provider driven strategies. Additionally, the PPS is also facilitating monthly multi-PPS conference calls with PPSs across the state also participating in project 3.b.i. These discussions have been very beneficial to all involved, and the cross-PPS collaboration has helped the discussion group move forward with CDSMP strategy, which has remained a focal point of the conference call. Other continual discussion points have been implementation of Million Lives strategies, tobacco cessation hand offs, sharing of implementation plans, and best practices to date. The Multi-PPS Collaborative continues to meet the first Tuesday of the month 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
	1 hour. We do not anticipate any barriers or roadblocks to completing milestones at this time. The project team anticipates having multiple partner contracts signed for project 3bi by the close of DY2, Q1.

Milestone Review Status

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

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

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.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 DY1 Q4 should include patients previously reported in DY1 Q3 plus new patients engaged in DY1 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	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4
PPS Reported	Baseline Commitment	0	29	95	238
	Quarterly Update	0	0	0	0
	Percent(%) of Commitment		0.00%	0.00%	0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment		0.00%	0.00%	0.00%

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
Fail	

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	In Progress	04/01/2015	03/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH and/or APCM have been included. The PPS has received agreement from those PCPs not PCMH and/or APCM certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1b. Develop Pre-Engagement Assessment and disperse among potential partners within PPS.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 1c. Analyze data from Pre-Engagement Assessment to ascertain what Primary Care Providers (PCPs) are currently PCMH certified and those who are in the process of obtaining certification.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 1d. Develop agreements with PCPs committing to integrate palliative care into their practice model.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	DY2 Q4	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2b. Develop Pre-Engagement Assessment and disperse among potential partners within PPS.		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 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	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form. PPS has trained staff addressing role-appropriate competence in palliative care skills.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3b. The 3gi Project Team is compromised of key palliative care and hospicare entities from throughout the Care Compass Network nine county community. The Project 3gi Team will convene to determine clinical guidelines which serve as palliative care triggers, using existing standards where applicable. Special consideration will be given to the guidelines, services, and implementation of the MOLST (Medical Orders for Life Sustaining Treatment) and electronic based "e-MOLST" forms, as well as CAPC (Center for the Advancement of Palliative Care) guidance. Once the comprehensive project plan and requirements has been drafted by the Project 3gi Team they will be presented to the PPS Clinical Governance Committee for review. The Clinical Governance Committee is comprised of PPS regional as well as specialty representation. The Clinical Governance Committee will review, revise (where necessary), and endorse the project 3gi clinical guidelines. Lastly, the Clinical Governance Committee will present the PPS Board of Directors with the proposed project 3gi clinical standards and related guidance's for formal review and approval.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3c. The CCN Provider Relations team along with the Project Management Office and Project 3gi Team will develop provider education/training forums where the clinical guidelines will be discussed. Clarity, transparency, and accountability to the clinical		Project		In Progress	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
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	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Staff has received appropriate palliative care skills training, including training on PPS care protocols.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4b. Train PCP staff to identify established "clinical triggers" in patients and how to refer these to appropriate PCMH.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4c. Develop PPS care protocols in conjunction with the Clinical Governance Committee.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4d. Train PCMH staff on PPS care protocols.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 5b. Identify MCOs within the Care Compass Network nine county region.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5c. Initiate discussions with MCOs, legal counsel, compliance, and/or the Department of Health (as required) to identify approaches and solutions relative to palliative care supports and offerings provided by MCOs as aligned with DSRIP goals.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5d. Engage with MCOs to understand, for palliative care services not currently covered, how to build associated rates into existing programs.		Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.	DY2 Q4	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

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
PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 6b. Partner the 3gi Project Team with IT consultants and the PPS IT Project Manager in order to develop appropriate platforms for tracking 3gi patients in conjunction with the IT & Data Governance Committee and overall infrastructure/IT Vision developed by the PPS.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6c. Identify feasible, complete, and appropriate use of e-MOLST system to satisfactorily meet core IT requirements, including the need to monitor partner performance and track actively engaged patients.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6d. Implement eMOLST, or other supporting applications as needed, where appropriate.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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 in DY1, Q4; however, we are deferring this milestone and corresponding step to DY2, Q3. By the end of September 2015, the Pre-Engagement Assessment had been completed by 92 organizations. This survey included information regarding PCMH status. The results of the survey were subsequently made available and were analyzed by the CBO Engagement Council and RPU Leads (Step 1c). Per the Assessment, there were no organizations that self-indicated as being in the process of obtaining PCMH certification. Through pre-contracting meetings, the PPS is ascertaining which, if any, PCPs have or will achieve PCMH Level 1 certification by the required time frame. Once identified, we will then be able to enter into formal agreements that a PCP will obtain this certification and fulfill step 1a. As the project requirements have changed we are still waiting to contract with partners as the Palliative Care Outcome Scale and requirements are approved by CMS and made clearer to the partners. Until then we cannot partner with any agency to fulfill Milestone 1.
Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	For the DY1Q4 report step 2d from Milestone 2 is due and has been completed. The Community resource guide being created within the guidelines of the 2.c.i Navigation project lists a database from The Hospice & Palliative Care Association of New York (http://www.hpcanys.org/find-care/). The database was checked for completeness by searching for all available organizations within our 9 county PPS. Each Hospice and Palliative Care organization was listed. As well, the Hospice agencies utilize this listing to keep their service listing up to date. (Step 2d-Complete) The PPS is comprised of partners from primary care, community based organizations, hospital systems and the like. Each of the 5 Hospice and Palliative Care organizations within the 9 county PPS are present at all 3.g.i team work meetings as well as regional and PPS wide stakeholders meetings. This support service works 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
	tandem with the Palliative Care specialists from the hospital settings. The PPS is actively working to formally contract with these agencies, but, the partnership has been developed to bring these services into the PCMH setting to aid in the members team based care approach. Milestone 2 and Step 2a are in process and expected to be completed per their required due date.
Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	There are currently no steps due within Milestone 3 for the DY1Q4 report. The 3.g.i team continues to evaluate and adopt definitions, guidelines and trainings from content experts to utilize in creating a robust training for primary care physicians, their staff and the member. This will build on step 3b, which was previously completed in DY1Q3, but also build step 3c's training and education forums and material. Milestone 3 and steps 3a and 3c are in process and expected to be completed per their required due date.
Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	There are no tasks due for 3gi Milestone 4 in DY1Q4 however, Milestone 4 and all associated steps are in process.. Milestone 3 (Develop and adopt clinical guidelines agreed to by all partners including services and eligibility) will lend itself to the creation of the training materials and protocols to be used for training and education. The Palliative Care Outcome Scale identified in the newest updates to this project by DOH will also be utilized as it will help reinforce the training as well as education of Palliative Care to the member population as well as the practitioners. Once contracting is underway for this project we will be able to start the training of PCMH staff.
Engage with Medicaid Managed Care to address coverage of services.	In the 3gi Milestone 5 project plan there are four steps to implementation, two of which are due in DY1, Q4, however one is being reported as complete while the other we are looking to defer to align with other PPSs statewide. Utilizing the health.ny.gov website we have mapped by county the Managed Care Organization ("MCO") who offer benefit plans to members within the PPS. (step 5b - Complete) All 9 counties of the PPS have at least one MCO to service the population. Initial discussions and meetings are being setup PPS wide but will also involve collaboration between adjoining PPSs across the state to fully discuss the need for services to be covered under existing plans from the listed MCOs. Keeping in mind the need to provide seamless care for members across the state, we believe this is a joint initiative with other PPSs so uniform coverage can be achieved. For step 5a we are deferring the completion date to 3/31/18 to align with the other PPSs who are also working on Project 3.g.i.
Use EHRs or other IT platforms to track all patients engaged in this project.	There are no tasks due for 3gi Milestone 6 in DY1Q4. With the new Palliative Care Outcome Scale form identified from the DOH for this project we will work with PCMH locations to not only look into running eMOLST in parallel to their systems but incorporation of the POS form into their EHR's if appropriate. This will then track each member receiving care within the system. The PPS is awaiting final approval from CMS in order to incorporate this guideline into the contract and to begin contracting with partners for this project.

Milestone Review Status

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

Instructions :

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

DSRIP Implementation Plan Project

Care Compass Network (PPS ID:44)

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

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

Instructions :

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

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

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	03/31/2017	03/31/2017	DY2 Q4
Task 1a. Leveraging the 4aiii MEB project team, identify evidence-based screening tools which can meet DSRIP goals of strengthening mental health and substance abuse infrastructure of the PPS. Identified tools should be validated by the PPS Clinical Governance Committee and approved for PPS adoption by the Board of Directors.	Completed	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1b. Identify those primary and specialty care providers in each of the four regions of the PPS with whom the PPS can engage in the screening process and the associated staff education.	Completed	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1c. Identify and procure the evidence based targeted intervention services, for approval by CCN Clinical Governance Committee and Board of Directors.	In Progress	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1d. Engage with partner agencies across the PPS region to provide the targeted intervention services and associated training requirements.	In Progress	See Narrative.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone Milestone 2 - Expand efforts with DOH and 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	03/31/2016	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2a. On an as needed basis, engage DOH / OMH/ OASAS for feedback and recommendations on	In Progress	See Narrative.	04/01/2015	03/31/2016	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).	In Progress	See Narrative.	04/01/2015	03/31/2016	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone Milestone 3 - Share data and information on MEB health promotion and MEB disorder prevention and treatment.	In Progress	Share data and information on MEB health promotion and MEB disorder prevention and treatment.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3a. Leveraging the 4aiii MEB project team, develop the mechanism for collection and aggregation of all data as the project components are implemented, informed by the IT & Data Governance Committee for alignment (where appropriate) with other behavioral health initiatives and/or PPS integrated delivery system roadmaps.	In Progress	See Narrative.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3b. Behavioral Health quality subcommittee in place at each Regional Performance Unit (RPU) will evaluate program function and efficacy and report results to the PPS level Clinical Governance Committee. Identified quality improvement metrics, if any, as 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	12/31/2016	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)

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.	Care Compass Network has made significant progress on the 4aiii Mental Health and Substance Abuse Infrastructure project. Our strategy to develop Mental, Emotional and Behavioral Health promotion and disorder prevention partnerships complements and builds on two other Care Compass Network projects—Integrating Behavioral Health and Primary Care and Community-Based Navigation. The 4aiii Project Team has identified evidence-based screening tools to help identify unmet behavioral health needs in the population. These tools and follow up protocols build on the procedures developed for the Integration of Behavioral Health and Primary Care project; tools include the PHQ-9 (adults and adolescent version) to identify depression, the CAGE, AUDIT, and DAST for identifying substance abuse, GAD-7 for anxiety, PC-PTSD for post-traumatic stress disorder and a Suicide and Violence scale. Also approved is the screening tool embedded in a tablet-based screening solution called BH Works which covers 13 different domains of behavioral health. , as well as a screening tool embedded in a tablet-based screening tool called BH Works. The Clinical Governance Committee has endorsed these tools (October 1, 2015) and The Board of Directors has approved their use (October 13, 2015) (Step 1a – Complete). Care Compass Network is in the contracting process and is working with partners to identify primary and specialty care providers, as well as community-based organizations who can engage in screening and navigation to follow up services when necessary. In this way, the project implementation builds off of both the 3ai and the 2ci projects since the screening process will be very similar to the screening process as in 3ai in clinical settings and will dovetail with the navigation process in community settings. Moreover, community-based organizations are well poised to conduct screenings among students and work with schools on how to connect students to services when necessary. We expect primary care practices not participating in 3ai will participate in 4aiii. Furthermore, we foresee community-based organizations which provide Care Compass Network's Type 2 Navigation services (which is an intense episode of navigation services addressing cultural, clinical, financial, and logistics needs—as defined by Care Compass Network) to also participate in the project (Step 1b-Complete). The follow up and navigation process is expected to mirror Care Compass Network's navigation process under the 2ci Project (Step 1c—In progress). The 4aiii Project Team is engaging with partner organizations to complete the screening through Care Compass Network's contracting process (Step 1d – In progress).
Milestone 2 - Expand efforts with DOH and OMH to implement 'Collaborative Care' in primary care settings throughout NYS.	Although we have made progress on this project, we are requesting a deferment of Milestone 2 and related steps until a future date (3/31/2017). We are actively working on Milestone 2 (Expand efforts with DOH and OMH to implement 'Collaborative Care' in primary care settings throughout NYS). Care Compass Network's Behavioral Health Quality Subcommittees have begun tackling the topic of how to support primary care providers in managing the patients' behavioral health needs effectively and to foster a positive relationship between primary care providers and behavioral health community agencies. This work is developing in parallel with the Integration of Behavioral Health and Primary Care project to support a collaborative care model for all three behavioral health projects. For example, the 4aiii and 3ai Project Teams are planning an educational workshop for partners on how to integrate behavioral health services. Expanding these efforts across the PPS will be the basis of how Care Compass Network completes this milestone. Care Compass Network seeks to defer this milestone until 3/31/2017.
Milestone 3 - Share data and information on MEB health promotion and MEB disorder prevention and treatment.	The 4aiii Project Team continues to work within the vendor selection process to choose an IT solution for this and other behavioral health projects. We are planning to pilot a tablet solution under the Integrating Behavioral Health and Primary Care project with the intention of utilizing the same tablet solution to meet the needs of Crisis Stabilization (Project 3aii) and this project. We expect this IT solution to be selected and a contract to be signed by the end of DY2, Q1.

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

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

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 - Increase community partner participation in COPD prevention and management.	There are four milestones for project 4bii with no tasks due for the Q4 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. The project team has continued to meet monthly with additional meetings as needed. On February 9th the project team met with representatives from Bassett and Alliance PPSs to discuss Tobacco Cessation strategies. During the March 4th team meeting on the group began to develop guidelines for COPD symptoms, diagnosis, and treatment guidelines from the GOLD Standard documents which were previously approved for use by the Clinical Governance Committee. Once developed, these guidelines will be taken to the Clinical Governance Committee for approval. Additionally, the project team met with the CNY Regional Center for Tobacco Health Systems on February 9th. At this meeting the CCN Project Manager and Project Co-Leads focused on how to best implement patient centered strategies regarding tobacco cessation into the EHR. Contracting discussions have been fruitful, and the project team anticipates having several signed contracts by the close of DY2, Q1.
Milestone 2 - Establish PPS wide COPD screening protocols and clinical practice guidelines.	There are four milestones for project 4bii with no tasks due for the Q4 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. The project team has continued to meet monthly with additional meetings as needed. On February 9th the project team met with representatives from Bassett and Alliance PPSs to discuss Tobacco Cessation strategies. During the March 4th team meeting on the group began to develop guidelines for COPD symptoms, diagnosis, and treatment guidelines from the GOLD Standard documents which were previously approved for use by the Clinical Governance Committee. Once developed, these guidelines will be taken to the Clinical Governance Committee for approval. Additionally, the project team met with the CNY Regional Center for Tobacco Health Systems on February 9th. At this meeting the CCN Project Manager and Project Co-Leads focused on how to best implement patient centered strategies regarding tobacco cessation into the EHR. Contracting discussions have been fruitful, and the project team anticipates having several signed contracts by the close of DY2, Q1.
Milestone 3 - Increase pulmonary function testing (PFT)for COPD at risk adults.	There are four milestones for project 4bii with no tasks due for the Q4 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. The project team has continued to meet monthly with additional meetings as needed. On February 9th the project team met with representatives from Bassett and Alliance PPSs to discuss Tobacco Cessation strategies. During the March 4th team meeting on the group began to develop guidelines for COPD symptoms, diagnosis, and treatment guidelines from the GOLD Standard documents which were previously approved for use by the Clinical Governance Committee. Once developed, these guidelines will be taken to the Clinical Governance Committee for approval. Additionally, the project team met with the CNY Regional Center for Tobacco Health Systems on February 9th. At this meeting the CCN Project Manager and Project Co-Leads focused on how to best implement patient centered strategies regarding tobacco cessation into the EHR. Contracting discussions have been fruitful, and the project team anticipates having several signed contracts by the close of DY2, Q1.
Milestone 4 - Improve adherence to timely follow up of abnormal PFT screening results.	There are four milestones for project 4bii with no tasks due for the Q4 submission. Overall the project team is actively implementing the project and has no identified barriers preventing implementation efforts or completion of listed implementation targets. The project team has continued to meet monthly with additional meetings as needed. On February 9th the project team met with representatives from Bassett and Alliance PPSs to discuss Tobacco Cessation strategies. During the March 4th team meeting on the group began to develop guidelines for COPD symptoms, diagnosis, and treatment guidelines from the GOLD Standard documents which were previously approved for use by the Clinical Governance Committee. Once developed, these guidelines will be taken to the Clinical Governance Committee for approval. Additionally, the project team met with the CNY Regional Center for Tobacco Health Systems on February 9th. At this meeting the CCN Project Manager and Project Co-Leads focused on how to best implement patient centered strategies regarding tobacco cessation into the EHR. Contracting discussions have been fruitful, and the project team anticipates having several signed contracts by the close of DY2, Q1.

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:	Robin Marie Kinslow-Evans
Submission Date:	06/13/2016 03:49 PM

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**
DY1, Q4	Adjudicated	Robin Marie Kinslow-Evans	emcgill	06/30/2016 05:10 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 IA has adjudicated the DY1 Q4 Quarterly Report.	emcgill	06/30/2016 05:10 PM
Returned	The IA is returning the DY1, Q4 Quarterly Report for Remediation.	emcgill	05/31/2016 04:14 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 Report (Baseline) - READ ONLY	Completed
	IPQR Module 1.2 - PPS Budget Report (Quarterly)	Completed
	IPQR Module 1.3 - PPS Flow of Funds (Baseline) - READ ONLY	Completed
	IPQR Module 1.4 - PPS Flow of Funds (Ongoing) - DEFUNCT MODULE - READ ONLY	Completed
	IPQR Module 1.5 - Prescribed Milestones	Completed
	IPQR Module 1.6 - PPS Defined Milestones	Completed
	IPQR Module 1.7 - IA Monitoring	
Section 02	IPQR Module 2.1 - Prescribed Milestones	Completed
	IPQR Module 2.2 - PPS Defined Milestones	Completed
	IPQR Module 2.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 2.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 2.5 - Roles and Responsibilities	Completed
	IPQR Module 2.6 - Key Stakeholders	Completed
	IPQR Module 2.7 - IT Expectations	Completed
	IPQR Module 2.8 - Progress Reporting	Completed
	IPQR Module 2.9 - IA Monitoring	
Section 03	IPQR Module 3.1 - Prescribed Milestones	Completed
	IPQR Module 3.2 - PPS Defined Milestones	Completed
	IPQR Module 3.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 3.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 3.5 - Roles and Responsibilities	Completed
	IPQR Module 3.6 - Key Stakeholders	Completed
	IPQR Module 3.7 - IT Expectations	Completed
	IPQR Module 3.8 - Progress Reporting	Completed
	IPQR Module 3.9 - IA Monitoring	
Section 04	IPQR Module 4.1 - Prescribed Milestones	Completed
	IPQR Module 4.2 - PPS Defined Milestones	Completed

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 4.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 4.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 4.5 - Roles and Responsibilities	Completed
	IPQR Module 4.6 - Key Stakeholders	Completed
	IPQR Module 4.7 - IT Expectations	Completed
	IPQR Module 4.8 - Progress Reporting	Completed
	IPQR Module 4.9 - IA Monitoring	
Section 05	IPQR Module 5.1 - Prescribed Milestones	Completed
	IPQR Module 5.2 - PPS Defined Milestones	Completed
	IPQR Module 5.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 5.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 5.5 - Roles and Responsibilities	Completed
	IPQR Module 5.6 - Key Stakeholders	Completed
	IPQR Module 5.7 - Progress Reporting	Completed
	IPQR Module 5.8 - IA Monitoring	
Section 06	IPQR Module 6.1 - Prescribed Milestones	Completed
	IPQR Module 6.2 - PPS Defined Milestones	Completed
	IPQR Module 6.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 6.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 6.5 - Roles and Responsibilities	Completed
	IPQR Module 6.6 - Key Stakeholders	Completed
	IPQR Module 6.7 - IT Expectations	Completed
	IPQR Module 6.8 - Progress Reporting	Completed
	IPQR Module 6.9 - IA Monitoring	
Section 07	IPQR Module 7.1 - Prescribed Milestones	Completed
	IPQR Module 7.2 - PPS Defined Milestones	Completed
	IPQR Module 7.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 7.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 7.5 - Roles and Responsibilities	Completed

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 7.6 - Key Stakeholders	Completed
	IPQR Module 7.7 - IT Expectations	Completed
	IPQR Module 7.8 - Progress Reporting	Completed
	IPQR Module 7.9 - IA Monitoring	
Section 08	IPQR Module 8.1 - Prescribed Milestones	Completed
	IPQR Module 8.2 - PPS Defined Milestones	Completed
	IPQR Module 8.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 8.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 8.5 - Roles and Responsibilities	Completed
	IPQR Module 8.6 - Key Stakeholders	Completed
	IPQR Module 8.7 - IT Expectations	Completed
	IPQR Module 8.8 - Progress Reporting	Completed
	IPQR Module 8.9 - IA Monitoring	
Section 09	IPQR Module 9.1 - Prescribed Milestones	Completed
	IPQR Module 9.2 - PPS Defined Milestones	Completed
	IPQR Module 9.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 9.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 9.5 - Roles and Responsibilities	Completed
	IPQR Module 9.6 - Key Stakeholders	Completed
	IPQR Module 9.7 - IT Expectations	Completed
	IPQR Module 9.8 - Progress Reporting	Completed
	IPQR Module 9.9 - IA Monitoring	
Section 10	IPQR Module 10.1 - Overall approach to implementation	Completed
	IPQR Module 10.2 - Major dependencies between work streams and coordination of projects	Completed
	IPQR Module 10.3 - Project Roles and Responsibilities	Completed
	IPQR Module 10.4 - Overview of key stakeholders and how influenced by your DSRIP projects	Completed
	IPQR Module 10.5 - IT Requirements	Completed
	IPQR Module 10.6 - Performance Monitoring	Completed
	IPQR Module 10.7 - Community Engagement	Completed

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 10.8 - 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 Report (Baseline) - READ ONLY	Pass & Complete	
	Module 1.2 - PPS Budget Report (Quarterly)	Pass & Ongoing	
	Module 1.3 - PPS Flow of Funds (Baseline) - READ ONLY	Pass & Complete	
	Module 1.4 - PPS Flow of Funds (Ongoing) - DEFUNCT MODULE - READ ONLY	Pass & Ongoing	
	Module 1.5 - Prescribed Milestones		
	Milestone #1 Complete funds flow budget and distribution plan and communicate with network	Pass & Complete	
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 & Ongoing	
	Milestone #9 Inclusion of CBOs in PPS Implementation.	Pass & Ongoing	
Section 03	Module 3.1 - Prescribed Milestones		
	Milestone #1 Finalize PPS finance structure, including reporting structure	Pass & Complete	
	Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	Pass & Complete	
	Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Pass & Complete	
	Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	Pass & Ongoing	

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 #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	Pass & Ongoing	
	Milestone #6 Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	Pass & Ongoing	
	Milestone #7 Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	Pass & Ongoing	
	Milestone #8 >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	Pass & Ongoing	
Section 04	Module 4.1 - Prescribed Milestones		
	Milestone #1 Finalize cultural competency / health literacy strategy.	Pass & Complete	
	Milestone #2 Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	Pass & Ongoing	
Section 05	Module 5.1 - Prescribed Milestones		
	Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	Pass & Ongoing	
	Milestone #2 Develop an IT Change Management Strategy.	Pass & Ongoing	
	Milestone #3 Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	Pass & Complete	
	Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	Pass & Ongoing	
	Milestone #5 Develop a data security and confidentiality plan.	Pass & Ongoing	
Section 06	Module 6.1 - Prescribed Milestones		
	Milestone #1 Establish reporting structure for PPS-wide performance reporting and communication.	Pass & Complete	
	Milestone #2 Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	Pass & Ongoing	
Section 07	Module 7.1 - Prescribed Milestones		
	Milestone #1 Develop Practitioners communication and engagement plan.	Pass & Complete	
	Milestone #2 Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	Pass & Complete	
Section 08	Module 8.1 - Prescribed Milestones		
	Milestone #1 Develop population health management roadmap.	Pass & Ongoing	
	Milestone #2 Finalize PPS-wide bed reduction plan.	Pass & Ongoing	
Section 09	Module 9.1 - Prescribed Milestones		

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 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 & Ongoing	
	Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	Pass & Ongoing	
	Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	Pass & Ongoing	
	Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	Pass & Ongoing	
	Milestone #5 Develop training strategy.	Pass & Ongoing	
	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 & Ongoing	
	Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	Pass & Ongoing	
	Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Pass & Ongoing	
	Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Pass & Ongoing	
	Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	Pass & Ongoing	
	Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	Pass & Ongoing	
	Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	Pass & Ongoing	
	Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	Pass & Ongoing	
	Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	Pass & Ongoing	
2.b.iv	Module 2.b.iv.2 - Patient Engagement Speed	Fail	
	Module 2.b.iv.3 - Prescribed Milestones		
	Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	Pass & Ongoing	
	Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	Pass & Ongoing	
	Milestone #3 Ensure required social services participate in the project.	Pass & Complete	

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 #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	Pass & Ongoing	
	Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Pass & Ongoing	
	Milestone #6 Ensure that a 30-day transition of care period is established.	Pass & Ongoing	
	Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
2.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 & Ongoing	
	Milestone #3 Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	Pass & Ongoing	
	Milestone #4 Educate all staff on care pathways and INTERACT principles.	Pass & Ongoing	
	Milestone #5 Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	Pass & Ongoing	
	Milestone #6 Create coaching program to facilitate and support implementation.	Pass & Ongoing	
	Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	Pass & Ongoing	
	Milestone #8 Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	Pass & Ongoing	
	Milestone #9 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Pass & Ongoing	
	Milestone #10 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
2.c.i	Module 2.c.i.2 - Patient Engagement Speed	Fail	IA
	Module 2.c.i.3 - Prescribed Milestones		
	Milestone #1 Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.	Pass & Ongoing	
	Milestone #2 Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.	Pass & Ongoing	
	Milestone #3 Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.	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 #4 Resource appropriately for the community navigators, evaluating placement and service type.	Pass & Ongoing	
	Milestone #5 Provide community navigators with access to non-clinical resources, such as transportation and housing services.	Pass & Ongoing	
	Milestone #6 Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.	Pass & Ongoing	
	Milestone #7 Market the availability of community-based navigation services.	Pass & Ongoing	
	Milestone #8 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
2.d.i	Module 2.d.i.2 - Patient Engagement Speed	Fail	
	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 & Ongoing	
	Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.	Pass & Complete	
	Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	Pass & Complete	
	Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.	Pass & Ongoing	
	Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	Pass & Ongoing	
	Milestone #8 Include beneficiaries in development team to promote preventive care.	Pass & Complete	
	Milestone #9 Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using	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	
	PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.		
	Milestone #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 & Ongoing	
	Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	Pass & Ongoing	
	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 & Ongoing	
3.a.i	Module 3.a.i.2 - Patient Engagement Speed	Fail	
	Module 3.a.i.3 - Prescribed Milestones		
	Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Pass & Ongoing	
	Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Pass & 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	

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 #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #5 Co-locate primary care services at behavioral health sites.	Pass & Ongoing	
	Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Pass & Ongoing	
	Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Pass & Ongoing	
	Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #9 Implement IMPACT Model at Primary Care Sites.	Pass & Ongoing	
	Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Pass & Ongoing	
	Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Pass & Ongoing	
	Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	Pass & Ongoing	
	Milestone #13 Measure outcomes as required in the IMPACT Model.	Pass & Ongoing	
	Milestone #14 Provide "stepped care" as required by the IMPACT Model.	Pass & Ongoing	
	Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
3.a.ii	Module 3.a.ii.2 - Patient Engagement Speed	Fail	IA
	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 & Ongoing	
	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 & Ongoing	
	Milestone #5 Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.	Pass & Ongoing	
	Milestone #6 Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).	Pass & Ongoing	
	Milestone #7 Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.	Pass & Ongoing	
	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),	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	
	alerts and patient record look up by the end of Demonstration Year (DY) 3.		
	Milestone #9 Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.	Pass & Ongoing	
	Milestone #10 Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.	Pass & Ongoing	
	Milestone #11 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
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 & Ongoing	
	Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	Pass & Ongoing	
	Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	Pass & Ongoing	
	Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Pass & Ongoing	
	Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	Pass & Ongoing	
	Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	Pass & Ongoing	
	Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	Pass & Ongoing	
	Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	Pass & Ongoing	
	Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	Pass & Ongoing	
	Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	Pass & Ongoing	
	Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	Pass & Ongoing	

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 #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	Pass & Ongoing	
	Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	Pass & Ongoing	
	Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	Pass & Ongoing	
	Milestone #18 Adopt strategies from the Million Hearts Campaign.	Pass & Ongoing	
	Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	Pass & Ongoing	
	Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	Pass & Ongoing	
3.g.i	Module 3.g.i.2 - Patient Engagement Speed	Fail	
	Module 3.g.i.3 - Prescribed Milestones		
	Milestone #1 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.	Pass & Ongoing	
	Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	Pass & Ongoing	
	Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	Pass & Ongoing	
	Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	Pass & Ongoing	
	Milestone #5 Engage with Medicaid Managed Care to address coverage of services.	Pass & Ongoing	
	Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.	Pass & Ongoing	
4.a.iii	Module 4.a.iii.2 - PPS Defined Milestones	Pass & Ongoing	
4.b.ii	Module 4.b.ii.2 - PPS Defined Milestones	Pass & Ongoing	

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	10	285	0	58	0	0	0	0	10	0	0	163	0	0	4	228	0	81	0	0	9	0
	Safety Net	1	48	0	48	0	0	0	0	1	48	0	48	0	0	2	64	0	21	0	0	5	0
Practitioner - Non-Primary Care Provider (PCP)	Total	24	479	0	66	0	0	0	0	24	0	0	0	0	0	7	22	0	0	0	0	1	0
	Safety Net	0	43	0	43	0	0	0	0	0	43	0	0	0	0	0	5	0	0	0	0	0	0
Hospital	Total	6	7	6	5	0	0	0	0	6	0	0	0	0	0	6	0	0	0	4	0	6	0
	Safety Net	6	7	6	7	0	7	0	0	6	7	0	0	0	2	6	0	0	0	4	0	6	0
Clinic	Total	13	23	9	0	1	0	1	0	14	0	1	0	0	0	7	10	0	0	5	0	7	0
	Safety Net	13	24	8	0	1	0	1	0	14	24	1	0	0	0	7	14	0	0	5	0	7	0
Case Management / Health Home	Total	12	12	2	7	0	0	1	0	13	0	0	0	1	0	2	12	0	0	6	0	2	0
	Safety Net	9	7	2	7	0	0	1	0	9	0	0	0	1	3	2	7	0	0	6	0	2	0
Mental Health	Total	23	63	8	0	1	0	5	0	24	0	5	37	6	0	6	0	1	0	20	0	6	0
	Safety Net	23	28	8	0	1	0	5	0	24	0	5	16	6	7	6	0	1	0	20	0	6	0
Substance Abuse	Total	10	14	1	0	0	0	1	0	10	0	1	0	0	0	1	0	0	0	10	0	1	0
	Safety Net	10	13	1	0	0	0	1	0	10	0	1	0	0	7	1	0	0	0	10	0	1	0
Nursing Home	Total	3	20	1	0	19	0	0	0	3	0	0	0	1	0	12	0	0	0	1	0	7	0
	Safety Net	3	18	1	0	19	19	0	0	3	0	0	0	1	0	12	0	0	0	1	0	7	0
Pharmacy	Total	5	0	1	0	0	0	1	0	5	0	0	0	0	0	3	0	0	0	0	0	4	0
	Safety Net	3	0	1	0	0	0	1	0	3	0	0	0	0	0	2	0	0	0	0	0	2	0
Hospice	Total	2	4	3	0	0	0	0	0	1	0	0	0	0	0	2	0	3	4	1	0	3	0

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	2	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	1	0	2	0
Community Based Organizations	Total	3	26	4	0	0	0	7	0	10	0	3	0	3	0	3	20	1	0	1	0	3	0
	Safety Net	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
All Other	Total	65	375	21	95	15	0	5	0	66	0	3	0	3	0	30	31	6	0	28	0	27	0
	Safety Net	34	95	13	95	13	0	3	0	35	95	0	0	0	0	18	31	1	0	22	0	19	0
Uncategorized	Total	1	0	3	0	0	0	2	0	3	0	0	0	0	0	2	0	0	0	1	0	1	0
	Safety Net	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
mrbobc	Report(s)	44_1_4_20160503101143_IPP_Module_1.8_Ongoing_Funds_Flow_PIT_Report.xlsx	IPP Module 1.8 Ongoing Funds Flow PIT Report	05/03/2016 10:12 AM
sculley	Rosters	44_1_4_20160429130924_CCN_PIT_File_Template.xls	List of Providers not in PIT who are interested in participating with Care Compass Network.	04/29/2016 01:10 PM

Narrative Text :