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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

TABLE OF CONTENTS

Bassett Medical Center (PPS ID:22)

Bassett Medical Center (PPS ID:22)

Bassett Medical Center (PPS ID:22)

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Quarterly Report - Implementation Plan for Bassett Medical Center

Year and Quarter: DY1, Q3 **Quarterly Report Status:** Adjudicated

Status By Section

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

Status By Project

Project ID	Project Title	Status
2.a.ii	Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))	Completed
2.b.vii	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)	Completed
2.b.viii	Hospital-Home Care Collaboration Solutions	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.iv	Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs	Completed
3.d.iii	Implementation of evidence-based medicine guidelines for asthma management	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.i	Promote tobacco use cessation, especially among low SES populations and those with poor mental health.	Completed

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Section 01 – Budget

IPQR Module 1.1 - PPS Budget Report (Baseline)

Instructions :

This table contains five budget categories. Please add rows to this table as necessary in order to add your own sub-categories. The budget categories used in this table should reflect the budget categories you used in your application. If budget entered varies from PPS application or previous implementation plan submission, please describe changes and justifications in the box provided.

Budget Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	10,671,239	11,372,033	18,390,005	16,284,279	10,671,239	67,388,793
Cost of Project Implementation & Administration	**7,642,588**	**2,275,045**	**3,088,455**	**2,474,732**	**1,964,087**	**17,444,907**
Implementation planning	6,207,224	273,005	441,208	390,747	170,790	7,482,974
Administration/PMO Office	1,114,468	2,002,040	2,647,247	2,083,985	1,793,297	9,641,037
Project Implementation contracts	320,896	0	0	0	0	320,896
Revenue Loss	**0**	**910,018**	**2,206,040**	**2,604,981**	**683,161**	**6,404,200**
ED/Inpatient loss of revenue resulting from transformation	0	910,018	2,206,040	2,604,981	683,161	6,404,200
Internal PPS Provider Bonus Payments	**2,928,651**	**5,456,914**	**9,124,638**	**8,860,082**	**6,572,275**	**32,942,560**
Provider bonus payments for meeting/exceeding metrics	2,928,651	5,456,914	9,124,638	8,860,082	6,572,275	32,942,560
Cost of non-covered services	**0**	**910,018**	**1,470,693**	**911,743**	**683,161**	**3,975,615**
Services that will lead to transformation & VBS	0	910,018	1,470,693	911,743	683,161	3,975,615
Other	**100,000**	**1,820,036**	**2,500,179**	**1,432,739**	**768,555**	**6,621,509**
Contingency (Unexpected/unanticipated occurrences within PPS)	100,000	455,009	735,347	651,245	426,975	2,368,576
Sustain Fragile Providers (Support financially fragile providers in PPS who are essential to successful transformation)	0	910,018	1,029,485	390,747	170,790	2,501,040
Innovation (Innovative ideas leading to greater PPS success)	0	455,009	735,347	390,747	170,790	1,751,893
Total Expenditures	**10,671,239**	**11,372,031**	**18,390,005**	**16,284,277**	**10,671,239**	**67,388,791**
Undistributed Revenue	**0**	**2**	**0**	**2**	**0**	**2**

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

Bassett Medical Center (PPS ID:22)

Narrative Text :

Note that original table submitted in Excel version of implementation plan made the assumption that PPS would only receive 80% of total possible funding, in order to be conservative. Numbers in the table above differ from original submitted table in that full waiver revenue is listed above. Percentages for each category remain consistent.

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

Bassett Medical Center (PPS ID:22)

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
10,671,239	67,388,793	5,693,389	62,410,943

Budget Items	DY1 Q3 Quarterly Amount - Update	Cumulative Spending to Date (DY1 - DY5)	Remaining Balance in Current DY	Percent Remaining in Current DY	Cumulative Remaining Balance	Percent Remaining of Cumulative Balance
Cost of Project Implementation & Administration	**4,238,267**	**4,977,850**	**2,664,738**	**34.87%**	**12,467,057**	**71.47%**
Implementation planning	4,238,267					
Administration/PMO Office	0					
Project Implementation contracts	0					
Revenue Loss	**0**	**0**	**0**		**6,404,200**	**100.00%**
ED/Inpatient loss of revenue resulting from transformation	0					
Internal PPS Provider Bonus Payments	**0**	**0**	**2,928,651**	**100.00%**	**32,942,560**	**100.00%**
Provider bonus payments for meeting/exceeding metrics	0					
Cost of non-covered services	**0**	**0**	**0**		**3,975,615**	**100.00%**
Services that will lead to transformation & VBS	0					
Other	**0**	**0**	**100,000**	**100.00%**	**6,621,509**	**100.00%**
Contingency (Unexpected/unanticipated occurrences within PPS)	0					
Sustain Fragile Providers (Support financially fragile providers in PPS who are essential to successful transformation)	0					
Innovation (Innovative ideas leading to greater PPS success)	0					
Total Expenditures	**4,238,267**	**4,977,850**				

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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.

3/15/16 additional narrative - Bassett PPS already had required subcategories. Resubmitting original information.

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

Bassett Medical Center (PPS ID:22)

IPQR Module 1.3 - PPS Flow of Funds (Baseline)

Instructions :

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

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

Funds Flow Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	10,671,239	11,372,033	18,390,005	16,284,279	10,671,239	67,388,793
Practitioner - Primary Care Provider (PCP)	77,704	111,151	179,744	159,163	104,301	632,063
Practitioner - Non-Primary Care Provider (PCP)	0	0	0	0	0	0
Hospital	4,554,047	6,632,463	11,315,827	10,280,265	6,309,110	39,091,712
Clinic	0	0	0	0	0	0
Case Management / Health Home	293,714	420,138	679,415	601,620	394,247	2,389,134
Mental Health	0	0	0	0	0	0
Substance Abuse	0	0	0	0	0	0
Nursing Home	1,007,805	1,441,593	2,331,238	2,064,302	1,352,756	8,197,694
Pharmacy	0	0	0	0	0	0
Hospice	100,403	143,620	232,252	205,658	134,770	816,703
Community Based Organizations	67,514	96,574	156,172	138,290	90,623	549,173
All Other	366,641	524,455	848,109	750,997	492,135	2,982,337
PPS PMO	1,482,257	2,002,040	2,647,247	2,083,985	1,793,297	10,008,826
Total Funds Distributed	**7,950,085**	**11,372,034**	**18,390,004**	**16,284,280**	**10,671,239**	**64,667,642**
Undistributed Revenue	**2,721,154**	**0**	**1**	**0**	**0**	**2,721,151**

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

Bassett Medical Center (PPS ID:22)

The table above differs from the one submitted in the implementation plan in that the originally submitted plan estimated total revenue at 80% of the total based on an assumption of 80% success rate in meeting metrics. Percentages for each budget category have been adjusted upward to reconcile with the entire waiver amount (rather than 80%) listed.

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

Bassett Medical Center (PPS ID:22)

IPQR Module 1.4 - PPS Flow of Funds (Quarterly)

Instructions :

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

Benchmarks

Waiver Revenue DY1	Total Waiver Revenue	Undistributed Revenue YTD	Undistributed Revenue Total
10,671,239	67,388,793	5,693,389	62,410,943

Funds Flow Items	DY1 Q3 Quarterly Amount - Update	Total Amount Disbursed	Percent Spent By Project										DY Adjusted Difference	Cumulative Difference
			Projects Selected By PPS											
			2.a.ii	2.b.vii	2.b.viii	2.c.i	2.d.i	3.a.i	3.a.iv	3.d.iii	3.g.i	4.a.iii	4.b.i		
Practitioner - Primary Care Provider (PCP)	0	0	0	0	0	0	0	0	0	0	0	0	0	77,704	632,063
Practitioner - Non-Primary Care Provider (PCP)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital	3,284,987	4,024,570	5	1	6.5	15.5	13.3	11	15	8.3	5.4	8.8	10.2	529,477	35,067,142
Clinic	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Case Management / Health Home	0	0	0	0	0	0	0	0	0	0	0	0	0	293,714	2,389,134
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Substance Abuse	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nursing Home	189,422	189,422	0	100	0	0	0	0	0	0	0	0	0	818,383	8,008,272
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospice	0	0	0	0	0	0	0	0	0	0	0	0	0	100,403	816,703
Community Based Organizations	0	0	0	0	0	0	0	0	0	0	0	0	0	67,514	549,173
All Other	24,275	24,275	0	0	0	0	0	100	0	0	0	0	0	342,366	2,958,062
PPS PMO	739,583	739,583	9.09	9.09	9.09	9.09	9.09	9.09	9.09	9.09	9.09	9.09	9.09	742,674	9,269,243
Total Funds Distributed	**4,238,267**	**4,977,850**													

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

Bassett Medical Center (PPS ID:22)

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

The "All other" institution to which funds flowed in DY1Q3 was a developmental disabilities residential facility.

3/15/16 Remediation notes: Have revised (identified funds flow to PPS PMO) as per IA Guidance.

Module Review Status

Review Status	IA Formal Comments
Pass (with Exception) & Ongoing	The amounts and percentages reported in the Provider Import/Export Tool does not align with the amounts and percentages reported in MAPP. Please update all amounts and percentages to ensure alignment and accuracy during the DY1, Q4 reporting period.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task 1. Finance Committee to re-assess funds flow categories after review of application and needs of PPS partners	Completed	Funds flow categories reassessed.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 2. Finance Committee to establish "Funds Flow Principles" for review at every meeting	Completed	Funds Flow priniciples developed.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 3. Finance Committee to establish draft budget for all funds flow categories	Completed	Draft Budget for funds flow categories completed.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 4. Establish meetings with Project Teams and Finance Committee to explain concepts of funds flow model and review budget templates	Completed	Meetings held with project teams and Finance committee.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 5. Determine from project teams the assessment of provider level involvement in project success over the demonstration years	Completed	Assessment completed.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 6. Distribute budget templates (project and institution level) to each project team for completion	Completed	Budget templates distributed.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 7. Host training and education sessions with	Completed	Education sessions completed.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
each project team for budget completion									
Task 8. Prepare PPS, Provider and Project level funds flow budgets after project training and education review sessions with network providers for review and approval by Finance Committee	Completed	Initial budgets completed and submitted.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 9. Finalize funds flow model for review/approval by Executive Governance Body	Completed	Funds Flow model finalized	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 10. Finalize PPS funds flow contract and requisite compliance documents for PPS partner review and signature	Completed	Funds flow contract and compliance documents finalized	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 11. Distribute Funds Flow policy and procedure to include reporting requirements by PPS partners and anticipated fund distribution dates to PPS partners	Completed	Task in progress.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 12. Finalize plan for educating PPS partners regarding final funds flow model, reporting requirements, and compliance requirements	Completed	Plan finalized	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 13. Implement education plan - via WebEx, individual and/or group meetings for all PPS partners	Completed	Budget and funds flow education sessions completed via webex	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Complete funds flow budget and distribution plan and communicate with network	amyvk	Meeting Materials	22_MDL0103_1_3_20160125152708_Meeting_Schedule_Template_Finance_DY1Q3.xlsx	Finance Meeting Schedule Template DY1Q3	01/25/2016 03:27 PM

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 & Ongoing	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

IPQR Module 1.6 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

IPQR Module 1.7 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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 1. Choose PPS governance model	Completed	Governance model determined.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 2. Develop PPS organizational structure based on collaborative model (chosen by PAC/PPS)	Completed	Organization structure developed.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 3. Determine composition and membership of Executive Governance Body (EGB), utilizing "swim lane" methodology for representation as well as geographical considerations	Completed	EGB composition developed.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 4. Determine standing committees, membership structure and roles (Compliance, Workforce, Clinical Performance, Finance, IT/Data Analytics Committee--ITDAC) with lead agency chair and partner co-chair, when possible; identify additional committees as needed	Completed	Committees established.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 5. Identify specific standing committees and membership, including lead agency chair/Partner co-chair	Completed	Committees established.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 6. Finalize charters for each committee; obtain	Completed	Charters finalized.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
approval and sign off by EGB									
Task 7. Determine initial standing committee meeting and establish meeting frequency	Completed	Meeting frequency established.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 8. Finalize final committee membership (compliance, workforce, clinical performance, IT/Data Analytics); schedule first meeting for each	Completed	Committee membership finalized and meetings scheduled.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 9. Identify need for subcommittees for Clinical Performance based on project scope and scale (to include metric tracking, protocol development, etc.) for reporting to Clinical Performance Committee.	Completed	Subcomittees being established.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 10. Identify membership for each subcommittee and specific functions for each	Completed	Subcommittee membership to be established.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 11. Develop a communication plan for dissemination of Governance activities to include minutes of Exec Governance Body meetings, annual operating plans, policiy and procedure statements, and general items for communications	Completed	Communication plan developed.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 12. Determine the types of reports that the Exec Governance Body requires from standing committees, management office, finance, etc. For each of these a target audiences will be determined, incuding but not limited to partners and lead agency	Completed	Reports determined.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Completed	This milestone must be completed by 12/31/2015. Clinical Quality Committee charter and committee structure chart	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task	Completed	Charters 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

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
1. Develop Clinical Performance Committee Charter									
Task 2. Determine number of members and structure of Clinical Performance Committee for approval by EGB	Completed	Final structure of committee in progress.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3. Define appropriate subcommittees to track clinical practice, quality, clinical integration and care coordination for 11 projects	Completed	Subcommittees under discussion.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4. Draft charters for all functional subcommittees	Completed	In progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5. Develop project reporting process for quality metrics to appropriate subcommmittee	Completed	Not started	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6. Based on PPS geography and expertise, identify members of subcommittees	Completed	In progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 7. Propose membership of subcommittees with consideration given to project requirements (participation) & swim lane representation (as appropriate) for recommendation to Clinical Performance Committee	Completed	Subcommittee membership in progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 8. Finalize membership for functional subcommittees for approval by Clinical Performance Committee Chair(s)	Completed	Subcommittee membership in progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 9. Draft charters for Practitioner Engagement, Population Health committee; finalize membership	Completed	Task in progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 10. Identify prescribed and additional clinical performance metrics for performance tracking and periodic reporting to EGB	Completed	Prescribed metrics reviewed by committee.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #3	Completed	This milestone must be completed by 9/30/2015. Upload of	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Finalize bylaws and policies or Committee Guidelines where applicable		bylaws and policies document or committee guidelines.							
Task 1. Draft and Approve Articles of Governance for Executive Governance Body	Completed	Articles of Governance drafted and approved.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 2. Identify key policies for LCHP governance participation	Completed	Key policies identified	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3. Draft and adopt dispute resolution procedures	Completed	Dispute resolution procedures drafted and adopted	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4. Develop, adopt and communicate procedures for underperforming Partners	Completed	Procedures developed, adopted and communicated.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5. Share Articles of Goverance with PPS Partners	Completed	Shared with partners	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 6. Develop and adopt PPS compliance policies and procedures	Completed	Developed and adopted.	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 monitoring processes	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 1. Develop LCHP/PPS organizational chart with reporting structure	Completed	Organization chart finalized	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 2. Finalize Project Advisory Committee (PAC) Charter; membership	Completed	PAC membership finalized	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 3. Determine method and tools for collecting data from providers and CBOs	Completed	Task in progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4. EGB will provide oversight and ongoing monitoring on all implentation plans and committee progress	Completed	Task in progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task	Completed	In development	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
4a. Develop dashboard (executive level summary) for committees and projects to report metrics/milestones on an ongoing basis for EGB review									
Task 4b. Incorporate 'review of dashboards' as an ongoing agenda item for EGB to review progress, risks, and remediation	Completed	Not started	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4c. Develop and distribute partner agreements which outline remediation tactics for those not fulfilling responsibilities of partner within the PPS.	Completed	Not started	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5. Develop standard practice for sharing best practices among provider groups, CBOs & other stakeholders	Completed	Not started	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6. Establish and communicate PPS-wide compliance policies with all Partners & stakeholders	Completed	Task in progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 7. Establish communication plan to include, among other elements, 2-way communication between/among EGB, Partners, Committees (e.g.-routine sharing of meeting minutes and other relevant information across PPS)	Completed	Task in progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	Completed	Community engagement plan, including plans for two-way communication with stakeholders.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task 1. Through implementation planning process, engage partners in project implementation including CBOs, etc.	Completed	Complete	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 2. Select Medicaid members in PAC membership	Completed	Complete	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
structure									
Task 3. Develop oversight role - Director, PPS & Patient Engagement; recruit	Completed	Complete	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4. Establish engagement and communication plan with community stakeholders	Completed	Task in progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4a. Hiring marketing and communications expert to develop communication plan and strategy.	Completed	Communications expert hired.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4b. Engage school-based health programs and colleges for utilizing existing training programs like substance abuse	Completed	Not started	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4c. Communication (e.g. townhalls) with other community organizations such as churches, housing providers, law enforcement, transportation providers will include education on DSRIP initiative and discussion on how community organizations can assist in this effort	Completed	Task in progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4d. Develop a CBO Council to enhance communication with CBO's and develop specific strategies and tactics towards greater involvement of community organizations to achieve success of PPS.	Completed	Not started	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5. Update website & maintain as communication tool with public and Partners	Completed	Website developed and enhancements underway.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6. Establish communication plan to include, among other elements, 2-way communication between/among CBOs and other community stakeholders and PPS leadership	Completed	Communication plan in development.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #6 Finalize partnership agreements or contracts with	In Progress	Signed CBO partnership agreements or contracts.	04/01/2015	12/31/2015	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
CBOs									
Task 1. Through detailed implementation planning with project committees, engage appropriate CBOs and other partners	Completed	Complete	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Meet with project chairs and committees to identify CBOs who need to be involved in projects and the nature of that involvement	Completed	Complete	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3. Reach out to identified organizations to determine their willingness to participate and execute partner agreements for interested CBOs	Completed	Complete	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4. For new partners willing to engage that are not official members of LCHP PPS, work with the state to add them when the network reopen. Efforts will be made to contract with key organizations which are not yet official partners.	Completed	Task in progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5. Create CBO partnership/affiliation contracts to reflect the nature of their association with the PPS	Completed	Complete	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 6. Execute CBO partnership/affiliation contracts	In Progress	Task in progress	04/01/2015	12/31/2015	10/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 7. Determine appropriate participation/representation from CBOs on PAC and committees	Completed	Complete	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #7 Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	In Progress	Agency Coordination Plan.	04/01/2015	12/31/2015	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task 1. Meet with project chairs and committees to	Completed	Complete	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
identify state agencies needed to be involved in projects and the nature of that involvement									
Task 2. DSRIP Program Manager will reach out to identified state agencies to determine their willingness to participate and execute partner agreements	Completed	Complete	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3. Work with existing partners and foster relationships to coordinate activities	Completed	Task in progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4. Identify new partners needed for successful implementation of projects, engage them and develop process for their inclusion in the official DSRIP partnership when the network reopens	Completed	Task in progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5. Engage with overlapping PPS' and public sector agencies to determine best approach to optimize resources, avoiding unnecessary duplication of efforts	In Progress	Task in progress	04/01/2015	12/31/2015	10/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Milestone #8 Finalize workforce communication and engagement plan	In Progress	Workforce communication & engagement plan, including plans for two-way communication with all levels of the workforce, signed off by PPS workforce governance body (e.g. workforce transformation committee).	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task 1. Review each project implementation plan, assessing stakeholder's commitment and required level of engagement to meet project goals/metrics	Completed	Not started	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. Determine most effective means of communicating with Partners and PPS stakeholders including, but not limited to, surveys, partner meetings, etc.	Completed	Task in progress - communication plan under development by communications specialist.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Create and maintain list of contacts for each Partner for routine and urgent communications	Completed	List created and under refinement. CRM vendor selection in progress.	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

Bassett Medical Center (PPS ID:22)

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 4. Develop workforce communication and engagment plan, ensuring bi-lateral communication between and among stakeholders throughout PPS and appropriate engagement of workforce stakeholders; Have plan approved by EGB	In Progress	Task in progress.	04/01/2015	12/31/2015	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	
Milestone #9 Inclusion of CBOs in PPS Implementation.	Completed	Explain your plans for contracting with CBOs and their continuing role as your PPS develops over time; detail how many CBOs you will be contracting with and by when; explain how they will be included in project delivery and in the development of your PPS network.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO

IA Instructions / Quarterly Update

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

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize governance structure and sub-committee structure	amyvk	Meeting Materials	22_MDL0203_1_3_20160122081904_Governance_Committee_Membership_DY1Q3.xlsx	Governance Committee Membership DY1Q3	01/22/2016 08:19 AM
	amyvk	Meeting Materials	22_MDL0203_1_3_20160122081507_Governance_Meeting_Schedule_DY1Q3.pdf	Governance Meeting Schedule DY1Q3	01/22/2016 08:15 AM
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	amyvk	Meeting Materials	22_MDL0203_1_3_20160125143926_Meeting_Schedule_Clinical_Performance_Meeting_DY1Q3.xlsx	Clinical Performance Meeting Schedule DY1Q3	01/25/2016 02:39 PM
	amyvk	Other	22_MDL0203_1_3_20160125143830_Practitioner_Engagement_Subcommittee_Charter.doc	Practitioner Engagement Subcommittee Charter	01/25/2016 02:38 PM
	amyvk	Other	22_MDL0203_1_3_20160125143746_Clinical_Quality_Subcommittee_Charter_DY1Q3.doc	Clinical Quality Subcommittee Charter DY1Q3	01/25/2016 02:37 PM

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	amyvk	Other	22_MDL0203_1_3_20160125143706_Clinical_Performance_Committee_Charter.doc	Clinical Performance Committee Charter DY1Q3	01/25/2016 02:37 PM
	amyvk	Other	22_MDL0203_1_3_20160125143309_Clinical_Governance_Committees_DY1Q3.xlsx	Clinical Governance Committee Membership List DY1Q3	01/25/2016 02:33 PM
	amyvk	Other	22_MDL0203_1_3_20160119091814_DSRIP_Org_Chart_v13.pdf	Committee Structure Chart	01/19/2016 09:18 AM
Finalize bylaws and policies or Committee Guidelines where applicable	amyvk	Other	22_MDL0203_1_3_20160125144338_(MIBH)__Clean__EGB_Dispute_Resolution_Policy_and_Procedure_(10-20-15).doc	Policy update - Dispute Resolution	01/25/2016 02:43 PM
	amyvk	Other	22_MDL0203_1_3_20160125144158_(MIBH_DSRIP)_Articles_of_Governance_(12-7-15)_(2).doc	Amended Articles of Governance DY1Q3	01/25/2016 02:41 PM
Establish governance structure reporting and monitoring processes	amyvk	Other	22_MDL0203_1_3_20160126162454_Governance_and_Committee_Reporting_and_Monitoring_Mechanisms.docx	Bassett PPS Governance and Committee Reporting and Monitoring Mechanisms	01/26/2016 04:24 PM
	amyvk	Other	22_MDL0203_1_3_20160126142650_DY1Q2_Workforce_Committee_and_Subcommittee_Updates_to_EGB.docx	Bassett PPS DY1Q2 Workforce Committee update to Governing Body	01/26/2016 02:26 PM
	amyvk	Other	22_MDL0203_1_3_20160126142556_DY1Q2_ITDAC_Updates_to_EGB.docx	Bassett PPS DY1Q2 ITDAC Update to Governing body	01/26/2016 02:25 PM
	amyvk	Other	22_MDL0203_1_3_20160126142513_DY1Q2_Finance_Committee_Update_to_EGB.docx	Bassett PPS DY1Q2 Finance Committee Update to Governing body	01/26/2016 02:25 PM
	amyvk	Other	22_MDL0203_1_3_20160126142436_DY1Q2_Compliance_Committee_Update_to_EGB.docx	Bassett PPS DY1Q2 Compliance Committee update to governing body	01/26/2016 02:24 PM
	amyvk	Other	22_MDL0203_1_3_20160126084932_Partners_Financial_Sustanability_Assessment_Tool.xlsx	Bassett PPS Partners Financial Sustainability Assessment Tool (referenced in Governance and Committee Reporting document)	01/26/2016 08:49 AM
	amyvk	Other	22_MDL0203_1_3_20160126084606_(MIBH)_DSRIP_Compliance_Policy_FINAL.doc	Bassett PPS Compliance Policy (referenced in Governance and Committee Reporting document)	01/26/2016 08:46 AM
	amyvk	Other	22_MDL0203_1_3_20160126084431_EGB_Policy_and_Procedure_for_Underperforming_PPS_Partners.docx	Bassett PPS - Policy for underperforming partners (referenced in Governance and Committee Reporting document)	01/26/2016 08:44 AM
	amyvk	Other	22_MDL0203_1_3_20160126084346_Key_Performance_Indicator_Report_DY1Q2.pdf	Bassett PPS - Dashboard monitoring report to Governing Body	01/26/2016 08:43 AM
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	amyvk	Documentation/Certification	22_MDL0203_1_3_20160125144656_Community_Engagement_Plan.xlsx	Community Engagement Template DY1Q3	01/25/2016 02:46 PM
	amyvk	Documentation/Certification	22_MDL0203_1_3_20160119094134_Community_Engagement_Plan_FINAL.docx	Community Engagement Plan Approved by governing body Dec 2015	01/19/2016 09:41 AM

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize partnership agreements or contracts with CBOs	swathirg	Templates	22_MDL0203_1_3_20160127170829_CBO_Template_DY1Q3.xlsx	CBO Template DY1Q3	01/27/2016 05:08 PM
	amyvk	Other	22_MDL0203_1_3_20160125150750_PAC_Meeting_Schedule_DY1Q3.xlsx	Project Advisory Committee Meeting Schedule Template DY1Q3	01/25/2016 03:07 PM
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.)	amyvk	Other	22_MDL0203_1_3_20160125145759_PublicSector_Template_DY1Q3.xlsx	Public Sector Agency Template DY1Q3	01/25/2016 02:57 PM
Inclusion of CBOs in PPS Implementation.	amyvk	Other	22_MDL0203_1_3_20160126090110_CBO_Template_DY1Q3.xlsx	CBO Template	01/26/2016 09:01 AM
	amyvk	Other	22_MDL0203_1_3_20160126090040_Community_Engagement_Plan_FINAL.docx	Community Engagement Plan	01/26/2016 09:00 AM
	amyvk	Other	22_MDL0203_1_3_20160126090004_Plan_to_Include_CBOs.docx	Bassett Medical Center Plan to Include CBOs	01/26/2016 09:00 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize governance structure and sub-committee structure	
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	DY1Q3 Update: PPS has decided to charter one Clinical Quality committee that includes appropriate project team representation in order to address quality issues that span all projects. It is felt that this structure will provide a more robust reporting mechanism to share clinical quality concerns. Clinical Performance committee will be focusing on performance and clinical metrics over the coming months; subcommittee membership has been proposed and subcommittees will commence meeting first quarter.
Finalize bylaws and policies or Committee Guidelines where applicable	
Establish governance structure reporting and monitoring processes	DY1Q3 Narrative: With regard to data sharing with partners, several mechanisms have been put into place. The PPS has implemented the Performance Logic program as one method for collecting progress data from partners. Additionally, a secure server has been created to electronically allow transfer of actively engaged data from partners. The PPS web site has been expanded to be a more robust source of information sharing for partners, and the PPS is now utilizing a quarterly newsletter for partner updates. Quarterly reports from committees are provided to EGB for review; every project team is presenting to EGB throughout the year; updates from EGB will be posted to the website on a regular basis.
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers,	DY1Q3 Narrative: Patient and Partner Engagement position has been filled. Orientation is underway, including meeting partners, etc. Community Engagement plan has been completed with the intention of moving forward with various forums for communication with community stakeholders such as town halls, etc...

Bassett Medical Center (PPS ID:22)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
law enforcement)	
Finalize partnership agreements or contracts with CBOs	Changed back to In Progress per IA guidance as specific contracts were not available to review.
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.)	Changed status back to In Progress based in IA guidance as specific contracts were not available for review.
Finalize workforce communication and engagement plan	
Inclusion of CBOs in PPS Implementation.	Stakeholders from CBOs have been very involved with project application planning and project implementation. Partner agreements have been sent to >20 CBOs, including regional ARCs, social services organizations, councils on alcoholism, substance abuse organizations, and centers of independence for developmentally disabled individuals. Our PAC has involved stakeholders from community based organizations (including LEAF, a substance abuse counseling service). CBOs and educational institutions have been extremely instrumental in developing the Community Needs Assessment. CBOs will be invaluable as "hot spots" for implementing projects such as Navigation (2.c.i) and PAM (2.d.i). Where circumstances permit, the LCHP PPS intends to include contributing CBOs in bonus and incentive payments.

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 & Complete	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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.

Ineffective communication of DSRIP goals to engage key practitioners and community stakeholders in the governance process can reduce effectiveness of the initiative and disrupt the development of trust. This risk will be mitigated through timely communication plan processes, which will include town hall meetings, presentations, regular Partner meetings, website, access to leadership, having a voice in decisions, etc. The PPS will engage a Director-PPS and Patient Engagement to lead this work. We will also ensure communication of the importance of this transformative work, to further engage practitioners and community stakeholders in a shared vision. Expectations of partner and practitioner engagement will be outlined in an addendum to the partner agreement. Failure to meet expectations will result in reduction or elimination of DSRIP funds and/or potential removal from PPS.

Developing trust among key stakeholders; will be mitigated through development of a fair and transparent funds flow model, and a participative style of leadership to encourage participation of LCHP Partners, CBOs, and other stakeholders.

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.)

In order to be successful, LCHP must employ an integrated approach in the pursuit of DSRIP objectives. For example, IT and Data Analytics, Workforce and Finance functions must adopt a philosophy of customer-orientation to the other functional committees as well as to the project teams. Therefore, collaboration and communication among LCHP entities will be paramount. LCHP will adopt a thematic approach in many respects in order to assure inclusion and coordination among the voluminous activities employed toward Program success and practitioner engagement. This will minimize the "silo effect" and lead to optimizing resources and work effort toward accomplishing goals and objectives. The previously-referenced communications plan will focus emphatically on the requirement for internal bi-directional communication and decision-making in this regard.

The culture of LCHP will be directed toward effective working relationships among all entities within the organization. Emphasis on team and interdependency and shared success will manifest the need to recognize the requirements for one another's success.

Under IT Systems and Processes, we are recommending an IT Governance Structure consisting of sub-committees or task forces that report to the ITDAC. Establishing this more detailed structure will require additional participation by partners, but we expect to pay off in terms of long-term

efficiency.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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
Lead Agency	Bassett Medical Center--Lead agency for LCHP--Leatherstocking Collaborative Health Partners	Completing structures, work processes, communication plans, compliance with DSRIP requirements, membership on EGB, multiple committees
LCHP Operations Team	Susan van der Sommen DSRIP; Management Team	Project implementation, DSRIP administration functions, management of LCHP care delivery system
Actualization of DSRIP Projects	Project Chair(s)/ Committees	Establishing work groups and completing project plans
Executive Governance Body (EGB)	EGB Committee Membership	Fulfillment of PPS governance functions, appoint power to all committee membership
Director-PPS and Patient Engagement	Kara Travis, Bassett Medical Center (Lead Agency)	Stakeholder engagement
Organizational Support Teams	e.g., Finance, IT, Data Analytics, Workforce	Provide essential resources to project teams, LCHP administration for mission success
ACO, Medicaid Health Home	Bassett Medical Center--Lead agency for LCHP	Navigation, case management, protocol development

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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		
Bassett Medical Center	Lead agency for LCHP (Leatherstocking Collaborative Health Partners); participants in EGB	Funding, leadership personnel; expertise in network development; committee chairs; EGB members
AO Fox Memorial Hospital	Lead agency affiliate hospital	AO Fox Nursing Home VP active member of INTERACT
Tri-Town Regional Hospital/O'Connor Hospital	Lead agency affiliate hospital	CEO chairs EGB; committee member; participant in projects
At Home Care	Lead agency affiliate agency	Active member of Hosp-Home Care Collaborations Committee
Springbrook	Leadership, participant	CEO Co-Chair EGB; CIO co-chair IT committee
Medicaid beneficiaries	Participant	PAC membership
County Mental Health Agencies and other LGUs	Participant	"PAC membership, committees participation as SME"
4 County Coalition	Directors of Community Services	Develop strategies to further the accomplishment of PPS objectives
Community Memorial Hospital	Leadership, participant	EGB member; PCMH member
Valley Health Services	Participant	EGB member
Ulster County Mental Health Assn	Leadership, participant	EGB member; MHSA
External Stakeholders		
Medicaid Beneficiaries	Consumers of care	Membership on PAC, participate in focus groups and feedback on patient satisfcation
NYS DOH	Administration of DSRIP Program	Administration of DSRIP Program

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.

Interdependent IT infrastructure is essential for effective data sharing for milestone and metric reporting. It supports the decision-making process at various levels within the organization, and enables patient and provider service requirements to be fulfilled and reported to Executive Governance Body (EGB), e.g., referral management, performance improvement, financial management, interoperability, portal access for feedback and Partner reporting, website management, and sharing of information between and among Partners and LCHP leadership. This includes development of information sharing capabilities, data collection and analysis, and business intelligence in a consistent manner throughout the PPS. A survey of all PPS partner's IT capabilities will serve as a baseline and allow the PPS to perform a gap analysis. SIgnificant capital investments will be required to close the gap in the development of the infrastructure of the PPS.

LCHP will leverage diverse resources to ensure interconnectivity, enabling real-time sharing of relevant information to support efficient and effective patient care, and two-way communications among PPS partners within this rural geography. Since it is unlikely that any single method of data-sharing will suffice for the diverse needs of LCHP, multiple methods will be used to coordinate patient care across the raral LCHP network.

It represents the foundation for successful performance of the clinical objectives of LCHP, including the Clinical Performance Committee, EGB, Project leadership, as well as the functions of Clinical Integration and Care Coordination.

IPQR Module 2.8 - Progress Reporting

Instructions :

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

Governance milestones will be regularly monitored and progress measured against commitments. Creation of necessary organizational structures--e.g., project teams, governance bodies--evidence they are functioning effectively and according to plan will be accomplished through regular conduct of meetings, preparation and distribution of minutes, creation of action plans, dashboard reporting. All will be posted on the website for review and comment, as well as to demonstrate active movement toward goals.

All policies and procedures will be developed and published, and adherence will be monitored.

Incorporation of project management principles will serve as an important method for accountability purposes. Every initiative—whether a selected project or an Organizational workstream—will be managed by the DSRIP Operations Team using a sophisticated project management tool (e.g., Microsoft Project). Each sub-project will be structured to reflect Milestones and committed due dates for that project, for each Partner (in the case

of the 11 Projects) or each "committee" (in the case of Organizational initiatives such as Financial Sustainability). The % Complete for each will be captured from the project management system data as part of regular progress reporting and rolled up into the DOH-specified progress reporting mechanism, using the performance reporting infrastructure and defined/standardized processes.

IPQR Module 2.9 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Section 03 – Financial Stability

IPQR Module 3.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize PPS finance structure, including reporting structure	Completed	This milestone must be completed by 12/31/2015. PPS finance structure chart / document, signed off by PPS Board.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 1. Hire Director of Finance Operations for the PPS whose role will be the role will be to develop an internal plan for auditing, facilitate external audits, engage PPS partners to represent on finance committee, and report up to EGB , finance committee of PPS and ultimately to the CFO of the PPS.	Completed	Director of DSRIP Finance Operations hired	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Establish finance committee to include financial experts wtihin PPS with direct reoporting relationship to EGB (Executive Governance Body.)	Completed	Finance Committee established.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 3. Develop finance organizational chart, including reporting structure. Identify and appoint a CFO of PPS for oversight of PPS financial activities	Completed	Task in process	04/01/2015	12/31/2015	04/01/2015	12/29/2015	12/31/2015	DY1 Q3	
Task 4. Determine membership in board with adequate representation of partner/PPS diversity including, but not necessarily limited to, those in PPS with expertise in Finance, swimlane and /or	Completed	Task in process	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
geographical representation from PPS partners									
Task 5. Determine meeting frequency	Completed	Meeting frequency determined. The Finance Committee meets once every week.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 6. Prepare charter for finance committee for review and sign off by PPS board	Completed	Charter complete	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 7. Complete workplan for finance committee for PPS; review with PPS board	Completed	Task in process	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	In Progress	This milestone must be completed by 3/31/2016. Network financial health current state assessment (to be performed at least annually). The PPS must: - identify those providers in their network that are financially fragile, including those that have qualified as IAAF providers; -- define their approach for monitoring those financially fragile providers, which must include an analysis of provider performance on the following financial indicators: days cash on hand, debt ratio, operating margin and current ratio; -- include any additional financial indicators that they deem necessary for monitoring the financial sustainability of their network providers	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task 1. Assessment of partners' financial sustainability with the following metrics - days cash on hand, debt ratio, operating margin, current ratio and days in A/R for partners	In Progress	Task in process.	04/01/2015	12/31/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2. Identify any additional metrics for those partners determined to be "financially fragile	In Progress	Task in process	04/01/2015	12/31/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 3. Perform an assessment of data received from partners to determine financial stability	In Progress	Task in process	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 4. Determine relative importance of financially fragile partners in meeting the goals of healthcare transformation and accomplishment of DSRIP objectives	In Progress	Task not started	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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 5. In support of financially fragile partners, develop a remedial action plan to return said partners to financial feasibility. The plan may include external consulting services, as determined necessary by the Finance Committee and Executive Governance Body of the PPS.	In Progress	Task not started	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 6. Develop ongoing monitoring plan of those institutions determined to be "financially fragile" to include quarterly reports of key financial indicators	In Progress	Task not started	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 7. Assure to the extent possible that steps in the plan are being implemented with "course correction" as necessary	In Progress	Task not started	10/01/2015	03/31/2016	10/01/2015	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	12/29/2015	12/31/2015	DY1 Q3	YES
Task 1. Create a Compliance Committee for PPS for review/approval by PPS Executive Governance Body	Completed	Task in process. Compliance Committee newly formed.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Retain a compliance officer for the PPS, hired by the lead agency	Completed	Task in process	04/01/2015	12/31/2015	04/01/2015	12/29/2015	12/31/2015	DY1 Q3	
Task 3. Prepare a compliance plan for submission to and approval by the Executive Governance Body of the PPS	Completed	Task in process	04/01/2015	12/31/2015	04/01/2015	12/29/2015	12/31/2015	DY1 Q3	
Task 4. Assess partners on their compliance plan using a survey tool and identify gaps to comply with New York State Social Services Law 363-d	Completed	Task complete - compliance survey sent and received.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5. Compliance Committee will educate network members on compliance at All Partner Meeting in	Completed	Complete	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

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
September 2015									
Task 6. Prepare quarterly reports and presentation to the Executive Governance Body and lead agency personnel	Completed	Task in process	04/01/2015	12/31/2015	04/01/2015	12/29/2015	12/31/2015	DY1 Q3	
Task 7. Ensure the compliance plan is tailored to the appropriate management and utilization of DSRIP funds	Completed	Task in process	04/01/2015	12/31/2015	04/01/2015	12/29/2015	12/31/2015	DY1 Q3	
Task 8. Develop annual compliance training to be conducted on all partners who are identified to be in need of said training.	Completed	Task in process	04/01/2015	12/31/2015	04/01/2015	12/29/2015	12/31/2015	DY1 Q3	
Task 9. Develop an annual Compliance Plan for review by Executive Governance Body and lead agency	Completed	Task in process	04/01/2015	12/31/2015	04/01/2015	12/29/2015	12/31/2015	DY1 Q3	
Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	In Progress	This milestone must be completed by 3/31/2016. Value-based payment plan, signed off by PPS board	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task 1. Identify key stakeholders of partners, providers, and financial/insurance subject matter experts to form a VBP Task Force	Completed	Not started	10/01/2015	12/31/2015	10/01/2015	12/29/2015	12/31/2015	DY1 Q3	
Task 2. Obtain approval of membership from EGB	Completed	Not started	10/01/2015	12/31/2015	10/01/2015	12/29/2015	12/31/2015	DY1 Q3	
Task 3. VBP Task Force to develop charter for Executive Governance Body review/approval	In Progress	Not started	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 4. Develop a value-based payment transition plan- Phase I	In Progress	Not started	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 5. Assure task force has appropriate resources to fulfill its charge - information services, SMEs on	In Progress	Not started	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
reimbursement methodologies, assumption and management of risk, predictive modeling, etc.									
Task 6. VBP Task Force to perform a baseline assessment within PPS of percentage of Medicaid and non-Medicaid revenue that is considered "value-based" payments	In Progress	Not started	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 7. Develop a reporting methodology for use with partners to acquire necessary information to establish an adequate database - types and volumes of services, method of reimbursement, levels of risk, etc.	In Progress	Not started	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 8. Provide reports at least quarterly to Executive Governance Body and PPS partners	Not Started	Not started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	In Progress	This milestone must be completed by 12/31/2016. Value-based payment plan, signed off by PPS board	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3	YES
Task 1. Finalize VBP plan for sign-off by Executive Governance Body- Phase II	Not Started	Not started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 2. Utilizing the baseline assessment, charge the VBP Task Force with the development of strategies and tactics to achieve 90% value-based payments across the PPS network by year 5 of the DSRIP program consistent with VBP plan - Phase II	Not Started	Not started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 3. Identify and plan for the incorporation of the resources necessary to achieve the transformation - staffing, database, communication mechanisms with MCO's, etc.	In Progress	Not started	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task 4. Develop methods for ongoing communication	Not Started	Not started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
with and inclusion of partners in transition initiative.									
Task 5. Create formal negotiating mechanisms with MCOs with ample lead time to develop mutually acceptable outcomes/reimbursement models regarding movement to VBP goal.	Not Started	Not started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 6. Link work regarding Medicaid payers to relationships/negotiations with non-Medicaid payers to ensure comprehensiveness/symmetry of approach to VPB model on all fronts	Not Started	Not started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Milestone #6 Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	Not Started		01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3	YES
Milestone #7 Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	Not Started		01/01/2016	12/31/2018	01/01/2016	12/31/2018	12/31/2018	DY4 Q3	YES
Milestone #8 >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	Not Started		01/01/2016	12/31/2019	01/01/2016	12/31/2019	12/31/2019	DY5 Q3	YES

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize PPS finance structure, including reporting structure	amyvk	Meeting Materials	22_MDL0303_1_3_20160115123342_Meeting_Schedule_Template_Finance_DY1Q3.xlsx	Finance Committee Meeting Schedule Template DY1Q3	01/15/2016 12:33 PM
	amyvk	Other	22_MDL0303_1_3_20160115095235_EGB_Signed_Approval_Letter_DSRIP_Org_Structure_DY1Q2.pdf	Evidence of Governing Body Approval of Finance Committee Structure	01/15/2016 09:52 AM
	amyvk	Other	22_MDL0303_1_3_20160115095148_BassettPPS22FinanceOrgChartDY1Q3.pdf	Bassett PPS Finance Structure Organization Chart	01/15/2016 09:51 AM
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	amyvk	Documentation/Certification	22_MDL0303_1_3_20160314081417_Bassett_NYS_Mandatory_Provider_Compliance_Program_Certificate.pdf	Bassett OMIG Certificate of Approval of Compliance plan	03/14/2016 08:14 AM
	amyvk	Implementation Plan & Periodic Updates	22_MDL0303_1_3_20160120083909_Bassett_Medical_Center_PPS_Compliance_Plan_-Dec_2015.docx	Bassett Medical Center PPS Compliance Plan	01/20/2016 08:39 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize PPS finance structure, including reporting structure	
Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	DY1Q3 Narrative: Most of the work to date completed by the Finance Committee has been focused on the development of a Funds Flow model. The committee has just begun the process of developing a financial health current state assessment to complete this milestone by 03/31/16. Meterics to measure financial sustainability have been discussed; this will continue to be an ongoing work item for the Finance Committee.
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Milestone 3 - OMIG certificate of approval of plan submitted as requested by remediation guidance - 3/14/16.
Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	
Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	
Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	
Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	
>=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Complete	
Milestone #2	Pass & Ongoing	
Milestone #3	Fail	The documentation submitted was insufficient to demonstrate completion of the milestone. The PPS failed to submit the certification confirmation received from the New York State Office of Medicaid Inspector General (OMIG) indicating that the compliance program meets the requirements of the law and regulations. Failure to meet this milestone in DY1 Q3 will impact your payment in DY1 Q4. If you wish to appeal, you must do so within 5 business days. DY1 Q3 appeals will not be considered in subsequent periods.
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

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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.

Risks and mitigation strategies for such risks include:

There may be inadequate data to conduct negotiations with third-party payers. To mitigate it, we will procure adequate IT, business intelligence and data analytic resources to provide necessary information for negotiations with third-party payers.

Revenue stream may not be adequate to provide services necessary for population health management approach. With an adequate database, we will demonstrate to third-party payers the ability to deliver care in the new environment. The PPS will include a tiered approach with respect to assuming financial risk, utilizing an incremental approach by which partners would assume a greater revenue stream risk share over time.

Culture needs to shift to adapt to transformation of care delivery in the new environment. Through LCHP and partner leadership, we will develop a detailed approach to incorporate principles of population health management, mechanisms to monitor financial performance, including loss of revenue and provision for course correction, and embed appropriate incentives to reconfigure and reorient partner organizations in the new model of care delivery.

As much of the transformation under DSRIP there will be significant capital requirements for IT, cost accounting systems, predictive modeling software, etc. Inadequate capital support will place limits on the ability to achieve outcomes which may be progressive but inadequate in terms of accomplishment of the desired transformation.

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.)

Due to the dramatic culture and practice shift that a move to value-based purchasing will entail, there will be a dependency on multiple workstreams within the PPS network. These will include, but may not be limited to: Clinical performance and integration, as provider understanding and acceptance of new payment model necessary; workforce, as the PPS will need the appropriate staffing and subject matter experts to perform this work; Information technology, as the PPS will need to obtain and track information relating to claims and metrics leading toward a VBP model; Finance and Compliance Committees will be an integral part of this transition.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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
Executive Director, DSRIP Operations	Sue van der Sommen	Oversight and staffing of VPB Task force; leader in VBP transition
Chief Financial Officer, Lead Agency	Sue Andrews	Oversight of PPS financial activities
Director, DSRIP Finance Operations	Michael Sweet Bassett Medical Center--Lead agency for LCHP--Leatherstocking Collaborative Health Partners	Leading finance committee and VBP task force through transition and direct oversight of financial sustainability plan
Finance Committee	Members include Finance experts from several partner organizations including lead agency	Develop funds flow process; implement financial sustainability plan
Compliance Officer/Lead PPS	Bassett Medical Center--Lead agency for LCHP	Lead PPS in compliance matters; development and maintenance of compliance plan for PPS network.
Internal Auditors	Lead agency	Internal Audit of PPS Funds Flow Process
External Auditors	KPMG	External Audit of PPS Funds Flow Process
Community Based Organizations (CBOs)	Partner organizations; sometimes funds flow recipients	Active engagement in project development and eventual success
Local Government Agencies	Partner organizations	Active engagement in project development and eventual success

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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		
Chief Clinical Officer, Lead Agency	Culture change; leadership	Practitioner engagement, education about change in reimbursement/practice model
CFO and/or Finance leads for PPS partners	Financial lead	Responsible for leading change to VBP model with regard to finance-related/reimbursement strategies in PPS network
PPS Compliance Committee	Compliance lead	Responsible for developing and overseeing compliance program for PPS; quarterly reporting to Exec Gov Body
Workforce Committee	Oversight of all training strategies, including practitioner education / training described above	Input into practitioner education / training plan
IT/Data Analaytics Committee	Provision of data and information to enable practitioners to complete their goals and objectives	Availability of information in a timely way and in the desired format
PPS Project Management Office	Bassett Medical Center--Lead agency for LCHP	Leading initiative; culture change
Finance Committee	Develop funds flow process; implement financial sustainability plan	Funds Flow Model
Executive Governance Body of PPS	Oversight of VBP plan and compliance planning	Responsible for review of reporting and oversight of compliance and finance committee with regard to transition to VBP
External Stakeholders		
MCOs	Insurers	Work with PPS to negotiate risk relationships with providers
NYS DOH	Administration of DSRIP Program	Administration of DSRIP Program

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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.

Information technology will play a key role in the financial sustainability of the PPS network. The dependence on shared information is a key to tracking metrics and system transformation. Additionally, moving to a population-health based model of care for our patients will be dependent on tracking and monitoring claims data, as well as clinical services and outcome metrics.

A well-established relationship, with clearly defined roles between IT and Finance is crucial to DSRIP success. Finance requires integration with a shared IT infrastructure in the following areas: 1) Data collection and reporting; 2) Ability to access financial information such as templates and funds flow; 3) Ability to collect data to determine and monitor status of financially fragile partners, and to deploy resources where necessary (e.g., web-based training, advisory services).

Due to the rural nature of the PPS and the large geographic footprint it is essential that technology be leveraged wherever possible to mitigate the potentially fragmented communications and data sharing fundamental to implementing and maintaining a stable, supportive environment.

IPQR Module 3.8 - Progress Reporting

Instructions :

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

Success of this workstream will be managed through routine reporting of the Finance Committee to the Executive Governance Body. Partner financial sustainability will be a key factor in the success of the PPS, so oversight of this is vital.

This workstream's success will be indicated by collection of metrics from our partners including performance measures, (i.e., domain 2 and 3 and claims based outcomes measures), progress measures - (domain 1 milestone achievement) and participation measures (are partners providing substantive contributions to ongoing project effort). We will continually monitor the level of engagement and involvement of providers in the performance reporting systems and processes that are established. 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 Performance Committee about performance dashboards). We will also set targets for performance against these metrics. The Practitioner Champions and the Project-specific Leads will be held accountable for driving up these levels of involvement. Measurement methods for accountability include Salient dashboards, meeting attendance rosters, provision of additional supporting documentation as requested/required, etc.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

IPQR Module 3.9 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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 1. Director-PPS Partner and Patient Engagement to develop work groups and engage stakeholders in defining the cultural competency needs and determining the focus for the PPS	Completed	Task in progress	04/01/2015	12/31/2015	04/01/2015	11/17/2015	12/31/2015	DY1 Q3	
Task 2. In attempt to identify populations and geographic areas where most work is needed, utilize CNA data and other key analyses, e.g. Upstate Health and Wellness Survey, Healthy People 2020, results from County Public Health	Completed	Task in progress	04/01/2015	12/31/2015	04/01/2015	12/10/2015	12/31/2015	DY1 Q3	

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Dept Screenings, New York State, Cancer Prevention Plan, New York State Comprehensive Cancer Control Plan 2012-2017, updates from NYS required community service plans, etc. to identify priority groups experiencing health disparities; continue to build and develop community needs assessment to determine changing and growing needs of our PPS including health disparities and the underserved									
Task 3. Utilizing data from key analyses, create a workplan to address highest priorities, and obtain approval from EGB.	Completed	Task in progress	04/01/2015	12/31/2015	04/01/2015	12/10/2015	12/31/2015	DY1 Q3	
Task 4. Leverage resources in existing Medicaid Health Home as a model to be replicated in addressing cultural competency issues in LCHP, while providing coordinated, comprehensive medical and behavioral health care	Completed	Task in progress	04/01/2015	12/31/2015	04/01/2015	12/10/2015	12/31/2015	DY1 Q3	
Task 5. As part of the work plan, utilize existing resources with cultural competency expertise within the PPS (e.g., NYSDOH Cancer Services Program, CBOs) as well as projects relating to serving the uninsured and low utilizers, to better meet the health care needs of PPS disparate population	Completed	Task in progress	04/01/2015	12/31/2015	04/01/2015	12/10/2015	12/31/2015	DY1 Q3	
Task 6. Building on lead agency's Institute for Learning, continue to develop educational programs dedicated to building cultural competency among key stakeholders including, but not limited to, provider and other clinical staff, front line staff and leadership. Determine how CBOs, as well as 11th Project stakeholders, can engage in this work to better serve the population	Completed	Task in progress	04/01/2015	12/31/2015	04/01/2015	12/10/2015	12/31/2015	DY1 Q3	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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 7. Develop culturally and linguistically appropriate materials for patient education based on defined needs of population	Completed	Task in progress	04/01/2015	12/31/2015	04/01/2015	12/10/2015	12/31/2015	DY1 Q3	
Task 8. Engage navigators in CBOs and other organizations to determine needs of population with regard to food, clothing, shelter, healthcare access	Completed	Task in progress	04/01/2015	12/31/2015	04/01/2015	12/10/2015	12/31/2015	DY1 Q3	
Task 9. Director of PPS Partner & Patient Engagement to lead PPS Collaborative Learning initiative to better engage and educate the target population based on information derived from the community needs assessment holding community forums, PAM assessments, patient navigation and key community stakeholders	Completed	Task not yet started - still identifying PPS Partner and Patient Engagement Director.	07/01/2015	12/31/2015	07/01/2015	12/10/2015	12/31/2015	DY1 Q3	
Task 10. Identify metrics to evaluate and monitor ongoing impact of cultural competency / health literacy initiatives. Develop method to track metrics for annual reporting and publish on PPS website	Completed	Not started	10/01/2015	12/31/2015	10/01/2015	12/10/2015	12/31/2015	DY1 Q3	
Task 11. Market the availability of community based navigation services to public	Completed	Task in progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 12. Gather information as input to a resource guidebook that outlines community services in conjunction with Navigation/PAM project teams to ensure appropriate and ready access to necessary information	Completed	Task in progress	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 addressing the drivers of health disparities (beyond the availability of language-appropriate material).	In Progress	This milestone must be completed by 6/30/2016. Cultural competency training strategy, signed off by PPS Board. The strategy should include: -- Training plans for clinicians, focused on available evidence-based research addressing health disparities for particular	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		groups identified in your cultural competency strategy -- Training plans for other segments of your workforce (and others as appropriate) regarding specific population needs and effective patient engagement approaches							
Task 1. Identify administrative leader within PPS to direct and oversee partner and patient engagement work	In Progress	Task in progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 2. Engage Population Health Improvement Program (PHIP) team within lead agency to identify drivers of health disparities	In Progress	Task in progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 3. Identify patient health disparity training needs for clinicians based on CNA data and practitioner focus groups	In Progress	Task in progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 4. Based on identified training needs, develop training criteria for clinicians; utilize mechanisms such as grand rounds and/or other electronic training systems to deliver trainings	In Progress	Task in progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 5. Utilizing workforce consultant resources, develop a training strategy for non-clinical staff	In Progress	Task in progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 6. Based on identified training needs, develop training criteria for non-clinicians; utilize mechanisms such as departmental meetings and/or other electronic training systems to deliver trainings	In Progress	Task in progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 7. By implementing the lead agency's proven methods, share training and education models with PPS workforce to engage patient populations as determined by CNA analysis	In Progress	Task in progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 8. Develop training schedule throughout PPS	In Progress	Task in progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
region to ensure greater attendance/participation									
Task 9. Collaborate with other PPS' regarding their training strategy for similar patient populations to repurpose concepts and materials	In Progress	Task in progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 10. Explore ways to leverage technology in training delivery and curricula, e.g., Healthstream or other online learning programs, offerings from professional societies and catalog best practices	In Progress	Task in progress	07/01/2015	06/30/2016	07/01/2015	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.	amyvk	Other	22_MDL0403_1_3_20160315081518_Governance_Approval_of_CCHL_Strategic_Plans.pdf	Bassett Governing Body approval of CCHL Strategic Plan	03/15/2016 08:15 AM
	amyvk	Other	22_MDL0403_1_3_20160315081438_CCHL_Strategic_Plan_-_Rev._201603.pdf	Bassett PPS CCHL Strategic Plan Revised per IA Guidelines	03/15/2016 08:14 AM
	amyvk	Meeting Materials	22_MDL0403_1_3_20160114135605_Meeting_Schedule_Temple_CCHL_DY1Q3.xlsx	Cultural Competency and Health Literacy DY1 Q 3 Meeting schedule	01/14/2016 01:56 PM
	amyvk	Documentation/Certification	22_MDL0403_1_3_20160114135508_DSRIP_22_CCHL_M1_StrategicPlan_20151207.pdf	Bassett PPS Cultural Competency and Health Literacy Strategic Plan	01/14/2016 01:55 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize cultural competency / health literacy strategy.	DY1Q3- The strategic plan for CCHL has been completed, and approved by EGB. CCHL Leads have attended the PPS wide CCHL forum led by PCG and will continue to be engaged in these meetings. CCHL has blended forces with Population Health Improvment Plan and will be incorporating respresention from the patient engagement and Navigation team. The following tasks are addressed with EGB approved objectives in the CCHL Strategic Plan:

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	Task 1 - Objective 2.1 in CCHL Strategic Plan Task 2 - Objective 1.1 in CCHL Strategic Plan Task 3 - Objective 1.2 in CCHL Strategic Plan Task 4 - Objective 3 in CCHL Strategic Plan Task 5 - Objective 1.3 in CCHL Strategic Plan Task 6 - Objective 3.4 in CCHL Strategic Plan Task 7 - Objective 4.1 in CCHL Strategic Plan Task 8 - Objective 5.5 in CCHL Strategic Plan Task 9 - Objective 2.2 in CCHL Strategic Plan Task 10 - Objective 2.3 in CCHL Strategic Plan Task 11 - Objective 3.2 in CCHL Strategic Plan Task 12 - Objective 3.1 in CCHL Strategic Plan Additional Note 3/15/16: Have uploaded revised CCHL Plan as per IA Guidance.
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	

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

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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.

Provider buy-in is a challenge due to need for providers to understand the needs of this population. Through an evidence-based, data-driven approach, information will be communicated to LCHP providers and staff that will enable collaboration and engagement in preparing tactics to address health disparity opportunities.

Measuring impact will be especially challenging as defining these metrics requires proficiency in areas typically unfamiliar to healthcare providers. However, we are committed through various means, such as collaborating with other PPS', to employing methodology to measure the levels of success.

We anticipate many geographical and logistical challenges within this rural area. Affordable, public transportation across the region is not easily available; this has been assigned to Navigators as a priority and awareness goal.

Since statistical information on these populations is scarce, it will be difficult to identify target population. There is no data gathering method, what information is available is generally anecdotal. We will leverage the data warehouse mechanism to collect population data for analysis, and development of tactics to address priority areas.

Patient Engagement will be a risk to this workstream. To mitigate this, Director of Patient and Partner Engagement willl be charged with developing specific set of strategies that will compile an approach and function. Additionally, patients will be members of PAC, and focus groups will be held to assess patient engagement.

As a medical school and medical/surgical residency program, the Lead Agency needs to reflect that English may not be the primary language of the practitioner and patient populations, and adjust training programs accordingly.

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.)

LCHP has identified a variety of online resources, including the NYLearnsPH.com Learning Management System (LMS) and the Empire State Public Health Training Center (ESPHTC), which it will incorporate into its comprehensive training program. A Learning Management System (LMS) has been implemented (HealthStream); an administrator for the system is in place; content-area experts will be identified, recruited, and trained.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Training on cultural competency topics will impact on the Practioner Engagement, and Workforce and the IT/Data Analytics workstreams, who will play a role in training design and execution. Training delivered across a large, geographically distributed network requires the traditional IT support structures (i.e., network administrator, help desk, etc.). It also will require a named position to coordinate the various types of required training and keep content updated to reflect new needs (Workforce). System-specific topics modules will be needed and will require content-area experts from a variety of disciplines who themselves will need to be trained on how to create training modules. Practioner Engagement will be key to content development and successful outcomes.

While not major dependencies, under IT Systems & Processes we state an intent to acquire an automated survey instrument and a Learning Management system. Both of these will allow aspects of the Cultural Competency Strategy to be executed more quickly and efficienctly.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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
Research Department	Bassett Medical Center--Lead Agency for LCHP (Leatherstocking Collaborative Health Partners)	CNA analysis; PHIP engagement
Partner and Patient Engagement	Kara Travis, Bassett Medical Center Director of Partner and Patient Engagement	Direct and oversee partner and patient engagement work, linguistics gaps
Practitioner Engagement	Tom Manion, Director of DSRIP Network Operations	Practitioner training program development , Clinical Integration, and Cultural Competency
Medicaid Health Home	Bassett Medical Center--Lead Agency for LCHP (Leatherstocking Collaborative Health Partners)	Resource development
Bassett Institute for Learning	Bassett Medical Center (Diana Parker)	Provide guidance regarding development of training curriculum for health literacy - providers and patients
IT & Data Analytics (Business Intelligence) Department	Lead Agency	Analytical tools; online educational and training media; software procurement
Director, PPS Performance Metrics	Amy Van Kampen, Bassett Medical Center	Coordination of related tasks; liaison between Workforce and IT/Data Analytics functions; design of desired product
Executive Governance Body	PPS	Oversight of implementation/metrics/ measurement
Bassett Medical Center	Susan van der Sommen, Executive Dir, DSRIP	Project implementation oversight
Workforce Consultant	Anita Merrell-AHEC	Cultural Competency and Health Literacy

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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		
Diana Parker	Director, Bassett Institute for Learning	Assist in development of learning curriculum
Sara Albright	Vice President of Human Resources, Bassett Healthcare (Lead Agency)	Oversight of workforce development plan
External Stakeholders		
AHEC	Workforce consultant	Utilize proven methods of training for curriculum development/distance learning
Dr. David Strogatz	CNA Development Committee	Ongoing feedback regarding assessment of health disparities, and impact of plans to address same
Catholic Charities	CBO; Care coordination services	Community-based navigation
County Mental Health Departments (Otsego, Schoharie, Delaware, Madison, Herkimer)	Mental health providers	Participation in Projects 3.a.i; MHSA 4.a.iii
Southern Tier Aids program	CBO	Community-based navigation

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.

IT and data analytics will support development of analytical tools, provide a structure for management of online educational and training media, and assist with software procurement such as the ability to access an external learning collaborative to promote available trainings and best practices.

Data collection and reporting - There is a need to connect partners within the PPS for the purpose of developing standardized workforce training requirements. AHEC will work with IT and Performance Reporting workstreams to identify and develop a workforce training program focused on enhancing cultural competency and health literacy, and delivery methods that adapt to the PPS' wide geographical footprint.

Learning collaborative - The ability to connect partners within LCHP and contiguous PPS' will encourage the use of existing best-practices and the sharing of training materials, eliminating the need to re-create curricula. We will explore ways to collaborate with other PPSs to leverage common training needs and curricula. The AHECs are pursuing outside funding opportunities to further develop a digital platform through Health Workforce New York (HWNY) that could serve as the framework for a learning collaborative that would support access on a PPS, regional, and statewide level.

Training - LCHP leadership will work with IT to assess partner capability for tracking training progress (who's been trained/retrained, etc.) and reporting to MAPPS. Training programs will be developed based on outcome of CNA and other key data analyses.

IPQR Module 4.8 - Progress Reporting

Instructions :

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

Annual review of the Community Needs Assessment will inform continued prioritization of target populations, and will assist in defining effectiveness of initiatives. When combined with specific Program metrics for target populations will further identify effectiveness of specific activities such as patient engagement and cultural support. Communication and information sharing with CBOs will afford opportunities to more effectively understand the extent to which initiatives have been successful.

Additionally, we will track the number of clinicians and staff educated in cultural competency principles, and obtain feedback regarding the practical application of what they learned.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

IPQR Module 4.9 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Section 05 – IT Systems and Processes

IPQR Module 5.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	In Progress	Detailed IT current state assessment. Relevant QEs (RHIOs/HIEs) should be involved in performing this assessment.	04/01/2015	03/31/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task 2. Assess IT capabilities of partners	In Progress	Task in progress - partner IT survey in process.	07/01/2015	12/31/2015	07/01/2015	07/31/2016	09/30/2016	DY2 Q2	
Task 2.1-Establish current state reporting dimensions – including at least:	Completed	Task in progress - partner IT survey in process	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2.1.1-EHR and other patient-related software applications	Completed	Task in progress - partner IT survey in process	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2.1.2-User Adoption of clinical software (may use MU level as proxy)	Completed	Task in progress - partner IT survey in process	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2.1.3-Data interchange capabilities (e.g., HIE participation, DIRECT, integration engines, etc.)	Completed	Task in progress - partner IT survey in process	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2.1.4-Security and confidentiality (require partners to supply current [<1 yr] security risk assessment to facilitate) in compliance with DEAA requirements	Completed	Task in progress - partner IT survey in process	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2.2-Require partners to self-assess using the	Completed	Task in progress - partner IT survey in process	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
criteria established in 2.1.1 above.									
Task 2.3-PPS to validate data submitted from partners and compile into comprehensive current state assessment	In Progress	Task not started - awaiting completion of partner IT survey	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 3. ITDAC to establish periodic reporting requirements from partners on changes to their individual IT capabilities, adoption, etc.	Completed	Task not started - awaiting completion of partner IT survey	10/01/2015	03/31/2016	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4. Establish the ITDAC and clarify its scope, duties and role within the LCHP Governance structure	Completed	Task completed. Committee established.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4.1-Establish subcommittees to the ITDAC - Security, Change Control and Data Governance	Completed	Task completed. Subcommittees to be Security and Data Governance. For now Change Control will remain under the purview of the ITDAC committee.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5. Develop an overall LCHP IT Strategic Plan	In Progress	Task in progress	04/01/2015	12/31/2015	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 6. Review the LCHP IT Strategic Plan with DSRIP program management and PPS partners	Not Started	Task not yet started	10/01/2015	12/31/2015	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task 7. Identify gaps between minimum requirements and current state	In Progress	Task not yet started	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 8. Finalize the LCHP IT Strategic Plan	Not Started	Task not yet started	10/01/2015	03/31/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 1. IT and Data Analytics Committee (ITDAC) to establish minimum EHR capabilities, EHR adoption, system integration/interoperability and security expectations for partners	Completed	At minimum, the Electronic Health Record for partners participating in the LCHP PPS as providers of hospital or primary care will be Meaningful Use ("MU") certified. The EHR will be capable of producing CCD (Continuity of Care) documents. With regard to the ability to exchange data, EHRs will be expected to have the capability of connecting with Health Information Exchanges (HIEs) such as HIXNY, HealthlinkNY, HealtheConnections, etc... Partners will be expected to have Business Associates' Agreements (BAA) in place in order to ensure the security of any shared clinical data. Any shared Medicaid data provided	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		by New York State will be governed by New York State data security policies including NYS-P03-002, NYS-P10-006, NYS-S13-004, NYS-S14-006 and NYS-S14-007, as well as section 367b(4) of the NYS social services law, NYS social services law section 369 (4) and Article 27-F of the New York Public Health Law & 18 NYCRR 360-8.1. as outlined by the System Security Plan that will be submitted in conjunction with the DY1Q2 Quarterly IT report on October 31.							
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	09/30/2016	09/30/2016	DY2 Q2	NO
Task 1. Work with IT and Data Analytics Committee (ITDAC) to develop a global change management process consisting of two change control parts--PPS and Partners:	Not Started	Task not yet started	10/01/2015	03/31/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 1.1-PPS change control - Policies and procedures governing testing, training, documentation and approval of changes to:	Not Started	Task not yet started	10/01/2015	03/31/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 1.1.1-Identify PPS controlled IT capabilities including internal systems (e.g., PPS accounting, e-mail)	Not Started	Task not yet started	10/01/2015	03/31/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 1.1.2-Identify services provided to partners (e.g., population health analytics)	Not Started	Task not yet started	10/01/2015	03/31/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 1.1.3-Manage integration capabilities with and between partners	Not Started	Task not yet started	10/01/2015	03/31/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task	In Progress	Task not yet started	10/01/2015	03/31/2016	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

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
1.2-Partners change control									
Task 1.2.1-Firmly delineate Partner IT capabilities relevant to PPS participation (e.g., integration capabilities, EHR changes, hosting services)	In Progress	Task not yet started	10/01/2015	03/31/2016	10/01/2015	04/30/2016	06/30/2016	DY2 Q1	
Task 1.2.1.1-Develop and execute policies and procedures requiring advance reporting to PPS of significant partner changes	In Progress	Task not yet started	10/01/2015	03/31/2016	10/01/2015	04/30/2016	06/30/2016	DY2 Q1	
Task 1.2.1.2-Develop and execute process for assessing impact on PPS of significant partner changes in IT capabilities.	In Progress	Task not yet started	10/01/2015	03/31/2016	10/01/2015	04/30/2016	06/30/2016	DY2 Q1	
Task 1.2.1.3-Identify partner responsibilities to PPS as result of changes	In Progress	Task not yet started	10/01/2015	03/31/2016	10/01/2015	04/30/2016	06/30/2016	DY2 Q1	
Task 1.2.2-Develop process for partner integration of ITDAC standards into partner systems (e.g., standardized master files, metrics reporting)	Not Started	Task not yet started	10/01/2015	03/31/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 1.2.2.1-Include process for PPS/ITDAC notifications to partners	Not Started	Task not yet started	10/01/2015	03/31/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 1.2.2.2-Provide for reasonable time-frame for partner implementation	Not Started	Task not yet started	10/01/2015	03/31/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 1.2.2.3-Include Partner reporting requirements during implementation	Not Started	Task not yet started	10/01/2015	03/31/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 1.2.2.4-Implement functional (partner) and integrated (PPS) testing process	Not Started	Task not yet started	10/01/2015	03/31/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 2. Assist partners in Integrating PPS change control into their own local change control processes	On Hold	Task not yet started	10/01/2015	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 3. Monitor and adjust as indicated	On Hold	Task not yet started	10/01/2015	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

Bassett Medical Center (PPS ID:22)

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 4. Create an IT Governance Change Management Oversight process	In Progress	Task in Progress	07/01/2015	03/31/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task 4.1-Establish Change Control subcommittee	Completed	Complete - currently this subcommittee work will be accomplished by full committee membership	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4.2-Establish Change Control operating procedures and control documents (or automated control tools)	Not Started	Not started	10/01/2015	03/31/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task 5. Develop plan to communicate changes to partners and other stakeholders	Not Started	Not started	10/01/2015	03/31/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Milestone #3 Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	In Progress	Roadmap document, including current state assessment and workplan to achieve effective clinical data sharing and interoperable systems where required. The roadmap should include: -- A governance framework with overarching rules of the road for interoperability and clinical data sharing; -- A training plan to support the successful implementation of new platforms and processes; and -- Technical standards and implementation guidance for sharing and using a common clinical data set -- Detailed plans for establishing data exchange agreements between all providers within the PPS, including care management records (completed subcontractor DEAAs with all Medicaid providers within the PPS; contracts with all relevant CBOs including a BAA documenting the level of PHI to be shared and the purpose of this sharing).	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task 1. Determine PPS capabilities that will be centrally provided by the PPS and shared by the partners	Completed	Task in Progress	07/01/2015	03/31/2016	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 1.1-Conduct system search and selections for required capabilities	Completed	Task not yet started	10/01/2015	03/31/2016	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. Determine/define Partner data sharing requirements based upon role, information	Completed	Task in progress	07/01/2015	03/31/2016	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
needs, typical practice									
Task 3. Develop data sharing plan	In Progress	Task not yet started	10/01/2015	03/31/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 3.1-Utilizing current assessment (Milestone 1), identify current gaps	Completed	Task not yet started	10/01/2015	03/31/2016	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3.2-Evaluate the extent to which existing Health Information Exchanges (HIXNY and/or SHIN-NY and HealtheConnection) can meet the PPS data sharing requirements	In Progress	Task not yet started	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 3.3-Identify unmet gaps in data sharing capabilities	In Progress	Task not yet started	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 3.4-Assess potential approaches based on functionality, scalability, total cost of ownership, security/confidentiality, implementation timeframe and reliability	Completed	Task not started	10/01/2015	06/30/2016	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3.5-If SHINNY does not meet the needs of PPS, conduct search and selection for specific solution, e.g., private HIE	Completed	Task not yet started	01/01/2016	09/30/2016	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4. Develop integrated implementation plan for centrally-provisioned systems, HIE and data sharing capabilities based on the identified ability for existing HIEs to meet PPS data sharing requirements	In Progress	Task not yet started	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task 5. Develop data sharing policies between and among members of LCHP	Completed	Duplicate - entered in error	04/01/2015	03/31/2020	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6. Develop data sharing procedures between and among members of LCHP	Not Started	Task not yet started	10/01/2015	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 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	07/01/2015	09/30/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		isolated communities.							
Task 1. Assess technology-enabled patient engagement capabilities of individual partners	Completed	Task not yet started	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. Assess PPS patient participation in public HIEs (HIXNY, SHIN-NY and HealtheConnection)	Completed	Task in progress via partner IT survey	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Analyze patient participation to identify barriers to increased participation/usage of HIE and patient engagement technologies	Not Started	Task not yet started	10/01/2015	03/31/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 4. Survey sample of (anticipated) attributed members to further assess patient needs, interest and barriers to usage of technology tools to further engagement	Not Started	Task not yet started	10/01/2015	03/31/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 5. Educate partner front desk staff on benefits of HIE enrollment, and establish standard process for presenting HIE enrollment to patients	Not Started	Task not yet started	10/01/2015	09/30/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 6. Develop specific patient education approaches to address top three identified barriers or concerns (e.g., language, technology access, privacy concerns)	Not Started	Task not yet started	10/01/2015	03/31/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task 7. Determine PPS technologies (e.g., portal, secure messaging, reminders, online scheduling, online bill payment, patient education, personal health record) to support technology-based patient engagement	Not Started	Task not yet started	10/01/2015	09/30/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 8. Develop budget and implementation plan for selected technologies	In Progress	Task in progress	07/01/2015	09/30/2016	07/01/2015	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 Board, including: -- Analysis of information security risks and design of controls to mitigate risks	04/01/2015	03/31/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		-- Plans for ongoing security testing and controls to be rolled out throughout network.							
Task 1. Assemble security/confidentiality committee	Completed	Task in progress	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Designate Chief Security Officer (CSO) role (required by HIPAA)	Completed	Task in progress	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3. Develop HIPAA/HITECH compliant PPS-level security policies and procedures	In Progress	This work is being deferred until after the completion of the security plan work required by 10/31	04/01/2015	12/31/2015	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 4. Review Partner security risk assessments (Milestone 1, task 2.1.4)	On Hold	Task not yet started	10/01/2015	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 5. Identify partner gaps, establish gap resolution target dates, monitor resolution actions	On Hold	Task not yet started	10/01/2015	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 6. Establish partner requirements for reporting of security incidents to PPS	On Hold	Task not yet started	10/01/2015	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 7. Establish procedures for ongoing monitoring of PPS security practices and incidents	Completed	Task not yet started	10/01/2015	03/31/2016	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 8. Establish procedures for oversight of partner security and confidentiality practices, partner security incidents, etc.	On Hold	Task not yet started	10/01/2015	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 9. Establish process for annual review of PPS and partner security risk assessments	Completed	Task not yet started	10/01/2015	03/31/2016	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 10. Develop protocols for identification and security of all protected data while at rest and while in transit including during data collection, data exchange and data use	Completed	Task in progress via the completion of security plans.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 11. Develop procedures for secure disposal of protected data	Completed	Not started	10/01/2015	03/31/2016	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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).	amyvk	Meeting Materials	22_MDL0503_1_3_20160111095803_Meeting_Schedule_Template_ITDAC_DY1Q3.xlsx	ITDAC Meeting Schedule DY1 Q3	01/11/2016 09:58 AM
Develop a data security and confidentiality plan.	amyvk	Other	22_MDL0503_1_3_20160311095831_Bassett_SSP_System_Description_Updated_Jan_2016.docx	Bassett Medical Center SSP - Updated System Description (Password Encrypted)	03/11/2016 09:58 AM
	amyvk	Other	22_MDL0503_1_3_20160311095733_Bassett_SSP_(PE_Family).docx	Bassett Medical Center SSP - PE Family (Password Encrypted)	03/11/2016 09:57 AM
	amyvk	Other	22_MDL0503_1_3_20160311095518_Bassett_SSP_(IR_Family).docx	Bassett Medical Center SSP - IR Family	03/11/2016 09:55 AM
	amyvk	Other	22_MDL0503_1_3_20160311095418_Bassett_SSP_(AU_Family).docx	Bassett Medical Center SSP - AU Family (Password Encrypted)	03/11/2016 09:54 AM
	amyvk	Other	22_MDL0503_1_3_20160311095332_Bassett_SSP_(AT_Family).docx	Bassett Medical Center SSP - AT Family (Password Encryped)	03/11/2016 09:53 AM
	amyvk	Other	22_MDL0503_1_3_20160311095142_Bassett_SSP_(PS_Family).docx	Bassett Medical Center SSP - PS Family (Password Encrypted)	03/11/2016 09:51 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	Have pushed out the due date of this milestone based on initial assessment received through IT survey. IT Data Analytics Committee will be gathering additional information on partners' RHIO connectivity over the coming months. With regard to steps below, are marking task as completed to receive DEAA from partners - currently not sharing any Medicaid data with partners so some tasks originally required for data sharing are not necessary and are being marked as completed.
Develop an IT Change Management Strategy.	DY1Q3 Narrative - change management due date is being pushed out due to re-defined definition of data sharing plan. Although originally envisioned as the creation of a PPS-wide data warehouse, it has been recognized that this plan will now rely on RHIO connectivity. The coming months will focus on partner's RHIO connectivity and change management plan will be dependent upon the results of this work.
Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	
Develop a specific plan for engaging attributed members in	DY1Q3 - changing date to end of 2016 after results of partner survey indicate that many non-provider partners do not currently participate with RHIOs, so

NYS Confidentiality – High

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Qualifying Entities	significant work will need to be done to engage attributed members.
Develop a data security and confidentiality plan.	DY1Q3 Narrative - as definitions of data sharing workflow continue to evolve, it is clear that this plan will need continuing work. Initial data and security plan was submitted to state as part of DY1Q2 quarterly progress report. Full PPS plan will utilize information gathered during the preliminary plan development phase as well as ITDAC work in first quarter of 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

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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.

At this point in time, having not yet received confirmation of capital funding, it is not clear whether the PPS will have the capital and/or human resources to move forward with an integrated Software-as-a-Service platform across the network as discussed in original IT implementation plan. Current plans for clinical interoperability rely heavily on partner participation with a fully functioning HIE system, facilitated by IT subject matter experts within the PPS. If capital is approved and if IT human resources are identified, that that point in time the PPS could consider the development of a more integrated partner information technology infrastructure.

The availability of IT human resources is a potential risk with being able to achieve a variety of IT deliverables – specifically work items that involved modifications to current EMR programming as well as the development of clinical outcome dashboards.

IPQR Module 5.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

The PMO (Project Management Office)--DSRIP Operations Team, will depend on IT to set up and provide base-level support for products such as SharePoint for collaboration and Project Server to track large projects as well as custom reporting on progress, budgets, external dependencies, etc.

LCHP will ensure care quality and coordination using federally- and state-compliant data-sharing plans. To ensure that LCHP's PPS partners act in unison to safeguard data privacy and security, and to uphold all regulatory requirements including HIPAA privacy provisions, the LCHP has established the Information Technology and Data Analytics Committee (ITDAC). The ITDAC will finalize a data sharing plan to describe consent and change management approaches; incorporate federally- and state-compliant usage agreements; develop diverse data-sharing methods to ensure interconnectivity while guarding data security; outline processes for monitoring compliance with pertinent regulations and channels for implementing corrective action when necessary; and implement a consistent and universal data privacy and security training program.

To ensure privacy and security, all LCHP partners will uniformly use Business Associate and Data Use Agreements, which the ITDAC will finalize and oversee. LCHP will conduct an IT security audit to evaluation and mitigate risks. As LCHP will bring together diverse organizations and a diverse workforce, training will be necessary to ensure data privacy, security and universal adherence to HIPAA privacy provisions across LCHP.

LCHP will leverage diverse resources to ensure interconnectivity, enabling real-time sharing of relevant information to support efficient and effective patient care while meeting all security and privacy standards. Since it is unlikely that any single method of data-sharing will suffice for the diverse needs of LCHP, multiple methods will be used to coordinate patient care across the LCHP network and to ensure HIPAA privacy.

LCHP will explore a number of strategies including health information exchanges (HIEs) and HIE interconnections (leveraging the regional SHIN-NY/RHIO); direct messaging using Meaningful Use (MU)-compliant electronic health records (EHRs) and health standards profiles to share

data with partners who do not have EMR/fax capability; a service bureau to provide EMR access to providers currently using paper records or non-MU certified products that preclude data sharing; data warehousing; an enterprise master patient indexing system to share patient identifiers and records across disparate systems; and population health software to track medical and social needs. We will also accommodate state/federal regulations regarding which data can be shared and with whom (e.g., behavioral health data sharing with PCPs).

The PPS has purchased "Performance Logic" as a DSRIP specific project management tool. At this point in time, it is envisioned that Performance Logic will serve as a portal through which partners can provide required updates such as progress on work plans, measures, and actively engaged patients. Training on this tool is underway. As per information outlined in the previous "Risk" section, any plans to move forward with any other consolidated IT platforms across the network are completely dependent upon capital and human resource availability.

Additional dependencies may include: - Finance, - Workforce, - Operational/Clinical stakeholder input. AHEC will work with IT and Performance Reporting workstreams to identify and develop a data collection process for workforce.

The IT function along with Governance, Change Control and the ITDAC is integral to support most of the related initiatives.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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
Telecommunications manager	Telecommunications manager (Bassett Medical Center--Lead agency for LCHP--Leatherstocking Collaborative Health Partners)	Review data line contracts and order new service as necessary
Privacy Officer	Rob LaPolt, Privacy Officer (Bassett Medical Center--Lead Agency for LCHP)	Manage security/confidentiality program
Chief Medical Information Officer (CMIO)	Scott Cohen, MD, CMIO (Bassett Medical Center--Lead Agency for LCHP)	Oversight of IT and Data Analytics Committee activities; facilitate developing a plan for clinical interoperability
Network support/administration staff	Network Technology Division (Bassett Medical Center--Lead agency for LCHP)	Develop and execute data transfer testing plan
Systems analyst	Systems analyst (Bassett Medical Center--Lead agency for LCHP)	Create IT remediation plan based on test and inventory results
IT steering committee	ITDAC Members: Scott Cohen, Co-Chair Jack Sienkowicz, Co-Chair Amy Van Kampen Edward Marryott Brian Miller Scott Groom Frank Tilke Robert Lapolt Michelle Sowich-Shanley Steve Klem	Develop change management process and achieve buy-in
Operations manager(s)	Operations manager(s) (Bassett Medical Center--Lead agency for LCHP)	Make indicated changes in existing policies and procedures to support new change management process
Network and database staff	Network Technology Division (Bassett Medical Center--Lead agency for LCHP)	Plan analysis and interoperability
Sub-committee of ITDAC plus other key stakeholders	ITDAC Subcommittee (Members not yet known)	HIE search and selection
PMO resources	PMO Resources to be assigned at time of project (Bassett Medical Center--Lead Agency for LCHP)	Manage HIE implementation and rollout
Technical staff	IT Technical staff (Bassett Medical Center--Lead agency for LCHP)	Execute HIE implementation and rollout
Administrative support	Amy Van Kampen, Director Performance Metrics DSRIP (Bassett Medical Center--Lead Agency for LCHP)	Create and tabulate survey Poll partners for current security capabilities

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Application development staff	Clinical Applications Group (Bassett Medical Center--Lead Agency for LCHP)	Create mobile signup application
Search and selection personnel	IT management (Bassett Medical Center--Lead Agency for LCHP)	Identify, obtain, and implement kiosk software for signups
Content-area experts	Clinical Subject Matter Experts within PPS	Create appropriate training modules in LMS for navigators
Security/confidentiality committee	ITDAC has determined that currently this work will be accomplished by full committee membership - no subcommittee formed to date.	Oversee security program
Network and security staff	Rob LaPolt - Privacy Officer (Bassett Medical Center--Lead Agency for LCHP)	Implement security/confidentiality plan
External agency	Not yet known	Audit security/confidentiality plan compliance and perform penetration testing, etc.
Fixed asset staff from finance	Accounting Departments of Partners	Supply hardware inventory list

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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		
PPS Project Teams	PPS Project Teams	Rely on IT work to accomplish project requirements
PPS Performance Reporting Committee	PPS Performance Reporting Committee	Rely on IT work to accomplish project requirements
Key roles within partners to be involved from a Governance and Operational perspective include: - CEO - CIO - CFO - CMIO - CNO - Data, infrastructure and security leads - RHIO contacts, etc	CEO, CIO, CFO, CMIO, etc.	IT Governance, change management, IT and data architechture, data security, confidentiality plan data exchange plans, risk management and progress reporting
External Stakeholders		
NYS DOH	Administration of DSRIP Program	Administration of DSRIP Program
RHIO/HIE Providers, NYS	RHIO/HIE Providers, NYS	Will be impacted by IT Connectivity Execution
NYS-OMH	Subject Matter Expert (SME) with regard to mental health regulations	Guidance to PPS with regard to regulatory oversight of mental health regulations
NYS-OASAS	Subject Matter Expert (SME) with regard alcohol and substance abuse regulations	Guidance to PPS with regard to regulatory oversight and HIPAA Compliance for alcohol and substance abuse
Medicaid Beneficiaries	TBD	Participate and provide feedback

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

IPQR Module 5.7 - Progress Reporting

Instructions :

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

Every initiative—whether a selected project or an Organizational workstream—will be managed by the DSRIP Operations Team using a sophisticated project management tool (e.g., Microsoft Project). Each sub-project will be structured to reflect Milestones and committed due dates for that project, for each Partner (in the case of the 11 Projects) or each "committee" (in the case of Organizational initiatives such as Financial Sustainability). The % Complete for each will be captured from the project management system data as part of regular progress reporting and rolled up into the DOH-specified progress reporting mechanism, using the performance reporting infrastructure and defined/standardized processes.

Progress reporting may include:
- Tracking of IT Strategic Plan including workforce alignment and training, IT change strategy and IT budget
- Documentation of process and workflow demonstrating implementation of electronic health records across all partners
- Meaningful Use (MU) and PCMH level-3 tracking
- Documentation of patient engagement/communication system
- Evidence of use of telemedicine or other remote monitoring services
- Evidence of implementation of specific clinical workflows

IPQR Module 5.8 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Section 06 – Performance Reporting

IPQR Module 6.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Establish reporting structure for PPS-wide performance reporting and communication.	In Progress	Performance reporting and communications strategy, signed off by PPS Board. This should include: -- The identification of individuals responsible for clinical and financial outcomes of specific patient pathways; -- Your plans for the creation and use of clinical quality & performance dashboards -- Your approach to Rapid Cycle Evaluation	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task 1. Create a consolidated list of reporting (performance, progress and actively engaged patients) requirements, both those related to individual projects and overall	Completed	Have identified reporting requirements.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Analyze data requirements for all reporting (performance, progress and actively engaged patients) requirements	In Progress	Data requirements for reporting being analyzed by ITDAC committee.	04/01/2015	12/31/2015	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 3. Identify the sources of the required data for each partner	In Progress	Task in progress	04/01/2015	12/31/2015	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 3.1- Seek to leverage existing reporting requirements such as MU and PQRS	In Progress	Task in progress	04/01/2015	12/31/2015	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 3.2-Define data validation and data cleansing for imported data from PPS and State sources	In Progress	Task in progress	04/01/2015	12/31/2015	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 3.3-Evaluate NYS Medicaid Analytics	In Progress	Task in progress. MAPP not fully developed yet so not clear what capabilities it will ultimately possess with regard to	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

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Performance Portal (MAPP) and how we could use the data that it has.Examine ways to tie in with visual dashboards and easy report writer		performance reporting.							
Task 4. Develop gap analysis for missing data, and develop plan for resolving each gap	In Progress	Task in progress	07/01/2015	03/31/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 5. Develop technical approach to acquiring, in an automated and secure manner, required data from each partner	Completed	Task in progress	07/01/2015	03/31/2016	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6. Develop interim approach to acquiring required data from each partner	Completed	Task in progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 7. Design a central data repository (data warehouse) for PPS to store and organize the source data for reporting (performance, progress and actively engaged patients)	In Progress	Going live with "Performance Logic" to manage some aspects of performance reporting. Also have developed database to collect and report on actively engaged measures that are currently manually reported by partners.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 8. Develop reports from the data warehouse	In Progress	Task in progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 8.1-Consider the different and varied audiences for reporting (performance, progress and actively engaged patients)	Completed	Task in progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 8.2-Define Measures/Metrics/Baseline Reports	In Progress	Task in progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 8.3-Identify and develop interim data sources and reports to meet the specific needs and objectives of the DSRIP effort	In Progress	Task in progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 8.4-Develop data specifications	In Progress	Task in progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 8.5-Design/build database	In Progress	Task in progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task 8.6-Populate/Data – Develop ETLs (Extract Transform and Load); get partner data	Not Started	Task not yet started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task	Not Started	Task not yet started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
8.7-Generate/validate reports									
Task 9. Establish accountability for provision of all clinical and financial data from each unique source, as approved by EGB	Not Started	Task not yet started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 10. Develop self-service and ad hoc reporting tools for providers to enable RCE of treatment protocols for efficacy of results	On Hold	Task not yet started	10/01/2015	06/30/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 11.Identify primary focus areas for care integration (e.g., diabetes management, preventable readmissions) and begin tracking to develop baseline data	In Progress	Task in progress - discussed in Clinical Performance committee.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 12. Utilizing preliminary data, explore ways in which improved outcomes based on project implementation might inform transition to Value Based Payment	Not Started	Task not yet started	04/01/2016	09/30/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 13. Set financial targets for lowering total cost of patients with comorbid conditions through integrated care delivery	In Progress	Task not yet started	07/01/2015	06/30/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 14. Standardize workflows and communications SOP across the PPS for more predictable outcomes	In Progress	Task not yet started	07/01/2015	06/30/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3	
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.	07/01/2015	09/30/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task 1. Identify training requirements on a role-by-role basis for PPS partner staff members	In Progress	In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 1.1-Identify leaders within LCHP to champion, prioritize and influence training on use of performance data	In Progress	In progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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 2. Develop training curricula to address the needs for the majority of existing employees and new hires	In Progress	Task not yet started	10/01/2015	06/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task 3. Identify employees to train on MAPP Tool and other reporting tools used by PPS	In Progress	Task in progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 4. Use WebEx for training, support and engaging attributed members. Explore integration with Learning Management System (LMS)	In Progress	Task in progress	07/01/2015	03/31/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 5. Develop training competency evaluation tools	In Progress	Task not yet started	10/01/2015	03/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 6. Identify metrics to monitor the effectiveness over time of the training program	In Progress	Task not yet started	10/01/2015	03/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 7. Deliver training on use of performance data	In Progress	Task not yet started	10/01/2015	03/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 8. Evaluate training competency	Not Started	Task not yet started	01/01/2016	06/30/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 9. Monitor training effectiveness data	Not Started	Task not yet started	01/01/2016	09/30/2016	10/01/2016	12/31/2016	12/31/2016	DY2 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

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish reporting structure for PPS-wide performance reporting and communication.	Although originally it was thought that the ITDAC would have primary responsibility for performance reporting, as DSRIP progresses it has been recognized that the Clinical Performance team will in fact be heavily involved in this workstream. The chair of this organizational team has begun the process of working with key stakeholders to analyze data requirements for key performance indicator reporting and data analysis. The current milestone projected completion date remains 12/31/2016 but several tasks underneath this milestone are being pushed out further into 2016 in order to give this committee more time to complete this work. With regard to a central data repository, it has been decided that clinical data sharing will largely be completed via RHIO"s and SHIN-NY and will not rely on the building of any clinical data warehouse. However, the PPS has implemented the Performance Logic tool as a project management software for the PPS, and is in the process of analyzing what reports can be generated from this tool. Additionally, the PPS is awaiting the release of clinical dashboards in January of 2016 to have a better understand of what outcomes reporting capability will be centrally provided by NYS. This will inform the timeline and ability to complete the other tasks within this milestone as well as the content for any training in performance reporting.
Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	DY1Q3 Narrative: Clinical Performance team is beginning to take ownership of the use of performance data, and discussions have begun on how to start educating appropriate PPS members and individuals on the use of this data. This work will have better clarity once clinical dashboards area avilable from the state in that education will be able to be provided utilizing actual data.

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

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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.

Definition of metrics will first require agreement among Partners on how each metric is to be defined for each project, then a current state analysis of existing metrics/data elements and definition of gaps to realize metrics capture. There is a dependency on vendors' ability to enhance their systems timely, so manually providing metrics will be necessary in the meantime.

Unfamiliarity and complexity of data definitions from different data sources. Mitigation: Data Governance to define common terms and assure that data is mapped consistently.

Risk of varying utility of different data sets from a complex network of partners/providers. Mitigation: Data Governance to define common terms and assure that data is validated and mapped consistently.

Risk of cultural and communication variety among data source providers. Mitigation: Data Governance to assure that common data elements are mapped consistently and defined appropriately.

DY1 Second quarter - risks remain the same.

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.)

There is a dependency on IT Systems and Processes to design and construct a reporting database, and to identify/implement a Learning Management System for training on metrics. These dependencies impact implementation timing, so collaborative/interdependent workplans will be developed to manage the effort.

This initiative will rely heavily on the ability to collect data from a variety of disparate sources, normalize it, report off of it. This will be dependent on the network choosing a single reporting platform and using data governance principles to ensure consistency. Will also need to include data definitions, data ownership, metrics and related calculations. The latter will need to reflect metric data elements that are agreed-upon by PPS partners, and accommodated in each partner's respective vendor system. These data elements either already exist, or will need to be added, per a current state/gap analysis.

Performance reporting is dependent on Governance, IT Systems, Workforce, Practitioner Engagement and Finance/Budget to succeed. Effective

governance will be required to ensure the consistent reporting of metrics by partners. IT Systems development will be a critical milestone of the ability of partners to report in an efficient and effective manner. Practitioners will need to be enganged in the project work and appropriately utilize prescribed methods of clinical data capture to ensure ability of partners to successfully report on meeting requirements. Finally, Finance and Budget will have a substantial impact on funds flow model which will, in turn, affect partner's ability to obtain required reporting systems.

AHEC will work with IT and Performance Reporting workstreams to identify and develop a data collection process for workforce. AHEC will also support development of training curriculum and competency for performance reporting.

DY1 Second quarter - dependencies remain the same.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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
Network and database staff	Network and database staff (Bassett Medical Center--Lead agency for LCHP--Leatherstocking Collaborative Health Partners)	Data Analysis and planning; Analyze quality indicator and performance metrics
DSRIP Operations Team resources (Bassett Medical Center--Lead Agency for LCHP (Leatherstocking Collaborative Health Partners)	Amy VanKampen, Director of Performance Metrics, DSRIP (Bassett Medical Center--Lead agency for LCHP)	Oversight of project activities and of reporting process; Manage LMS (Learning Management System) implementation, course development and rollout; Develop and monitor LMS compliance by each Partner organization
Chief Medical Information Officer (CMIO)	Scott Cohen, MD (Bassett Medical Center--Lead Agency for LCHP)	Oversight of IT and Data Analytics Committee activities; facilitate developing a plan for clinical interoperability
Director, DSRIP Finance Operations	Michael Sweet (Bassett Medical Center--Lead Agency for LCHP)	Leading finance committee and VBP task force through transition and direct oversight of financial sustainability plan

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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		
Privacy Officer	Privacy Officer (in charge of IT security) - Rob Lapolt	Manage security/confidentiality program; Gatekeeper of PPS
PPS Project Teams	PPS Project Teams	Submit necessary documentation for performance reporting, working collaboratively with IT
PPS Clinical Performance Committee	PPS Performance Reporting	Identify performance reporting strategy for PPS in relationship to project requirements and organizational initiatives
Key roles within partners to be involved from a Governance and Operational perspective include: - CEO - CIO - CFO - CMIO - CNO - Data, infrastructure and security leads - RHIO contacts, etc	- CEO - CIO - CFO - CMIO - CNO - Data, infrastructure and security leads - RHIO contacts, etc	IT Governance, change management, IT and data architechture, data security, confidentiality plan data exchange plans, risk management and progress reporting
Partners	Data providers	Required reports consistent with metric definitions and data sources
Executive Governance Body of PPS	Oversight of VBP plan and compliance planning	Responsible for review of reporting and oversight of compliance and finance committee with regard to transition to VBP
External Stakeholders		
NYS DOH	Administration of DSRIP Program	Administration of DSRIP Program
Medicaid Beneficiaries (patients)	Service recipient	Participate and provide feedback
Managed Care Organizations (MCO)	Partner	Review of quality measures/metric reporting
Sub-committee of ITDAC plus other key stakeholders	ITDAC Subcommittees (currently include full ITDAC membership)	Data gathering
Technical staff	Business Intelligence Department - (Bassett Medical Center--Lead agency for LCHP)	Develop reporting tools
DSRIP Committee Chairs	DSRIP Committee Chairs - all projects	Champion adoption and design of dashboards and score cards

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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.

LCHP will access metrics contained in the Medicaid Data Warehouse. Web-based performance dashboards will provide baseline performance data and data by region. LCHP will collect and incorporate into its monthly performance monitoring qualitative feedback obtained from consumers and the community through the LCHP website, the Consumer Subcommittee, the compliance hotline, town hall meetings, letters and phone calls. We will work with IT to define and develop clear expectation and rules for appropriate dissemination and collection of reporting data (performance, progress, actively engaged patients).

IPQR Module 6.8 - Progress Reporting

Instructions :

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

Every initiative—whether a selected project or an Organizational workstream—will be managed by the DSRIP Operations Team using Performance Logic - a project management software tool specifically designed for the DSRIP project. Each sub-project will be structured to reflect Milestones and committed due dates for that project, for each Partner (in the case of the 11 Projects) or each "committee" (in the case of Organizational initiatives such as Financial Sustainability). The % Complete for each will be captured from the project management system data as part of regular progress reporting and rolled up into the DOH-specified progress reporting mechanism, using the performance reporting infrastructure and defined/standardized processes.

Progress reporting of the Performance Reporting workstream will involve establishment of timelines and milestones and reporting against them.

IPQR Module 6.9 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Section 07 – Practitioner Engagement

IPQR Module 7.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop Practitioners communication and engagement plan.	In Progress	Practitioner communication and engagement plan. This should include: -- Your plans for creating PPS-wide professional groups / communities and their role in the PPS structure -- The development of standard performance reports to professional groups --The identification of profession / peer-group representatives for relevant governing bodies, including (but not limited to) Clinical Quality Committee	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task 1. Share DSRIP introduction presentation with stakeholders throughout PPS	Completed	Task completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 2. Identify physician/provider stakeholders in PPS to engage in Clinical Quality Committee (a.k.a. Clinical Performance Committee)	Completed	Complete; Physician stakeholders are active participants on the clinical performance committee and tasks were identified to begin working on clinical quality initiatives.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 3. Ensure appropriate practitioner/clinician involvement in committees including, but not limited to, Clinical Performance Committee (e.g., Governance, Compliance, PAC, Workforce, ITDAC)	In Progress	Task in Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 4. In development of internal and external communication plans, dedicate a portion of plan to physician/clinical engagement	Completed	Task in Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task	Completed	Task in Progress	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

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
5. Identify dyad structures - (practitioners/administrators) leading this work									
Task 6. Share implementation progress and outcomes routinely with practitioners regarding project requirements and associated metrics via the Clinical Performance Committee; the goal is to encourage engagement and adoption of proven practices among PPS providers.	In Progress	Task in Progress	04/01/2015	12/31/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 7. Leverage existing Primary Care Council, Regional Medical Director group and Clinical Leadership Group as models for clinical integration and practitioner engagement in creating PPS-wide professional groups	Completed	Task in Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	In Progress	Practitioner training / education plan.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task 1. Develop training/education materials to engage physicians, clinicians and practitioners in evidence-based practices designed to reduce avoidable admissions & emergency room service usage	In Progress	In process, specifically with use of INTERACT principles to reduce avoidable admissions.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 2. Assign RNs and additional staff dedicated to engaging practitioners in protocol development, quality measures by working with PPS partners and the protocol development group	Not Started	Not started	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 3. Share Clinical Performance work plan and other work plans as appropriate to this work	Not Started	Not started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 4. Clinical Performance Committee will work with project teams to catalog, standardize, implement	Not Started	Not started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	

Bassett Medical Center (PPS ID:22)

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 monitor clinical protocols									
Task 5. Establish a communication plan to educate practitioners in project principles (e.g., INTERACT) in support of reducing avoidable hospital usage	In Progress	The INTERACT team has conducted several trainings already in efforts to educate providers.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task 6. Share meeting minutes/metrics/best practices with partners and participating practitioners throughout the PPS	Completed	Not started	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 7. Develop a presentation to educate practitioners regarding the funds flow model with particular reference to metrics and milestones on incentive and bonus payments	Completed	Presentation in place to explain funds flow; currently tailoring to a physicians audience.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 8. Working through project chairs, provide education and orientation programs for all practitioners regarding the specific requirements for milestone and metric achievement	Completed	The INTERACT team has conducted several trainings already in efforts to educate providers.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 9. Incorporate monitoring mechanisms to identify gaps between actual and expected outcomes metrics	Not Started	Not started	10/01/2015	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task 10. Where gaps exist, prepare plans for course correction and monitoring of progress against outcomes metrics	Not Started	Not started	10/01/2015	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 11. Working with lead agency's Corporate Communications team and PPS marketing staff, develop communications and an approach to provider/clinician engagement to further develop evidence-based practices and build provider buy-in	In Progress	Task in Progress	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

Bassett Medical Center (PPS ID:22)

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop Practitioners communication and engagement plan.	DY1Q3 Narrative: Stakeholders have been engaged through several forums and presented with the DSRIP introduction presentation. Additionally, physician stakeholders have been identified to participate in multiple committees, which can be referenced in our membership rosters. Communication plans are in development to ensure all key stakeholders are appropriately engaged. Dyad partnerships are currently being identified within respective projects. Ongoing presentations are being held in in numerous forums to inform physicians and other key stakeholders of our progress as a PPS. Utilizing the Bassett Medical Center newsletter that is sent to providers, updates regarding DSRIP progress and outcomes will be shared on an ongoing basis. This template and content will be shared with partners as well and the newletters will be posted on the LCHP website. This will begin in DY1 Q4. The primary care council, regional medical director group, and clinical leadership group were used as models to establish PPS wide professional groups such as the practitioner engagement subcommittee and its governing Clinical Performance Committee. The model groups were consulted numerous times when they were presented with DSRIP information regarding projects.
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.	DY1Q3 Narrative: Education materials have been identified and deployed for those providers learning to use INTERACT principles to decrease avoidable transfers. Currently updating communication plans to reflect this work and to ensure the appropriate stakeholders are engaged. Additionally, palliative care training materials have been procured and will be deployed shortly to existing provider staff in the primary care setting. Funds flow presentations have been created for a non-provider audience, and it is currently being retailored for a provider audience. Providers have been educated in numerous forums, including department and management meetings, to explain the metrics that need to be accomplished in specific projects. Communication plans continue to be updated to reflect plans to further provider buy-in. PPS wide in-services to train providers on best practices were completed. Specific examples include asthma grand rounds and palliative care training. Presentation created and tailored to provider group. It was developed by Swathi Gurjala and Amy VanKampen In addition to best practices being shared at in-services and trainings for palliative care and asthma, noting the significance to completing this work for achievement of DSRIP requirements was also communicated to providers by the chairs of the project committees. Provider groups are regularly updated with

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	these requirements when presentations are done at the clinical performance committee, primary care council, regional medical director group, and clinical leadership group. Additionally, town halls have been held to educate all interested parties about DSRIP, with a specific emphasis on behavioral health.

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

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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.

Key stakeholder engagement & buy in; to mitigate this risk, the PMO office will continue to engage practitioners in implementation planning, outcomes, metrics and other deliverables.

Rural nature of LCHP PPS limits ability for in-person training/education; can utilize alternative delivery options such as WebEx and other remote technologies. Need to ensure a communication plan that is effectively tailored to reach key stakeholders (i.e., in person, e-mail, webex, etc.) that incorporate geographic limitations within the plan.

Culture shift with the conversion to protocols; to mitigate this risk, we'll ensure key practitioner engagement in evidence-based practices from the onset to build consensus. The rural nature of the PPS can influence the practitioner's sense of engagement in the project and management of outcomes. This can be mitigated through direct outreach to practioner groups by LCHP and project leadership, peer sharing of best practices through printed and online newsletters. The funds flow model is being designed to recognize direct practitioner engagement.

Competing priorities continue to be an issue; to more effectively manage these concerns, we will seek to streamline communication in the most effective manner possible.

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.)

Practitioner engagement will be closely intertwined with many other workstreams. These include Clinical Integration, Population Health Management (working to improve the health of the population through culture change and a shift in thinking from fee-for-service to value-based reimbursement), Financial Sustainability (change in workflows= near term reduction in productivity; time away from clinic for requisite training=lower volumes/less money; shift to value-based reimbursement from fee-for service model); Cultural Competency and Health Literacy (practitioner engagement required to cultivate a transformation in the approach to healthcare delivery).

While not major dependencies, under IT Systems & Processes we state an intent to acquire an automated survey instrument and a Learning Management system. Both of these will allow aspects of the Provider Engagement Strategy to be executed more quickly and efficienctly. The need to incorporate monitoring mechanisms is dependent upon development of the Performance Reporting tools and technologies.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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
Chairs of Clinical Performance Committee	Steven Heneghan MD, Chief Medical Officer - Bassett Medical Center (Lead Agency for LCHP (Leatherstocking Collaborative Health Partners) and Partners)	Track Performance Metrics, Report to EGB (Executive Governance Body)
Chief Medical Information Officer	Scott Cohen MD, - Bassett Medical Center (Lead Agency for LCHP (Leatherstocking Collaborative Health Partners) and Partners	Chair of Practitioner Engagement Subcommittee of clinical performance committee
Hospitalist - Community Memorial	Robert DeLorme, MD, Community Memorial Hosp (Partner organization)	Prospective co-chair of Clinical Performance Committee
Chairs of Project Committees	Bassett Medical Center (Lead Agency for LCHP)	Training, Education, Practitioner Engagement
DSRIP Operations Manager	Bassett Medical Center (Lead Agency for LCHP)	Coordinate and facilitate Clinical Performance Committee activities
Senior Director of Care Coordination	Bassett Medical Center (Lead Agency for LCHP)	Coordinate and facilitate Clinical Coordination activities
Director of PPS Partner and Patient Engagement	Bassett Medical Center (Lead Agency for LCHP)	Communication, Practitioner Engagement
Executive Governance Body (EGB)	Bassett Medical Center (Lead Agency for LCHP)	Oversight of Practitioner Engagement
DSRIP Clinical Director	James Anderson, PhD, Bassett Medical Center (Lead Agency for LCHP)	Engage practitioners including Behavioral Health, Primary Care, etc along with appropriate LGUs

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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		
Members of PPS Medical Staff	Healthcare practitioners	Achieve Metrics and Milestones in relation to projects they are involved in; engage in standardized protocol development across PPS
Jennie Gliha, VP HR, AO Fox, Zoe Aponte, Catskill Area Hospice, Susan Cipolla, HR Director, Catholic Charities, Richard Diodati, HR Director, Sitrin, Pam Levy, Director, Catskill Center for Independence, George Seuss, CEO ARC of Delaware County, Megan Staring, Asst. Director, Catskill Center for Independence, Cynthia Sternard, HR Community Memorial Hospital"	Workforce Committee	A group of cross-functional resources (e.g., WF PM, HR, DSRIP lead, Union representative) responsible for overall direction, guidance and decisions related to the workforce transformation agenda
IT and Data Analytics Committee	Provision of data and information to enable practitioners to complete their goals and objectives	Develop change management process and achieve buy-in; Availability of information in a timely way and in the desired format.
Community Based Organizations	Training, navigation, developing resources available across PPS; providing support services in hard to reach populations and geographic areas	Develop and conduct training programs to educate on protocols and other provider-related care delivery methods
External Stakeholders		
AHEC	Workforce consultant	Utilize proven methods of training for curriculum development/distance learning
NYS DOH	Statement of principles of DSRIP Program	Monitor DSRIP requirements
Medicaid Beneficiaries	Consumers of care	Membership on PAC, participate in focus groups and feedback on patient satisfaction

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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.

The shared IT infrastructure is a necessary ingredient for practitioner engagement. Practititioners will need access to clincial and operational information to conduct their work. This will facilitate the implementation of agreed-upon clinical protocols, the mining of the clinical database to identify desired groups of patients, and the implementation of tactics and strategies to support population health management and attention to particular patient care requirements. Clinical information will be accessed via existing EMR systems and their associated data sharing capability (e.g., Epic CareLink). State-based information exchanges such as HIX-NY and SHIN-NY will be critical for practitioners to share information and be fully engaged in the care transformation process.

IPQR Module 7.8 - Progress Reporting

Instructions :

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

By enhancing proven methods of practitioner engagement (functional committees, meetings, individual meetings) and developing the Clinical Performance Committee, the PPS will measure the level of practitioner participation in this initiative. It is expected that in areas such as protocol development, interface with organizational committees (e.g., ITDAC, Workforce, EGB) and feedback with respect to performance improvement opportunities there will be ample opportunity to measure and report on practitioner engagement.

IPQR Module 7.9 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task 1. Establish and charter a Population Health Management Project Team	In Progress	Task in process.	04/01/2015	10/31/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2. Assess the level of awareness and practice of total population health management principles throughout the PPS	Not Started	Not started	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 3. Conduct a current state assessment of staff across the PPS and member organizations, in order to assess skill sets of staff to determine gaps in meeting population health management measures	In Progress	Task in process. An initial partner survey is under development.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 4. Population Health Management Project Team will prepare a comprehensive roadmap to improve population health for sign off by Executive Governance Body	Not Started	Not started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task	Not Started	Not started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
5.Conduct a PPS-wide CNA assessment to supplement the data available through the MAPP tool to define priority target populations.									
Task 6. Utilizing CNA data and collaborating with PHIP grant awardees, determine additional health needs and target populations	Not Started	Not started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 7. Define availability of data and determine steps required to access data (registries, health plan information, MAPP, Medicaid Health Home); Define IT resources ~ personnel and non-personnel ~ required and procurable to access and amalgamate data for use in this work	Not Started	Not started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 8. Within the limits of capacity for provision of data, create a dashboard of measures indicative of total population health methods as well as identifying mechanisms for reporting on the level of achievement of those measures	Not Started	Not started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task 9. Identify tactics to implement a cultural shift with respect to the delivery of services toward a total population health management approach	Not Started	Not started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 10. Develop care guidelines/protocols for providers on priority clinical issues; establish metrics for each clinical area to monitor progress in managing population health. Pursue this within the limits of partner capability - clinical information systems, etc.	Not Started	Not started	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 11. Continuously orchestrate the speed and shift of this process to meet the DSRIP milestone of 90% VBP for Medicaid enrollees by demonstration year 5, all the while referencing progress in negotiations with other third party payors toward the VBP model	Not Started	Not started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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 12. Determine clinical champions for PCMH 2014 PPS development, with the goal of geographical placement	In Progress	Task in process. One champion in PPS received training - supporting documentation will be provided in DY1 Q2 Quarterly report.	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 13. Through ongoing work of PCMH committee develop and execute a comprehensive plan to achieve PCMH 2014 level three certification throughout PPS	In Progress	Task in process. A consultant is in the process of being recruited to assist with PPS-wide implementation of PCMH.	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4	
Milestone #2 Finalize PPS-wide bed reduction plan.	In Progress	PPS Bed Reduction plan, signed off by PPS Board. This should set out your plan for bed reductions across your network, including behavioral health units/facilities, in line with planned reductions in avoidable admissions and the shift of activity from inpatient to outpatient settings.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task 1. Track avoidable hospital admissions occurring in PPS acute care facilities	Not Started	Not started	10/01/2015	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 2. Assess results for patterns, themes and clinical conditions and relate to the work of 11 project teams to determine/affirm actionable tactics for reduction	In Progress	Task in process	04/01/2015	12/31/2015	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 3. Reference health planning information and strategic data sets to identify projected population/bed ratios for areas served for specified clinical services.	Not Started	Not started	10/01/2015	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 4. Bassett (lead agency) will participate in the OMH Readmission Quality Collaborative which encourages the identification and sharing of best practices and lessons learned so hospitals may assist one another in enhancing outcomes and sustaining improvements with regard to behavioral health admissions	Completed	Task complete	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5. Track and analyze results relating to Readmission Quality Collaborative led by the	Completed	Not started	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
lead agency in an effort to reduce behavioral health-related avoidable admissions									
Task 6. Identify opportunities for reducing behavioral health-related avoidable admissions by evaluating care coordination at the point of discharge with primary care based on learnings from re-admissions quality collaborative.	Not Started	Not started	10/01/2015	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 7. Share best practices relating to Readmission Quality Collaborative with PPS members and develop a plan to expand successes to other areas of PPS hospital network	Not Started	Not started	10/01/2015	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 8. Working closely with Workforce Committee, analyze data from bed reduction activities as it relates to staffing reductions/redeployment and develop recommendations	Not Started	Not started	10/01/2015	12/31/2016	07/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 9. Develop bed-reduction plan for sign off by Executive Governance Body	Not Started	Not started	10/01/2015	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop population health management roadmap.	DY1Q3 Narrative: There has been a change in the executive leadership of Bassett Healthcare which is informing the development of a population health management plan. Conversations are occurring at the PPS executive level on appropriate membership of population health committee and whether existing membership roster should be modified. Based on these discussions, task 1 due date will be extended to 3/31/16.
Finalize PPS-wide bed reduction plan.	DY1Q3 Narrative: Clinical outcome dashboards will not be available until January 29, 2016 so PPS is unable to begin task of tracking avoidable admissions until that time. Based on modifications to population health committee, several tasks relating to bed reduction plan will not be started until mid-year in 2016.

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

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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.

Implementation of this plan may require significant infusion of capital to meet the information technology requirements. Should that be the case, every effort will be made to identify sources of capital with no guarantee that such will be available.

Accomplish a major culture shift in terms of the provision of health care services; to mitigate this risk, the PPS will engage a proven health care consultant and will utilize education and orientation programs for all personnel to understand and adopt important population health approaches. The widespread and rural geography of the PPS make it more difficult to actively engage all partners to the degree necessary to transform population health delivery methods. To mitigate this risk, outreach by LCHP leadership will be critical in achieving this culture shift. Socioeconomic factors within the PPS (e.g., financial means, obesity, educational status) increase the difficulty of directly affecting outcomes. To mitigate this risk we will collaborate with the PHIP, CBOs, social service agencies to educate providers (challenged by reduced provider availability within the PPS).

Health care leaders are disinclined to reduce beds in practice and/or on operating certificates; to mitigate this risk, the PPS will embrace formal expense management processes to ensure underutilized resources, such as inpatient beds, are reduced in scale. Of note, through the development and evolution of the Bassett Healthcare Network, a significant "right-sizing" of inpatient capacity was undertaken. This resulted in the reduction of a significant number of beds, as well as the closure of a hospital.

Achievement of 90% VBP by DY5; to mitigate this risk, the PPS will develop a formal EGB-approved plan outlining the specific actions and requirements to transition to this new model of reimbursement. Accountability will be established and every effort will be made to adhere to the tenets of the plan.There is significant risk in this with respect to a potential willingness of third-party payers to negotiate an equitable transformation to a value-based reimbursement model. Support from the DOH and other forces will be critical to a successful transformation.

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.)

In order to successfully achieve a workable level of clinical integration across such a large system, HIE (Health Information Exchange) capabilities are a requirement for each partner. This ties closely with other integration needs, and should be designed accordingly with connectivity infrastructure initiatives.

The Workforce Committee will be a key stakeholder in the success of this initiative, ensuring there are adequate staff trained to do this work.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Clinical Performance Committee will take a lead role in this initiative to ensure effective measurement and tracking of progress towards clinical integration.

Clinical leadership will ensure Practitioner Engagement as a necessary ingredient for buy-in to the enhanced model of care. With practitioner engagement, there will be a powerful and effective impact on other members of the PPS network in order to complete the culture shift necessary for successful adaptation.

Finance prioritization will be required to support the PPS in engaging in this work.

Implementation of the Population Health Management strategy is highly dependent upon the utilization of several IT programs and specialized personnel. The implementation of resources should be co-incident with the development and implementation of Population Health Management processes, procedures, workflows and workforce.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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
Executive Director, DSRIP	Susan van der Sommen, Bassett Medical Center (Lead Agency for LCHP--Leatherstocking Collaborative Health Partners)	Leading initiative; culture change
LCHP Operations Team	Bassett Medical Center (Lead Agency for LCHP)	Leading initiative; culture change
Director, PPS Partner & Patient Engagement	Kara Travis, Bassett Medical Center (Lead Agency for LCHP)	Education, organization, leadership of initiative
County Health Departments	PPS counties - Otsego, Schoharie, Delaware, Herkimer & Madison	Partner with PPS entities to actualize key components of the total population health management plan
Research Department	John May, MD Bassett Medical Center (Lead Agency for LCHP)	CNA development; population health management specialists
Executive Governance Body	Bassett Medical Center (Lead Agency for LCHP)	Oversight of implementation/metrics/ measurement

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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		
Clinical Performance Committee	PPS	Lead initiative; facilitate culture change
David Haswell, Martha Sunkenberg , Lisa Betrus , Christa Serafin, Laurie Neander , Carlton Rule, Ann Hutchison, Stephanie Lao, Deanna Charles, Ann Hutchison, Bonnie Post, Stephanie Lao, Deanna Charles, Celeste Johns, Marietta Taylor, Joseph Sellers, Mike Kettle , Chris Kjolhede, Philip Heavner, Jean Schifano, Connie Jastremski, Marion Mossman, Roy Korn, Norine Hodges	PPS Project Chairs	Incorporate principles of population health management in project activities
Community Based Organizations	Provide education to communities in general and medicaid beneficiaries in particular; providing support services in hard to reach populations and geographic areas	Engage community members/Medicaid recipients in population health management initiatives
Project Advisory Committee	Community Engagement and advisor to Executive Governance Body; Voice of Medicaid Recipients	Engage community members/Medicaid recipients in population health management initiatives
John May, MD - PHIP	Research	Collaborator on population health efforts
External Stakeholders		
Geisinger	Consultant	Lead initiative; facilitate culture change; model best practices
MCOs	Insurance	Assist in development of VBP model
NYS DOH	State-wide organization	Guidance and support in affecting the transformation
Medicaid Beneficiaries	Consumers of care	Membership on PAC, participate in focus groups and feedback on patient satisfcation

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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 shared IT infrastructure is a necessary ingredient for total population health management. Practitioners, PPS partners, organizational leaders and other key stakeholders will need access to clinical and operational information to conduct their work. This will facilitate implementing agreed-upon clinical protocols, dashboard metrics and milestones, mining of the clinical database to identify desired groups of patients, and implementation of tactics and strategies to support population health management and attention to prevention, screening, early detection, and timely intervention for disease processes.

This initiative underscores the need for a population health management analytic system, that includes predictive analytic for a variety of data markers. Such systems are commercially available.

IPQR Module 8.8 - Progress Reporting

Instructions :

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

A comprehensive set of dashboard measures will be identified and utilized in operational activities and project implementation. These measures will give testimony to the speed with which a culture of total population health management becomes embedded in the PPS structure. This information will be incorporated into the formal communication plan that governs information flow throughout the PPS. Further, through the availability of these continuous assessments, strategies will be adopted to ensure the assimilation of key principles in care delivery.

Reference will be made to numerous metrics which will assist in the evaluation of the success of the total population health management strategy. These measures will be identified through third-party payer relationships, reference to HEDIS, identifying and measuring successful outcomes based on patient stratification, metrics identified from public health agencies, Upstate Health and Wellness Survey, Smoking Cessation enrollment and successful outcomes, as well as reports received from the 11 project teams.The goal will be to track measures relating to the effectiveness of steps taken to improve the health of the population. Some examples of key population health metrics include # of patients who received tobacco cessation counseling; # of patients who are identified who are assigned to a PCP who keep their appointments; # of patients who go through SBIRT screening who are referred for treatment and keep the follow up appointment.

IPQR Module 8.9 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Section 09 – Clinical Integration

IPQR Module 9.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform a clinical integration 'needs assessment'.	In Progress	Clinical integration 'needs assessment' document, signed off by the Clinical Quality Committee, including: -- Mapping the providers in the network and their requirements for clinical integration (including clinical providers, care management and other providers impacting on social determinants of health) -- Identifying key data points for shared access and the key interfaces that will have an impact on clinical integration -- Identify other potential mechanisms to be used for driving clinical integration	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task 1. Survey providers in PPS network to determine areas for improvement regarding clinical integration; consideration given to ""natural"" relationships based on geography, under oversight of the Clinical Performance Committee. Reference Community Needs Assessment. Clinical Integration for the purpose of this effort is defined as coordination of care across a contiuum of services, settings and partners to optimize the care delivery system through interoperability, access, and patient and practitioner engagement. Clinical integration is needed to facilitate the coordination of patient care across conditions,	In Progress	Survey results received. Currently processing them to assess opportunities to improve clinical integration with PPS partners.	04/01/2015	12/31/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
providers, settings, and time in order to achieve care that is safe, timely, effective, efficient, equitable, and patient-centered.									
Task 2. Hold patient focus groups to determine their perceptions regarding the coordination of care among partners, under oversight of PAC	Not Started	Task not yet started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 3. Systemic review of high-volume referral processes - inpatient to home care, primary care to subspecialty care, nursing home to inpatient care, etc., under oversight of the Population Health/Care Coordination Committee of the Lead Agency	Not Started	Task not yet started	01/01/2016	03/31/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 4. Perform assessment of EHR capability for all partners in PPS network	In Progress	Task in progress - IT partner survey sent and preliminary results received.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 5. Identify key points where shared access does not exist	In Progress	List of target points for consideration of action in development.	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 6. Sign off of needs assessment by Clinical Performance Committee; review by EGB	In Progress	EGB Meeting minutes reflecting needs assessment approval	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 7. Perform Workforce Assessment- number and type of workforce personnel, geographical location, etc. ensuring integration with existing resources, , under oversight of the Workforce Committee	In Progress	List of strategies in development	04/01/2015	12/31/2015	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 8. Based on the above, develop clinical integration needs assessment to include data from Community Needs Assessment for Clinical Performance Committee review and sign off	Not Started	Roll up of all needs will be assessed once above tasks are achieved.	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
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	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

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		-- A 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							
Task 1. Create task force representing all care transition programs to improve patient and provider satisfaction and cost effectiveness	Not Started	Not started	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 2. Create a clinical integration strategy work plan including technology integration and change management as well as EHR capabilities. Key interfaces and shared access points to be addressed.	Not Started	Not started	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 3. Develop a comprehensive care coordination/transition plan as part of the clinical integration strategy work plan.	In Progress	Not started	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 4.Develop training program with partner input for providers across the continuum of care	Not Started	Not started	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 5. Establish education program for operations staff on the principles of care coordination and useful methods for such.	Not Started	Not started	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 6. Develop a plan to address workforce gaps as determined by Workforce Gap Analysis	In Progress	Task in progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 7. Implement the clinical integration strategy work plan and enhanced care coordination and and communication tactics and strategies	In Progress	Not started	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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'.	amyvk	Meeting Materials	22_MDL0903_1_3_20160119135132_Meeting_Schedule_Clinical_Performance_Meeting_DY1Q3.xlsx	Clinical Performance Meeting Schedule DY1Q3	01/19/2016 01:51 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform a clinical integration 'needs assessment'.	DY1Q3 Narrative: A survey of providers in the PPS still needs to occur. Initial surveys did not determine areas for improvement regarding clinical integration, but rather focused on types of services offered and other descriptive qualities unrelated to this task. The target date for completion will be moved from 12/31/15 to 3/31/16. Re: Workforce, recently, the DOH has amended the completion date for the compensation and benefits survey to 6/3016. Because this requirement is aligned with this workforce milestone/task, this clinical integration task shall be moved out to mirror the new timeline.
Develop a Clinical Integration strategy.	DY1Q3 Narrative: It has been determined that a number of tasks in this milestone will be accomplished by the Practitioner Engagement subgroup, which has only just formed. Based on its recent formation, several tasks in this section will not be started until first quarter of 2016.

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

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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.

Obtaining buy-in and support from clinicians and other key stakeholders, which in turn could impact DSRIP project success. To mitigate this risk, it will be important to engage key clinical staff, partners and other key stakeholders in the early stages of development. To the extent possible, a consensus approach will be taken in the implementation of these key tactics and strategies.

Funding of external consultant will be required. This will be included in the project management budget for consideration.

Funding for EHR interconnectivity is a barrier. Funding from CRFP has been requested. Awaiting determination from the State.

There are competing workloads and priorities. A culture shift will be required to ensure success in this project. To mitigate this risk, we'll engage an external consultant (as funding permits) and the Director of PPS Partner & Patient Engagement to assist in this work. Continuous communication with administrative and clinical leadership with respect to the required prioritization will be required for this initiative to proceed.

With respect to inadequate or unprepared workforce, we will collaborate with neighboring PPSs in our region to strive for equitable access for hard-to-recruit positions among PPSs, collborate among projects for effective use of resources, redeployment and retraining strategies as indicated in Workforce Strategy Section.

Clinical Integration for the purposeof this effort is defined as coordination of care across a contiuum of services, settings and partners to optimize the care delivery system through interoperability, access, and patient and practitioner engagement.

Clinical integration is needed to facilitate the coordination of patient care across conditions, providers, settings, and time in order to achieve care that is safe, timely, effective, efficient, equitable, and patient-centered.

IPQR Module 9.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

In order to successfully achieve a workable level of clinical integration across such a large system, HIE (Health Information Exchange) capabilities are a requirement for each partner. This ties closely with other integration needs, and should be designed accordingly with connectivity infrastructure initiatives.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Workforce Committee will be a key stakeholder in the success of this initiative, ensuring there are adequate staff trained to do this work. Clinical Performance Committee will take a lead role in this initiative to ensure effective measurement and tracking of progress towards clinical integration.

Clinical leadership will ensure practitioner engagement as a necessary ingredient for buy-in to the enhanced model of care. With practitioner engagement, there will be a powerful and effective impact on other members of the PPS network in order to complete the culture shift necessary for successful adaptation.

Finance prioritization will be required to support the PPS in engaging in this work.

Clinical Integration workplan will include a reference to the need to address cultural competency and health literacy for all patient referral processes utilizing navigation and care coordination across the care continuum. This will be done in a patient centered manner addressing the need for each individual patient.

An important enabler of Clinical Integration is EHR integration across the PPS. While the proposed HIE strategy will transport data from one system to another, for that data to be meaningful to the receiving clinician, individual partners will need to adopt a common/consistent clinical terminology and standardize their collection of clinical data. These decisions then need to be reflected in the design and setup of the individual partners' EHRs in order to improve the usefulness of data shared between and among partners.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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
Executive Director, DSRIP	Susan van der Sommen,Bassett Medical Center (Lead Agency for LCHP--Leatherstocking Collaborative Health Partners)	Lead initiative; facilitate culture change
Senior Director, Care Coordination	Donna Anderson, Bassett Medical Center (Lead Agency for LCHP)	Expertise in care coordination and transitions; culture change; leading initiative
LCHP Operations Team	Wendy Kiuber, Swathi Gurjala, Tom Manion, Amy Van Kampen, Mallory Mattson, Michael Sweet, James Anderson MD, Elizabeth Reed, Karen VandenBosch, Bassett Medical Center (Lead Agency for LCHP)	Lead initiative; facilitate culture change
Director, PPS Partner & Patient Engagement	Kara Travis, Bassett Medical Center (Lead Agency for LCHP)	Education, organization, lead initiative
Chief Clinical Officer	Steve Heneghan, MD, Bassett Medical Center (Lead Agency for LCHP)	Lead initiative; facilitate culture change
Chief Operating Officer	Actively recruiting, Bassett Medical Center (Lead Agency for LCHP)	Lead initiative; facilitate culture change
Executive Governance Body (EGB)	Co-Chairs-Carlton Rule, MD; Patricia Kennedy, Bassett Medical Center (Lead Agency for LCHP)	Oversight of Practitioner Engagement

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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		
Clinical Performance Committee	PPS	Lead initiative; facilitate culture change
All Partner types - Hospitals, Skilled Nursing Facilities, Home Care Entity, CBOs, etc.	Partners	Participation and collaboration of protocol development, use of best practices, etc.
Navigators and Care Coordinators	Link patients to healthcare services efficiently	Institutionalized care coordination and navigation
Training personnel	Ensure consistent training across providers	Deliver training programs to assure clinical competency per defined protocols
External Stakeholders		
Geisinger (IDS Consultant)	Consultant	Lead initiative; facilitate culture change; model best practices
Medicaid Beneficiaries and their families	Consumers of care	Membership on PAC, participate in focus groups and feedback on patient satisfcation

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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.

Clinical integration would not be possible without IT systems integration across the PPS, reflecting results of the assessments done within this workstream. LCHP members will need to share clinicial and non-clinical patient data and information in order to integrate care across the continuum of patient access. All partners will have access to information and reports based on their structures and roles in patient care.

Clinical information will be accessed via existing EMR systems and their associated data sharing capability (e.g., Epic CareLink). State-based information exchanges such as HIX-NY and SHIN-NY will be critical for practitioners to share information and be fully engaged in the care transformation process.

IPQR Module 9.8 - Progress Reporting

Instructions :

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

A master project management tool will be utilized to monitor the progress of this initiative. The master document will consist of various subsets required for the success - for e.g., workforce development, EHR capabilities, and adoption of clinical integration strategies . Key performance indicators will be identified and monitored. These will include milestones for projects, identification of obstacles and resolutions of such, points of interdependencies with other LCHP (Leatherstocking Collaborative Health Partners) entities, etc.

IPQR Module 9.9 - IA Monitoring:

Instructions :

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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.

Leatherstocking Collaborative Health Partner's (LCHP) approach to implementation planning has been to engage partners in high level and detailed planning sessions. These sessions include developing common tasks for each project's requirements, with expected completion dates adjusted as needed by individual partners.

Committee-level project planning has been a highly collaborative effort among different projects, Finance, IT and Data Analytics, Workforce and Performance Reporting Committees; to identify overlapping resource needs, ensure effective use of resources/funds and achieve economies of scale. Project planning and execution workgroups have also involved affected stakeholders to ensure realistic goals and commitments. To assist this effort, tools and templates were developed to facilitate these workgroup sessions, then project plans were developed for review by interested stakeholdrers.

Throughout this effort, and continuing through subsequent detailed planning and execution, the DSRIP Operations Team has facilitated meetings, and has ensured continuity, objectivity and convergence. The Operations Team has also assisted in identifying areas of potential project overlap, such as staffing, to enable collaboration among projects and partners to reduce cost and achieve continuity and consistency of project operations.

A Project management tool for all projects will be used by the DSRIP Operations Team, to ensure tracking of tasks to complete project requirements/milestones/delivrables, assign start/end dates and resource responsibility for each task. This allows for resource leveling and tracking of task interdependencies, and also enables consistent collection of data for project progress reporting. The intention is for each organization to report on their own progress in a web-based type tool, and for this tool to also be used to collect artifacts as supporting documentation. The Project management tool will also be used to track tasks in the Organizational Section projects to ensure consistent reporting and data collection.

The Project management tool will be used to track Risks and Issues affecting project completion, ensuring each has an owner and documented results/mitigation.

The DSRIP Operations Team will prepare PPS-level status and performance reporting to EGB (Executive Governance Body for PPS)

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

Instructions :

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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.

There is direct collaboration and engagement among projects, Finance, IT and Data Analytics, Workforce and Performance Reporting Committees; to identify overlapping resource needs, ensure effective use of resources/funds and achieve economies of scale. The Operations Team has also assisted in identifying areas of potential project overlap, such as staffing, to enable collaboration among projects and partners to reduce cost and achieve continuity and consistency of project operations and avoid duplication of costs/effort.

This collaborative effort will identify where IT supporting infrastructure needs exist, and to mitigate financial burden on individual partners where possible. Standardization of data collected and monitored will ensure effective and consistent patient care delivery and transformation as well as enable consistent outcomes reporting among partners. This will also identify where unique partner-specific needs exist to ensure adequate resources are planned for.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

IPQR Module 10.3 - Project Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Executive Director, DSRIP	Susan van der Sommen, Bassett Medical Center--Lead agency for LCHP--Leatherstocking Collaborative Health Partners	Lead initiative; oversee projects
Senior Director, Care Coordination	Donna Anderson, Bassett Medical Center-Lead Agency for LCHP	Expertise in care coordination and transitions; culture change; leading initiative
DSRIP Project Management Office	Bassett Medical Center, Lead Agency for LCHP	Lead initiative; facilitate culture change
Director, DSRIP Performance Metrics	Amy Van Kampen, Bassett Medical Center, Lead Agency for LCHP	Expertise in data management and reporting
Director, PPS Partner & Patient Engagement	Kara Travis, Bassett Medical Center-Lead Agency for LCHP	Education, organization, lead initiative
Network Director, DSRIP Operations	Tom Manion, Bassett Medical Center-Lead Agency for LCHP	Oversight of DSRIP Office operations for all projects
Director, LCHP Financial Management	Michael Sweet - Bassett Medical Center-Lead Agency for LCHP	Expertise in and oversight for finance and accounting
Chief Clinical Officer	Steven Heneghan, MD Bassett Medical Center-Lead Agency for LCHP	Lead initiative; facilitate culture change
Chief Operating Officer	Vacant - Recruiting - Bassett Medical Center-Lead Agency for LCHP	Lead initiative; facilitate culture change
Chief Financial Officer	Michael Taegeres, Bassett Medical Center-Lead Agency for LCHP	Lead initiative; facilitate culture change

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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		
LCHP Project Teams (10 teams for 11 projects)	Plan and implement project milestones, engage partners involved in planning and deliver on the requirements	Project Implementation Plan and execution; direct team towards progress of projects
LCHP Finance Committee	Develop mechanism for distribution of funds; achieve 90% value-based payments	Completion of financial sections of Implementation Plan; Funds Flow and Distribution Model; Build financial structure for PPS; plan to achieve 90% value-based payment; Execute the above
LCHP Clinical Performance Committee	Ensure meeting clinical quality standards	Engage in project team meetings to ensure clinical quality
IT and Data Analytics Committee	Ensure interoperability of EHR	Completion of IT and Performance Reporting sections of Implementation Plan; Engage in projects with stakeholders to accomplish plan, oversee technology infrastructure, and metric/reporting processes
LCHP PAC	Act as an advisory to the Executive Governance Body (EGB)	Ensure broad participation of partners in an advisory role; Assess project impact on the community
LCHP Operations Team	Coordinate, facilitate, guide and assist in implementation, communication, reporting, and administration of DSRIP-related activities	Liaison among projects, partners and State; Receive, interpret, and communicate information from State; Development of processes and tools to faciliate partner accountability; Provide LCHP leadership with program progress reporting; Evaluate usage of overlapping resources/funds/training/ expertise, etc., throughout the evolution and transformation of the DSRIP program
External Stakeholders		
None identified	None identified	None identified

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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.

IT and Data Analytics Committee (ITDAC) has been engaged in project planning to build the IT infrastructure required for achieving project requirements. IT infrastructure is needed in two areas - 1. Clinical Interoperability; 2. Reporting Metrics to State. LCHP will leverage the planned Medicaid Data Warehouse for collecting required data for reporting purposes. ITDAC is engaged in planning and executing interoperability strategy. ITDAC is also responsible for making sure their strategy includes confidentiality, compliance and security related to data sharing. Web-based performance dashboards will provide baseline performance data. LCHP will collect and incorporate into its regular performance monitoring qualitative feedback obtained from consumers and the community through the LCHP communication plan.

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.

Clinical Performance Committee, with project membership, is engaged in building the criteria for performance reporting as well as strategies to improve performance. IT and Data Analytics Committee (ITDAC) is also involved with planning a reporting infrastructure, while working closely with the Clinical Performance Committee. We will work with IT to define and develop clear expectation and rules for appropriate dissemination and collection of reporting data (performance, progress, actively engaged patients).

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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.

PAC (Project Advisory Committee) has a broad memebership, with not only Community based organizations, but also Medicaid Beneficiaries. PAC will oversee project planning and implementation and will play an advisory role to the Executive Governance Body (EGB). Learning Collaboratives and focus groups are planned to engage the community in DSRIP initiatives. LCHP Communication Plan will outline community engagement. Stakeholders from CBOs have been very involved with project application planning and implementation planning. Partner agreements have been sent to >20 CBOs, including regional ARCs, social services organizations, councils on alcoholism, substance abuse organizations, and centers of independence for developmentally disabled individuals. CBOs will be engaged in implementing and executing projects. For example, certain CBOs are "hot spots" for implementing projects such as Navigation (2.c.i) and PAM (2.d.i). Where circumstances permit, the LCHP PPS intends to include contributing CBOs in bonus and incentive payments; therefore execution of formal agency agreements will exist. Formalization of Funds Flow Model to include CBOs is essential to the success of projects, therefore it can be considered a risk.

IPQR Module 10.8 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Section 11 – Workforce

IPQR Module 11.1 - Workforce Strategy Spending

Instructions :

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

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

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

IPQR Module 11.2 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Define target workforce state (in line with DSRIP program's goals).	In Progress	Finalized PPS target workforce state, signed off by PPS workforce governance body.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task 1. Re-establish a standing Workforce Steering Committee (including HR representatives, education department representatives, union representation and other subject matter experts) tasked with making implementation recommendations and assisting in carrying out the tasks laid out in the Implementation Plan	Completed	Complete; See Workforce Steering Committee Charter and minutes.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. The Workforce Steering Committee will provide recommendations to the workforce consultant in order to establish work group for Health Literacy & Cultural Competency to include representatives from partner organizations with expertise in this realm	Completed	The Cultural Competency an Health Literacy Workgroup was formed, and met 5 times. It has been decided to transition these efforts to a larger, exsisting, workgroup "Disparity in Care and Diversity", in order to maximize and leverage DSRIP/PHIP efforts around Cultural Competency and Health Literacy.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3. The workforce consultant, with assistance from PPS staff, will work to form the following Workforce work groups: Training work group, Compensation and Benefits work group and Gap Analysis work group (including project leads, and other appropriate subject matter experts and key stakeholders) tasked with advising, implementing and executing workforce related activities as laid out in the Implementation Plan	Completed	Workgroups have been formed and met during this quarter as follows: Training Workgroup: X 4 Gap Analysis: X 2 Compensation and Benefits: X2	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4. The workforce consultant, will conduct a	In Progress	The Initial Training By Project Analysis was completed this quarter and reviewed by the Training Workgroup, as well as	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Project-by-Project Analysis to identify and map out the specific requirements of each DSRIP project (i.e., new services, workforce projections, turnover, training needs) through workshops, interviews and surveys with key stakeholders and project leads		the Workforce Steering Committee. The next steps will be to work with the project leads to further quantify and verify information.							
Task 5. Utilizing findings from project-by-project analysis, the workforce consultant and Workforce Steering Committee will conduct a Target State Workforce Needs Assessment to capture detailed information on the competencies and responsibilities of the roles required per project. This will be presented to project leads, for additional input, before finalization	In Progress	In process. Awaiting completion of partner contracting process and additional clarification on job titles. Job title information is anticipated as Compensation and Benefits	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 6. The Workforce Steering Committee will determine the degree and magnitude of impacts by role / provider organization, key roles and responsibility changes, skills/competency changes, impact to staffing patterns, impact to caseloads, etc., through an Organizational Impact Analysis facilitated by the workforce consultant	In Progress	In process - reviewing project budgets for new hire impact.	09/30/2015	03/31/2016	09/30/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 7. The Workforce Steering Committee will incorporate Capital Project Application determinations and adjust workforce impact as necessary	Not Started	Not started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 8. The workforce consultant will consolidate findings in a Target State Staffing Strategy Analysis to develop a comprehensive view of the areas within the PPS that will need more, less, or different resources to support the DSRIP projects and ultimately assist in identifying staffing locations for review, feedback and comment from the Workforce Steering Committee	In Progress	Not started	01/01/2016	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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 9. Based on data, finalize the Target Workforce State that defines a comprehensive view of project impacts across the PPS and identifies areas that require resource commitments	Not Started	Not started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 10. Obtain approval of target workfor state from PPS governing board	Not Started	Not started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	In Progress	Completed workforce transition roadmap, signed off by PPS workforce governance body.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task 1. Formalize a decision-making structure that defines how and by whom any decisions around resource availability, allocation, training, redeployment and hiring will be made and signed off	Completed	Complete. See Workforce Committee charter	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Identify solutions for positions that are difficult to recruit, train or retrain	Not Started	Dependent upon completion of Target State Staffing Strategy.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 3. Generate a Workforce Transition Roadmap to consolidate results from the Current Workforce State, Target Workforce State and the Detailed Gap Analysis; outlining specific changes needed within the PPS, incorporating speed and scale projections that will identify clear timelines, a recruitment plan for new hires, retraining/re-deployment strategies, training timelines and the inclusion of a Communication and Engagement plan	Not Started	Not yet started- Dependent on milestones 1-3.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 4. Workforce transition roadmap (including timeline for the transition of the workforce from the current state to the future state) is approved by Executive Governance Body	Not Started	Not yet started- Dependent on milestones 1-3.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #3 Perform detailed gap analysis between current	In Progress	Current state assessment report & gap analysis, signed off by PPS workforce governance body.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
state assessment of workforce and projected future state.									
Task 1. Conduct a current state assessment of staff across the PPS and member organizations, in order to assess: - Skill-sets of jobs to be reduced/eliminated vs. skill-sets required for jobs to be created; - Staff/positions that may involve direct re-deployment (re-deployment needs assessment) vs. re-deployment through up-skilling and training; - Skills and talents currently available in PPS labor pool (through workforce project team or online tools such as Health Workforce New York)	In Progress	Gap Analysis Committee met 2 times. The methods of Data Collection and reporting via Hwapps.org are being explored. Minutes from these meetings are available at Hwapps.org.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2. Ascertain alternative solutions for filling workforce gaps (joint employment/ sub-contracting with other PPS)	Not Started	Not yet initiated. Gap Analysis is still in process.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 3. Identify new hire needs by comparing current state assessment against target state workforce (defined in milestone above)	Not Started	Not yet initiated. Gap Analysis is still in process.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 4. Conduct a workforce budget analysis to establish revised WF budget for the projects over the duration of the DSRIP project	In Progress	Date pushed back per NYSDOH revised timeline	01/01/2016	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 5. Finalize Detailed Gap Analysis findings and incorporate into Workforce Roadmap to articulate how (e.g., retraining, redeployment) and when (e.g., timing of redeployments) the transition of the workforce from the current state to the future state will occur	Not Started	Gap Analysis initiated this quarter.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires,	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

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
particularly focusing on full and partial placements.									
Task 1. Conduct a comprehensive PPS-wide analysis of job category/job title and examine: - variations on a regional level - variations on a facility-type level	In Progress	Vendor quote to conduct a Compensation and Benefits Analysis has been secured, and is under review by the PPS management team.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 2. Utilizing the current and target state analyses performed in Milestones1 and 3, identify the origin and destination of staff that are being redeployed	In Progress	Current and target state analysis initiated this quarter, but is not yet complete.	01/01/2016	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 3. Work with HR to gather compensation and benefits information for existing roles that will potentially be redeployed	In Progress	See above on Compensation & Benefits Analysis	04/01/2016	06/30/2016	12/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 4. Evaluate changes to compensation and benefits of affected staff	In Progress	See above	04/01/2016	06/30/2016	12/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 5. Work with labor representatives, HR representatives and a third party vendor, if necessary, to determine: - Impacts to partial placement staff and potential contingencies - Create and incorporate policies for impacted staff or staff who refuse retraining/re-deployment - Identify methods and processes for tracking fully and partially place retrained/redeployed staff	In Progress	Information to address is not yet available	04/01/2016	06/30/2016	12/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 6. Obtain final approval of compensation and benefit analysis from governing body	Not Started	Information to address is not yet available	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Milestone #5 Develop training strategy.	In Progress	Finalized training strategy, signed off by PPS workforce governance body.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task 1. The workforce training work group will identify target state training needs, by project and position (through PPS project summaries, project	In Progress	Training by Project Analysis has been completed and reviewed by the Workgroups and the Workforce Steering Committee. The next step is to present this to the Project Leads for feedback and input.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
lead interviews and surveys)									
Task 2. Determine PPS current training/retraining capacity (the workforce vendor will work with PPS partners to identify and evaluate training capacity through Hwapps, surveys, interview, etc.)	In Progress	Hwapps.org Training Marketplace has been competed. The Workforce Vendor will conduct trainings for the PPS Partners and vendors in use of Hwapps to record training availability.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 3. Identify analyze training/retraining findings, including: - gaps in training (including certificate and post-secondary) - programs and practices for increasing training capacity and collaboration within and outside of PPS region	In Progress	In Process - the outcome is dependent upon the findings that have not yet been identified.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 4. Engage with existing state-wide programs to explore opportunities to coordinate efforts (ex: SUNY RP²)	In Progress	Workforce vendor serves as a liaison to SUNYRP2; the meetings are ongoing.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 5. The Training Work Group will provide a training strategy to the Workforce Steering Committee for review, to include: - Inputs from the Workforce Transition Roadmap and Gap Analysis to ensure all relevant health professionals are included - Training needs identifed in Step 1 (skill building, training for performance metrics, etc.) - A process and approach to training (e.g. volunatry vs. mandatory)	Not Started	In Process. The Training Committee met 4 times. Training by Project summary has been completed and reviewed by the Training Committee and Workforce Steering Committee. It will be reviewed by Project Leads to further verify and quantify existing information.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 6. Develop mechanism to measure training effectiveness in relation to established goals	Not Started	In process - As training needs are identified and verified, a means to measure will be established.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 7. Finalize detailed Training Plan, including: timing of trainings, delivery methods, and key messages required for training based on project needs. This includes consideration of geography,	Not Started	Not started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
language, level of education, training tools, and methods of delivery									

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Define target workforce state (in line with DSRIP program's goals).	amyvk	Meeting Materials	22_MDL1103_1_3_20160115142003_Meeting_Schedule_Template_Workforce_DY1Q3.xlsx	Workforce meeting schedule Template DY1Q3	01/15/2016 02:20 PM

Prescribed Milestones Narrative Text

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

Milestone Review Status

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

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
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

Bassett Medical Center (PPS ID:22)

IPQR Module 11.3 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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.

All other organizational workstreams have some level of interrdependency that must align with the workforce transformation plans, particularly in light of the fact that many workstreams (five in total) are required to develop a training strategy. The workforce workstream is constructing a training plan that incorporates the needs of all projects; thus, organizational workstream training needs must be incorporated into this overarching training plan to create cohesiveness and ensure integration.

The Workforce and the Governance workstream must have a well-defined relationship to establish appropriate reporting/approval procedures for making workforce decisions.

Another significant interdependency that exists is that of the workforce budget and the importance of directing funds to the providers in our network to support their training and redeployment needs, the connection between our PPS workforce committee and the financial workstreams is integral. To that end, we will ensure that the finance workstream has a member of workforce within the committee.

Workforce will need to be closely informed of the Physician Engagement workstream's ability to garner physician involvement and retention. This 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.

A responsibility of the Population Health Management workstream is to provide a PPS-wide bed reduction plan. The number of bed reductions will potentially 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.

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.)

All other organizational workstreams have some level of interrdependency that must align with the workforce transformation plans, particularly in light of the fact that many workstreams (five in total) are required to develop a training strategy. The workforce workstream is constructing a training plan that incorporates the needs of all projects; thus, organizational workstream training needs must be incorporated into this overarching training plan to create cohesiveness and ensure integration.

Bassett Medical Center (PPS ID:22)

The Workforce and the Governance workstream must have a well-defined relationship to establish appropriate reporting/approval procedures for making workforce decisions.

Another significant interdependency that exists is that of the workforce budget and the importance of directing funds to the providers in our network to support their training and redeployment needs, the connection between our PPS workforce committee and the financial workstreams is integral. To that end, we will ensure that the finance workstream has a member of workforce within the committee.

Workforce will need to be closely informed of the Physician Engagement workstream's ability to garner physician involvement and retention. This 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.

A responsibility of the Population Health Management workstream is to provide a PPS-wide bed reduction plan. The number of bed reductions will potentially 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.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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
DSRIP Executive Director	Sue van der Sommen, Bassett Health Network	Serves as liaison between the workforce committee and the LCHP (Leatherstocking Collaborative Health Partners) PPS Governance
Workforce Project Lead	Sara Albright, Bassett Health Network	Dedicated Project Manager accountable for development of IP and execution of all workforce-related activities
Workforce Consultant	Central and Northern AHECs	Responsible for the coordination and execution of workforce activities and analyses, reporting directly to the WF Project Manager
Workforce Committee	Jennie Gliha, VP HR, AO Fox Zoe Aponte, Catskill Area Hospice Susan Cipolla, HR Director, Catholic Charities Richard Diodati, HR Director, Sitrin, Pam Levy, Director, Catskill Center for Independence George Seuss, CEO ARC of Delaware County Megan Staring, Asst. Director, Catskill Center for Independence Cynthia Sternard, HR Community Memorial Hospital	A group of cross-functional resources (e.g., WF PM, HR, DSRIP lead, Union representative) responsible for overall direction, guidance and decisions related to the workforce transformation agenda
Workforce work groups	Training Workgroup: Rich Diodati, Sitrin Diane Parker, Bassett Gail Warchol, Mohawk Valley Community College Debra Gaige, Oneonta Job Corps; Comp & Benefits Workgroup: Denine Jacob, Bassett Cynthia Sternard, Community Memorial Hospital Gap Analysis Workgroup: Melanie Craig, Bassett Alice Savino, Workforce Development Board	A group of PPS individuals responsible for executing or supporting the execution of key portions of the Implementation Plan activities
WF Training Vendor	Workforce Training Vendor (Vendor not yet known)	A training vendor that can either support the execution of WF-related activities or provide training modules and/or certification training to support workforce re-training needs.
Labor Representation	Labor/Union Representation	Labor group(s) that can provide insights and expertise into likely

Bassett Medical Center (PPS ID:22)

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		workforce impacts, staffing models, and key job categories that will require retraining, redeployment, or hiring

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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		
Jennie Gliha, VP HR, Susan Cipolla, HR Director, Catholic Charities, Richard Diodati, HR Director, Sitrin, Cynthia Sternard, HR Community Memorial Hospital	HR Leads	Support data collection of compensation and benefit information; current state workforce information and potential hiring needs
Diana Parker (BHN), Richard Diodati (Sitrin)	Training Leads	Provide oversight and input to development of training needs assessment, and subsequent training strategy and plan
David Haswell, Martha Sunkenberg , Lisa Betrus , Christa Serafin, Laurie Neander , Carlton Rule, Ann Hutchison, Bonnie Post , Stephanie Lao, Deanna Charles, Ann Hutchison, Bonnie Post, Stephanie Lao, Deanna Charles, Celeste Johns, Marietta Taylor, Joseph Sellers, Mike Kettle , Chris Kjolhede, Philip Heavner, Jean Schifano, Connie Jastremski, Marion Mossman, Roy Korn, Norine Hodges	DSRIP Project Chairs	Provide insights and information related sources and destinations of redeployed staff by project
Susan van der Sommen, DSRIP Executive Director	LCHP Operations Team	Oversight of Workforce Committees activities in relation to DSRIP requirements
IT and Data Analytics Committee	PPS IT	Facilitate IT capabilities in relation to training needs for PPS
External Stakeholders		
AHEC	Training Vendor	Technical training curriculum development; recruiting support
Kari Burke (CNY CC); Lenore Boris (CCN); Tracy Leonard (NCI); Lottie Jameson (AHI)	Workforce Leads from neighboring PPSs	Communicate best practices and resources
Central and Northern AHECs	Workforce Consultant	Coordination and execution of workforce activities and analyses
Heather Eichen	SUNY RP²	Facilitate post-secondary capacity for training needs; assist in achieving consistency of job titles across PPS boundaries

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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 success of the Workforce workstream will be measured by its ability to meet milestone target completion dates and develop an effective means of gathering number of redeployed, retrained, and hired staff and the workforce budget. Working in collaboration with the Performance Reporting team, the Workforce team will collect and report progress on a quarterly basis with respect to Domain 1 Process Measures.

The Health Workforce New York (HWNY) platform under construction by the AHECs is capable of serving as a data collection and reporting tool for workforce measures. AHEC will work with IT and Performance Reporting workstreams to identify and develop a data collection process for workforce. Additionally, the AHECs will work with MV PPS to provide training for staff with respect to accessing the HWNY reporting platform and the importance of workforce data collection/reporting. Workforce will also work with Progress Reporting to determine a process for reporting MV PPS partner workforce budget investments. The internal workforce team will monitor the progress of the implementation plan through regular meetings and work plan review.

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 number of redeployed, retrained, and hired staff and the workforce budget. Working in collaboration with the Performance Reporting team, the Workforce team will collect and report progress on a quarterly basis with respect to Domain 1 Process Measures.

The Health Workforce New York (HWNY) platform under construction by the AHECs is capable of serving as a data collection and reporting tool for workforce measures. AHEC will work with IT and Performance Reporting workstreams to identify and develop a data collection process for workforce. Additionally, the AHECs will work with MV PPS to provide training for staff with respect to accessing the HWNY reporting platform and the importance of workforce data collection/reporting. Workforce will also work with Progress Reporting to determine a process for reporting MV PPS partner workforce budget investments. The internal workforce team will monitor the progress of the implementation plan through regular meetings and work plan review.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

IPQR Module 11.11 - IA Monitoring:

Instructions :

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project 2.a.ii – Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))

IPQR Module 2.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.

Risk:Participating providers in PPS meet NCQA 2014 Level 3.1 partner converting EMR during PCMH implementation period places high demands on staff resources and creates barriers for data reportingMitigation:Consultant support for partners/detailed plans for implementation and reporting needs/added staff resourcesRisk:Clinical Interoperability w/varying EHRsMitigation:EHR connectivity is not present across PPS. LCHP Ops Team will work w/partners as DSRIP projects rely on EHR systems & other technical platforms to track patient engagementRisk:Identify Physician champions & attain CCE (certified content expert) status due to limited frequency & high demand for NCQA training/examsMitigation:LCHP will use APCs in addition to MDs as championsRisk:Lack of RNs in workforce w/ambulatory experienceMitigation:A workforce impact consultant is engaged with LCHP to employ creative workforce strategies. The PPS will leverage Bassetts relationship with local colleges to create programs necessary to serve population. Utilizing expertise of the consultant, AHEC and the Collaborative Learning Committee, online and in-person training will be offered to retrain existing employees. Economies of scale will be implemented when training staff across the PPS. RNs will be hired without care coordination and other necessary experience. LCHP will work with AHEC on strategies to identify, attract and successfully recruit experienced RNs. All RN Care Managers will be trained with the intent to become certified Risk:Partner Engagement Mitigation:A non-safety net LCHP Partner has not been engaged in planning projects due to lack of designated resources to engage in planning and execution. LCHP Ops Team will reach out to partners who are deemed essential, and complete a funds flow model to better inform their involvement. Regular updates to partners through email, project and all partner meetings, and utilization of tools such as website, Constant Contact, survey tools and Health Workforce NY are some strategies used currently. The non-safety net provider sent representation to the PCMH kick off meeting in late July. All providers engaged in this project will work with the PCMH consultants on individualized plans to achieve NCQA recognition Risk:EHR meeting connectivity to RHIOs HIE and SHIN-NY requirements on time is contingent on SHIN-NY activation dateMitigation:If SHIN-NY activation's timeline varies from our commitment, we will not be able to meet this metric. LCHP will work on alternate possibilities such as plan modification to our strategy to accommodate any change in SHIN-NY roll-out timeline. For agencies without an EHR, the LCHP ITDAC will offer its expertise, with focus on standardization. For project participants who do not currently submit patient-level data to HIXNY or other RHIO, the ITDAC will share expertise with appropriate partners in joining RHIOs Risk:Negotiating contracts with MCOs for services not reimbursed/under-reimbursed Mitigation:To negotiate contracts with MCOs, there will be a need to combine efforts across LCHP PPS and with other PPSs to strengthen and consolidate the message and make patient care in DSRIP projects sustainable. NCQA recognition will be used to leverage MCOs when negotiating reimbursement Risk:Practitioner EngagementMitigation:LCHP has identified an overall risk of individual practitioners not being committed to the DSRIP activities. A comprehensive practitioner communication and engagement plan will be created by the Clinical Performance Committee to engage practitioners. This committee will have representation of different types of practitioners. LCHP will leverage existing gatherings of practitioners within partners such as Primary Care Council, Regional Medical Director Group and CLG as models for clinical integration and practitioner engagement in creating PPS-wide professional groups

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	16,934

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
9,551	12,418	177.00%	-5,402	73.33%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
amyvk	Rosters	22_PMDL2115_1_3_20160125125919_RosterPCMH_Actively_Engaged_DY1Q3.pdf	Bassett Medical Center 2aii PCMH Actively Engaged Pt Roster DY1Q3	01/25/2016 01:00 PM

Narrative Text :

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

Please note any items where name or date of birth (DOB) is blank means we do not have that information from that institution for that patient. We have at a minimum the CIN# as required by the State for each unique patient. List is de-duplicated (unique pts)

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

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Ensure that all participating PCPs in the PPS meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Hold kick-off meeting to communicate to the Partners' Medical Home Leadership Teams regarding the implementation planning specific to PCMH project	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Train all involved Partners and Medical Home Leadership Teams on PCMH concepts and models of care	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Perform Gap Analysis - current status vs requirements of NCQA	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Recognized Practices: Create a shared timeline - identify tasks that take more lead time to start with first, Phase the implementation, with each step building on the other	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5. Practices new to PCMH: Create a shared timeline - identify tasks that take more lead time (eg. access takes a lot of lead time), Phase the implementation	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6. Using the list of staffing resources identified for the project in the application phase, create a phased plan for adding staff to assist with the PCMH Transformation	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

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 7. Recruit and hire staff per staffing plan based on Phased Plan for 2015, 2016, 2017	Project		In Progress	06/01/2015	06/30/2017	06/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 8. Implement the Learning Collaborative for all DSRIP PCMH committed partners.	Project		In Progress	05/01/2015	06/30/2016	05/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 9. Develop inter-disciplinary PCMH governance structure for each partner	Project		Completed	05/15/2015	09/30/2015	05/15/2015	09/30/2015	09/30/2015	DY1 Q2
Task 10. Develop a program to engage patients/families/caregivers in PCMH Implementation, Performance Review and Plan modification via various methods of feedback (eg-in the moment validation, patient focus groups, etc.)	Project		In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 11. Implement the 6 Key Components of the Standard Implementation Process: PCMH Transformation Access, Team-Based Care, Population Health, Care Management, Care Coordination, and Performance Measurement and Quality Improvement following a standard Plan, Act, Do implementation process.	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 12. Implement NCQA PCMH Recognition Process - Sign Contract and Business Associate Agreement, Submit application with Payment, Arrange Conference Call with NCQA.	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 1a .Each Partner holds a PCMH kick off event for their primary care practices including providers and support staff to begin the practice transformation work.	Project		Completed	07/27/2015	12/31/2015	07/27/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #2 Identify a physician champion with knowledge of PCMH/APCM implementation for each primary care practice included in the project.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has identified physician champion with experience implementing PCMHs/ACPMs.	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 1. Define role of champion in practice	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task	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

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
2. Identify physician champions - Phase 1 & 2, Complete NCQA PCMH content expert training, take exam									
Task 3. Identify Advanced Practice Clinician (APC) champions	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4. Register for NCQA PCMH content expert training to develop physician and APC champion	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5. Create/Update Champion CV for evidence of content expertise	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Identify care coordinators at each primary care site who are responsible for care connectivity, internally, as well as connectivity to care managers at other primary care practices.	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Care coordinators are identified for each primary care site.	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 Care coordinator identified, site-specific role established as well as inter-location coordination responsibilities.	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 Clinical Interoperability System in place for all participating providers and document usage by the identified care coordinators.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1. Identify care coordinator staffing model for all involved partners including locations, phasing of hiring	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Identify current staffing availability	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 3. Identify gaps - additional staff needed	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Create organization-specific standardized job descriptions for Care Coordinators	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5. Hire care coordinators (RN level)	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6. Train care coordinator staff for all involved partners including locations, phasing of hiring	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

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
7. Develop Role descriptions that are site specific and include inter-location coordination responsibilities									
Task 8. Develop training material including orientation to assigned sites	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 9. Partner with interdisciplinary team comprised of IT, EMR, Clinicians, etc. to create information exchange workflow (eg. EPIC CareEverywhere, Healthy Connections, RHIOs like HIXNY)	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 10. Add "Care everywhere, Care Link, etc " for partners to pilot	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 11. Map workflows once defined	Project		In Progress	04/01/2016	09/30/2016	12/31/2015	09/30/2016	09/30/2016	DY2 Q2
Task 12. Educate providers and staff on the workflow	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone #4 Ensure 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 direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.	Project	N/A	In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS uses alerts and secure messaging functionality.	Project		In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1. Obtain RHIO Attestation of connectivity	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2. Report (e.g., from Business Intelligence or Meaningful Use team) to show evidence of active sharing HIE info - transaction info, e.g,. of public health registries - NYSIS, lab to DOH for infectious conditions, etc.	Project		Not Started	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 3. Obtain QE (Qualified Entity)participant agreements	Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 4. Identify use of alerts across PPS	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	06/30/2016	06/30/2016	DY2 Q1

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
5. Identify Best Practice alerts required for PCMH NCQA level 3									
Task 6. Work with IT to build any required alerts that don't yet exist	Project		In Progress	01/01/2016	09/30/2016	11/09/2015	09/30/2016	09/30/2016	DY2 Q2
Task 7. Obtain evidence from IT for use of alerts and secure messaging	Project		Not Started	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Project	N/A	In Progress	07/01/2015	12/31/2017	07/01/2015	12/31/2017	12/31/2017	DY3 Q3
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	07/01/2015	12/31/2017	07/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	12/31/2017	07/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 1. Determine current status of Meaningful Use Stage 1/2 for each partner organization level	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Determine current PCMH stage of each partner EHR	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/29/2015	12/31/2015	DY1 Q3
Task 3. Identify gaps in Meaningful Use and PCMH stages and required build	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 4. Work with IT to build functionality that does not yet exist to meet MU and PCMH level 3 standard	Project		In Progress	04/01/2016	12/31/2016	11/09/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5. Continue to monitor performance measures for meaningful use requirements	Project		Not Started	01/01/2017	12/31/2017	01/01/2017	12/31/2017	12/31/2017	DY3 Q3
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.	Project	N/A	In Progress	10/01/2015	12/31/2017	10/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	10/01/2015	12/31/2017	10/01/2015	12/31/2017	12/31/2017	DY3 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 1. Identify and implement vendor for population health management (e.g., Phytel, collaboration with PHIP)	Project		In Progress	10/01/2015	12/31/2017	10/01/2015	12/31/2017	12/31/2017	DY3 Q3
Milestone #7 Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management.	Project	N/A	In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Practice has adopted preventive and chronic care protocols aligned with national guidelines.	Project		In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Project staff are trained on policies and procedures specific to evidence-based preventive and chronic disease management.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 1. Share existing protocols and develop ones as appropriate	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2. Share existing protocols with new sites, for chronic conditions and preventive screenings, utilization measures and vulnurable populations for the PPS	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3. Perform gap analysis for what data needs are	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4. Define metrics for reports (already defined by NCQA)	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5. Create reports to measure outcomes	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 6. Adjust workflows, etc. to meet desired outcomes	Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 7. Create training-friendly documents - from the policies of procedures in the metric above	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 8. Identify the staff that needs this training	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 9. Build any training tools needed - online, for e.g.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 10. Schedule training sessions, continuous for onboarding	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #8 Implement preventive care screening protocols including behavioral health screenings (PHQ-2 or 9 for those screening	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

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
positive, SBIRT) for all patients to identify unmet needs. A process is developed for assuring referral to appropriate care in a timely manner.									
Task Preventive care screenings implemented among participating PCPs, including behavioral health screenings (PHQ-2 or 9, SBIRT).	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Protocols and processes for referral to appropriate services are in place.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1. Define which preventive screenings to use (include state's defined codes, as appropriate per practice type, as a minimum--99381-99387, 99391-99397)	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Create a workflow for screenings	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3. Train staff and providers on the workflow	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4. Create workflow for referrals, based on a positive finding including a follow up	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5. Train staff and providers on the workflow	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6. Generate reports on referral monitoring (tracking report)	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #9 Implement open access scheduling in all primary care practices.	Project	N/A	In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task PCMH 1A Access During Office Hours scheduling to meet NCQA standards established across all PPS primary care sites.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task PCMH 1B After Hours Access scheduling to meet NCQA standards established across all PPS primary care sites.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task PPS monitors and decreases no-show rate by at least 15%.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 1. Identify scheduling standards as per NCQA requirements (1A Access During Office Hours)	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/18/2015	12/31/2015	DY1 Q3
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

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
2. Determine the scheduling tool used (Scheduling tool IDX for Bassett, PPM, MedEnt for CMH)) (1A Access During Office Hours)									
Task 3. Modify schedule (1A Access During Office Hours)	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/18/2015	12/31/2015	DY1 Q3
Task 4. Implement schedule (1A Access During Office Hours)	Project		In Progress	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task 5. Monitor schedule (1A Access During Office Hours)	Project		In Progress	01/01/2016	12/31/2017	11/09/2015	12/31/2017	12/31/2017	DY3 Q3
Task 6. Update marketing materials (brochures, websites etc) with updated hours (1A Access During Office Hours)	Project		Completed	09/30/2015	12/31/2015	09/30/2015	12/18/2015	12/31/2015	DY1 Q3
Task 7. Identify scheduling standards as per NCQA requirements (1B After Office Hours)	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/18/2015	12/31/2015	DY1 Q3
Task 8. Determine the scheduling tool used (Scheduling tool (IDX for Bassett, MedEd for CMH)) (1B After Office Hours)	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 9. Modify schedule (1B After Office Hours)	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/18/2015	12/31/2015	DY1 Q3
Task 10. Implement schedule (1B After Office Hours)	Project		In Progress	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4
Task 11. Monitor schedule (1B After Office Hours)	Project		Not Started	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task 12. Update marketing materials (brochures, websites etc) with updated hours (1B After Office Hours)	Project		Completed	09/30/2015	12/31/2015	09/30/2015	12/18/2015	12/31/2015	DY1 Q3
Task 13. Create resources in place to see patients - staffing model	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 14. Baseline the no-show rate for medicaid patients	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 15. Determine what is "periodic" for the PPS	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/18/2015	12/31/2015	DY1 Q3
Task 16. Monitor the change in rate	Project		Not Started	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task 17. Make changes - to reduce the % of no show rate e.g., train	Project		Not Started	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
navigators to follow-up with chronic no-shows									

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Ensure that all participating PCPs in the PPS meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	0	0	0	0	0	0	12	12	12	150
Task 1. Hold kick-off meeting to communicate to the Partners' Medical Home Leadership Teams regarding the implementation planning specific to PCMH project										
Task 2. Train all involved Partners and Medical Home Leadership Teams on PCMH concepts and models of care										
Task 3. Perform Gap Analysis - current status vs requirements of NCQA										
Task 4. Recognized Practices: Create a shared timeline - identify tasks that take more lead time to start with first, Phase the implementation, with each step building on the other										
Task 5. Practices new to PCMH: Create a shared timeline - identify tasks that take more lead time (eg. access takes a lot of lead time), Phase the implementation										
Task 6. Using the list of staffing resources identified for the project in the application phase, create a phased plan for adding staff to assist with the PCMH Transformation										
Task 7. Recruit and hire staff per staffing plan based on Phased Plan for 2015, 2016, 2017										
Task 8. Implement the Learning Collaborative for all DSRIP PCMH committed partners.										
Task 9. Develop inter-disciplinary PCMH governance structure for										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
each partner										
Task 10. Develop a program to engage patients/families/caregivers in PCMH Implementation, Performance Review and Plan modification via various methods of feedback (eg-in the moment validation, patient focus groups, etc.)										
Task 11. Implement the 6 Key Components of the Standard Implementation Process: PCMH Transformation Access, Team-Based Care, Population Health, Care Management, Care Coordination, and Performance Measurement and Quality Improvement following a standard Plan, Act, Do implementation process.										
Task 12. Implement NCQA PCMH Recognition Process - Sign Contract and Business Associate Agreement, Submit application with Payment, Arrange Conference Call with NCQA.										
Task 1a .Each Partner holds a PCMH kick off event for their primary care practices including providers and support staff to begin the practice transformation work.										
Milestone #2 Identify a physician champion with knowledge of PCMH/APCM implementation for each primary care practice included in the project.										
Task PPS has identified physician champion with experience implementing PCMHs/ACPMs.	0	0	0	0	0	0	12	201	201	201
Task 1. Define role of champion in practice										
Task 2. Identify physician champions - Phase 1 & 2, Complete NCQA PCMH content expert training, take exam										
Task 3. Identify Advanced Practice Clinician (APC) champions										
Task 4. Register for NCQA PCMH content expert training to develop physician and APC champion										
Task 5. Create/Update Champion CV for evidence of content expertise										
Milestone #3 Identify care coordinators at each primary care site who are responsible for care connectivity, internally, as well as										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
connectivity to care managers at other primary care practices.										
Task Care coordinators are identified for each primary care site.	0	0	0	0	0	0	201	201	201	201
Task Care coordinator identified, site-specific role established as well as inter-location coordination responsibilities.	0	0	0	0	0	0	201	201	201	201
Task Clinical Interoperability System in place for all participating providers and document usage by the identified care coordinators.										
Task 1. Identify care coordinator staffing model for all involved partners including locations, phasing of hiring										
Task 2. Identify current staffing availability										
Task 3. Identify gaps - additional staff needed										
Task 4. Create organization-specific standardized job descriptions for Care Coordinators										
Task 5. Hire care coordinators (RN level)										
Task 6. Train care coordinator staff for all involved partners including locations, phasing of hiring										
Task 7. Develop Role descriptions that are site specific and include inter-location coordination responsibilities										
Task 8. Develop training material including orientation to assigned sites										
Task 9. Partner with interdisciplinary team comprised of IT, EMR, Clinicians, etc. to create information exchange workflow (eg. EPIC CareEverywhere, Healthy Connections, RHIOs like HIXNY)										
Task 10. Add "Care everywhere, Care Link, etc " for partners to pilot										
Task 11. Map workflows once defined										
Task 12. Educate providers and staff on the workflow										
Milestone #4 Ensure all PPS safety net providers are actively sharing EHR										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	21	21	21	21
Task PPS uses alerts and secure messaging functionality.										
Task 1. Obtain RHIO Attestation of connectivity										
Task 2. Report (e.g., from Business Intelligence or Meaningful Use team) to show evidence of active sharing HIE info - transaction info, e.g,. of public health registries - NYSIS, lab to DOH for infectious conditions, etc.										
Task 3. Obtain QE (Qualified Entity)participant agreements										
Task 4. Identify use of alerts across PPS										
Task 5. Identify Best Practice alerts required for PCMH NCQA level 3										
Task 6. Work with IT to build any required alerts that don't yet exist										
Task 7. Obtain evidence from IT for use of alerts and secure messaging										
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	0	0	0	0	0	0	0	0	0
Task 1. Determine current status of Meaningful Use Stage 1/2 for each partner organization level										
Task 2. Determine current PCMH stage of each partner EHR										
Task										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
3. Identify gaps in Meaningful Use and PCMH stages and required build										
Task 4. Work with IT to build functionality that does not yet exist to meet MU and PCMH level 3 standard										
Task 5. Continue to monitor performance measures for meaningful use requirements										
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.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task 1. Identify and implement vendor for population health management (e.g., Phytel, collaboration with PHIP)										
Milestone #7 Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management.										
Task Practice has adopted preventive and chronic care protocols aligned with national guidelines.										
Task Project staff are trained on policies and procedures specific to evidence-based preventive and chronic disease management.	0	0	0	0	0	0	201	201	201	201
Task 1. Share existing protocols and develop ones as appropriate										
Task 2. Share existing protocols with new sites, for chronic conditions and preventive screenings, utilization measures and vulnurable populations for the PPS										
Task 3. Perform gap analysis for what data needs are										
Task 4. Define metrics for reports (already defined by NCQA)										
Task 5. Create reports to measure outcomes										
Task 6. Adjust workflows, etc. to meet desired outcomes										
Task										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
7. Create training-friendly documents - from the policies of procedures in the metric above										
Task 8. Identify the staff that needs this training										
Task 9. Build any training tools needed - online, for e.g.										
Task 10. Schedule training sessions, continuous for onboarding										
Milestone #8 Implement preventive care screening protocols including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) for all patients to identify unmet needs. A process is developed for assuring referral to appropriate care in a timely manner.										
Task Preventive care screenings implemented among participating PCPs, including behavioral health screenings (PHQ-2 or 9, SBIRT).	0	0	0	0	0	201	201	201	201	201
Task Protocols and processes for referral to appropriate services are in place.										
Task 1. Define which preventive screenings to use (include state's defined codes, as appropriate per practice type, as a minimum--99381-99387, 99391-99397)										
Task 2. Create a workflow for screenings										
Task 3. Train staff and providers on the workflow										
Task 4. Create workflow for referrals, based on a positive finding including a follow up										
Task 5. Train staff and providers on the workflow										
Task 6. Generate reports on referral monitoring (tracking report)										
Milestone #9 Implement open access scheduling in all primary care practices.										
Task PCMH 1A Access During Office Hours scheduling to meet NCQA standards established across all PPS primary care sites.	0	0	0	0	174	174	174	174	174	174
Task PCMH 1B After Hours Access scheduling to meet NCQA standards established across all PPS primary care sites.	0	0	0	0	174	174	174	174	174	174

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task PPS monitors and decreases no-show rate by at least 15%.	0	0	0	0	0	0	0	0	0	0
Task 1. Identify scheduling standards as per NCQA requirements (1A Access During Office Hours)										
Task 2. Determine the scheduling tool used (Scheduling tool IDX for Bassett, PPM, MedEnt for CMH)) (1A Access During Office Hours)										
Task 3. Modify schedule (1A Access During Office Hours)										
Task 4. Implement schedule (1A Access During Office Hours)										
Task 5. Monitor schedule (1A Access During Office Hours)										
Task 6. Update marketing materials (brochures, websites etc) with updated hours (1A Access During Office Hours)										
Task 7. Identify scheduling standards as per NCQA requirements (1B After Office Hours)										
Task 8. Determine the scheduling tool used (Scheduling tool (IDX for Bassett, MedEd for CMH)) (1B After Office Hours)										
Task 9. Modify schedule (1B After Office Hours)										
Task 10. Implement schedule (1B After Office Hours)										
Task 11. Monitor schedule (1B After Office Hours)										
Task 12. Update marketing materials (brochures, websites etc) with updated hours (1B After Office Hours)										
Task 13. Create resources in place to see patients - staffing model										
Task 14. Baseline the no-show rate for medicaid patients										
Task 15. Determine what is "periodic" for the PPS										
Task 16. Monitor the change in rate										
Task										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
17. Make changes - to reduce the % of no show rate e.g., train navigators to follow-up with chronic no-shows										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Ensure that all participating PCPs in the PPS meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	201	201	201	201	201	201	201	201	201	201
Task 1. Hold kick-off meeting to communicate to the Partners' Medical Home Leadership Teams regarding the implementation planning specific to PCMH project										
Task 2. Train all involved Partners and Medical Home Leadership Teams on PCMH concepts and models of care										
Task 3. Perform Gap Analysis - current status vs requirements of NCQA										
Task 4. Recognized Practices: Create a shared timeline - identify tasks that take more lead time to start with first, Phase the implementation, with each step building on the other										
Task 5. Practices new to PCMH: Create a shared timeline - identify tasks that take more lead time (eg. access takes a lot of lead time), Phase the implementation										
Task 6. Using the list of staffing resources identified for the project in the application phase, create a phased plan for adding staff to assist with the PCMH Transformation										
Task 7. Recruit and hire staff per staffing plan based on Phased Plan for 2015, 2016, 2017										
Task 8. Implement the Learning Collaborative for all DSRIP PCMH committed partners.										
Task 9. Develop inter-disciplinary PCMH governance structure for each partner										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 10. Develop a program to engage patients/families/caregivers in PCMH Implementation, Performance Review and Plan modification via various methods of feedback (eg-in the moment validation, patient focus groups, etc.)										
Task 11. Implement the 6 Key Components of the Standard Implementation Process: PCMH Transformation Access, Team-Based Care, Population Health, Care Management, Care Coordination, and Performance Measurement and Quality Improvement following a standard Plan, Act, Do implementation process.										
Task 12. Implement NCQA PCMH Recognition Process - Sign Contract and Business Associate Agreement, Submit application with Payment, Arrange Conference Call with NCQA.										
Task 1a .Each Partner holds a PCMH kick off event for their primary care practices including providers and support staff to begin the practice transformation work.										
Milestone #2 Identify a physician champion with knowledge of PCMH/APCM implementation for each primary care practice included in the project.										
Task PPS has identified physician champion with experience implementing PCMHs/ACPMs.	201	201	201	201	201	201	201	201	201	201
Task 1. Define role of champion in practice										
Task 2. Identify physician champions - Phase 1 & 2, Complete NCQA PCMH content expert training, take exam										
Task 3. Identify Advanced Practice Clinician (APC) champions										
Task 4. Register for NCQA PCMH content expert training to develop physician and APC champion										
Task 5. Create/Update Champion CV for evidence of content expertise										
Milestone #3 Identify care coordinators at each primary care site who are responsible for care connectivity, internally, as well as connectivity to care managers at other primary care practices.										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Care coordinators are identified for each primary care site.	201	201	201	201	201	201	201	201	201	201
Task Care coordinator identified, site-specific role established as well as inter-location coordination responsibilities.	201	201	201	201	201	201	201	201	201	201
Task Clinical Interoperability System in place for all participating providers and document usage by the identified care coordinators.										
Task 1. Identify care coordinator staffing model for all involved partners including locations, phasing of hiring										
Task 2. Identify current staffing availability										
Task 3. Identify gaps - additional staff needed										
Task 4. Create organization-specific standardized job descriptions for Care Coordinators										
Task 5. Hire care coordinators (RN level)										
Task 6. Train care coordinator staff for all involved partners including locations, phasing of hiring										
Task 7. Develop Role descriptions that are site specific and include inter-location coordination responsibilities										
Task 8. Develop training material including orientation to assigned sites										
Task 9. Partner with interdisciplinary team comprised of IT, EMR, Clinicians, etc. to create information exchange workflow (eg. EPIC CareEverywhere, Healthy Connections, RHIOs like HIXNY)										
Task 10. Add "Care everywhere, Care Link, etc " for partners to pilot										
Task 11. Map workflows once defined										
Task 12. Educate providers and staff on the workflow										
Milestone #4 Ensure all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	21	21	21	21	21	21	21	21	21	21
Task PPS uses alerts and secure messaging functionality.										
Task 1. Obtain RHIO Attestation of connectivity										
Task 2. Report (e.g., from Business Intelligence or Meaningful Use team) to show evidence of active sharing HIE info - transaction info, e.g,. of public health registries - NYSIS, lab to DOH for infectious conditions, etc.										
Task 3. Obtain QE (Qualified Entity)participant agreements										
Task 4. Identify use of alerts across PPS										
Task 5. Identify Best Practice alerts required for PCMH NCQA level 3										
Task 6. Work with IT to build any required alerts that don't yet exist										
Task 7. Obtain evidence from IT for use of alerts and secure messaging										
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	21	21	21	21	21	21	21	21	21	21
Task 1. Determine current status of Meaningful Use Stage 1/2 for each partner organization level										
Task 2. Determine current PCMH stage of each partner EHR										
Task 3. Identify gaps in Meaningful Use and PCMH stages and										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
required build										
Task 4. Work with IT to build functionality that does not yet exist to meet MU and PCMH level 3 standard										
Task 5. Continue to monitor performance measures for meaningful use requirements										
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.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task 1. Identify and implement vendor for population health management (e.g., Phytel, collaboration with PHIP)										
Milestone #7 Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management.										
Task Practice has adopted preventive and chronic care protocols aligned with national guidelines.										
Task Project staff are trained on policies and procedures specific to evidence-based preventive and chronic disease management.	201	201	201	201	201	201	201	201	201	201
Task 1. Share existing protocols and develop ones as appropriate										
Task 2. Share existing protocols with new sites, for chronic conditions and preventive screenings, utilization measures and vulnurable populations for the PPS										
Task 3. Perform gap analysis for what data needs are										
Task 4. Define metrics for reports (already defined by NCQA)										
Task 5. Create reports to measure outcomes										
Task 6. Adjust workflows, etc. to meet desired outcomes										
Task 7. Create training-friendly documents - from the policies of										

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
procedures in the metric above										
Task 8. Identify the staff that needs this training										
Task 9. Build any training tools needed - online, for e.g.										
Task 10. Schedule training sessions, continuous for onboarding										
Milestone #8 Implement preventive care screening protocols including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) for all patients to identify unmet needs. A process is developed for assuring referral to appropriate care in a timely manner.										
Task Preventive care screenings implemented among participating PCPs, including behavioral health screenings (PHQ-2 or 9, SBIRT).	201	201	201	201	201	201	201	201	201	201
Task Protocols and processes for referral to appropriate services are in place.										
Task 1. Define which preventive screenings to use (include state's defined codes, as appropriate per practice type, as a minimum--99381-99387, 99391-99397)										
Task 2. Create a workflow for screenings										
Task 3. Train staff and providers on the workflow										
Task 4. Create workflow for referrals, based on a positive finding including a follow up										
Task 5. Train staff and providers on the workflow										
Task 6. Generate reports on referral monitoring (tracking report)										
Milestone #9 Implement open access scheduling in all primary care practices.										
Task PCMH 1A Access During Office Hours scheduling to meet NCQA standards established across all PPS primary care sites.	201	201	201	201	201	201	201	201	201	201
Task PCMH 1B After Hours Access scheduling to meet NCQA standards established across all PPS primary care sites.	201	201	201	201	201	201	201	201	201	201

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task PPS monitors and decreases no-show rate by at least 15%.	201	201	201	201	201	201	201	201	201	201
Task 1. Identify scheduling standards as per NCQA requirements (1A Access During Office Hours)										
Task 2. Determine the scheduling tool used (Scheduling tool IDX for Bassett, PPM, MedEnt for CMH)) (1A Access During Office Hours)										
Task 3. Modify schedule (1A Access During Office Hours)										
Task 4. Implement schedule (1A Access During Office Hours)										
Task 5. Monitor schedule (1A Access During Office Hours)										
Task 6. Update marketing materials (brochures, websites etc) with updated hours (1A Access During Office Hours)										
Task 7. Identify scheduling standards as per NCQA requirements (1B After Office Hours)										
Task 8. Determine the scheduling tool used (Scheduling tool (IDX for Bassett, MedEd for CMH)) (1B After Office Hours)										
Task 9. Modify schedule (1B After Office Hours)										
Task 10. Implement schedule (1B After Office Hours)										
Task 11. Monitor schedule (1B After Office Hours)										
Task 12. Update marketing materials (brochures, websites etc) with updated hours (1B After Office Hours)										
Task 13. Create resources in place to see patients - staffing model										
Task 14. Baseline the no-show rate for medicaid patients										
Task 15. Determine what is "periodic" for the PPS										
Task 16. Monitor the change in rate										
Task										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
17. Make changes - to reduce the % of no show rate e.g., train navigators to follow-up with chronic no-shows										

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
Ensure that all participating PCPs in the PPS meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.	DY1Q3: The PCMH partners continue to engage in progression of their work plans with the assistance of PCDC during their coaching sessions. Partners that have conducted their kick off meetings include Bassett (new practices and existing practices), LFH, Fox, and CMH. Slocum Dickson (non-safety net provider) has not engaged in work beyond the PCDC self assessment. Learning Collaboratives started in November 2015 and will continue through DY1Q4.
Identify a physician champion with knowledge of PCMH/APCM implementation for each primary care practice included in the project.	DY1Q3: Physician champions continue to be identified, attend NCQA PCMH training, take exam and CV's are updated.
Identify care coordinators at each primary care site who are responsible for care connectivity, internally, as well as connectivity to care managers at other primary care practices.	DY1Q3: Each partner and practices within partner agencies have evaluated their staffing needs to achieve the PCMH transformation. They are all challenged with staffing to current demand and are determining the best model to fill in gaps. Each practice will maintain their list of staffing fulfilling the role of care coordination.
Ensure 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 direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.	DY1Q3: PCMH project team will look to ITDAC to assist with inventory of HIE/RHIO/SHIN-NY amongst partners. Safety net providers will need to communicate via HIE. This will impact the estimated completion dates of some of the tasks in this milestone.
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	
Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management.	
Implement preventive care screening protocols including behavioral	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
health screenings (PHQ-2 or 9 for those screening positive, SBIRT) for all patients to identify unmet needs. A process is developed for assuring referral to appropriate care in a timely manner.	
Implement open access scheduling in all primary care practices.	DY1Q3: Scheduling standards are defined by NCQA for both during and after hours access. PCDC looks at current access by practices at partner agencies to ensure their current practice is in line with standards. All active partners in the PCMH project have made adjustments to schedules. Have not yet been able to obtain no-show data just restricted to Medicaid population, so that task will be pushed out to 3/31/16.

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	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

IPQR Module 2.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

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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.

Risk: Availability of current data on nursing home to hospital transfers to measure the effectiveness of the project. Additionally, identifying which nursing home to hospital transfers are/are not preventable has been a challenge
Mitigation: LCHP will develop a consistent approach to collecting and reporting on the same data points in order to identify which hospital admissions are or are not preventable. IT and data Analytics team's support will be needed to define data elements to be collected. Currently, there is no known standard to identify the definition of which type of nursing home to hospital transfers are deemed preventable. The INTERACT team will research further for available standards. If none are found, the team will work on defining preventable nursing home to hospital transfer for this project reporting

Risk: Hospital Engagement
Mitigation: LCHP will plan on involving hospitals in the PPS in all applicable DSRIP projects. The INTERACT team will contact the Hospital partners in our PPS to engage them in implementation of INTERACT. INTERACT team will collaborate with hospitals to develop needed education to hospital partners for identified aspects such as accurate diagnosis of nursing home to hospital transfers.

Risk: Patient engagement
Mitigation: Champions, care coordinators, patient navigators, case managers, and health educators will be critical team members at community-based provider sites. These staff will engage patients and their families in care, include INTERACT education at Annual Care Conferences at each SNF to facilitate implementation of INTERACT for better patient outcomes. Referral tracking and patient follow-up will be part of the ongoing strategies used to engage and re-engage patients in care

Risk: Staff and Practitioner Engagement
Mitigation: A comprehensive practitioner communication and engagement plan will be created by the Clinical Performance Committee to engage practitioners in the initiatives under DSRIP Program. This committee will have representation of different types of practitioners. LCHP will also leverage existing gatherings of practitioners within partners such as Primary Care Council, Regional Medical Director Group and Clinical Leadership Group as models for clinical integration and practitioner engagement in creating PPS-wide professional groups. Recruiting INTERACT champion(s) is key to alleviating staff concerns, as is providing ongoing training and support

Risk: EHR meeting connectivity to RHIOs HIE and SHIN-NY requirements on time is contingent on SHIN-NY activation date
Mitigation: In case SHIN-NY activation's timeline varies from our commitment, we will not be able to meet this metric. LCHP will work on alternate possibilities such as plan modification to our strategy to accommodate any change in SHIN-NY roll-out timeline. For agencies without an EHR, the LCHP IT/Data Analytics Committee will offer its expertise, with a primary focus on standardization of IT products. For project participants who do not currently submit patient- level data to HIXNY or another RHIO, the IT/Data Analytics Committee will share expertise with appropriate partners

in joining RHIOs Risk: Clinical Interoperability - Varying EHRs among partners present a challenge in interconnectivity. Mitigation: Patient registries will be required to track target patients and their care in the service area. Universal EHR connectivity is not present across service area providers. LCHP Operations Team will collaborate with partners since several proposed DSRIP projects will also rely on EHR systems and other technical platforms to track patient engagement

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	3,020

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
1,024	1,244	89.69%	143	41.19%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (1,387)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
swathirg	Rosters	22_PMDL3215_1_3_20160124231117_2bvii-Actively_Engaged_Patient_Roster_DY1Q3_Submitted.pdf	2bvii Actively Engaged Patient Roster DY1Q3	01/24/2016 11:11 PM

Narrative Text :

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

Each line in the report below represents a unique patient. We have provided the CIN# of our actively engaged patients at the minimum according to the guidance from the State.
Cumulative number of actively engaged patients from DY1 Q1 through DY1 Q3 is 1244.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.	Project	N/A	In Progress	06/01/2015	12/31/2017	06/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task INTERACT principles implemented at each participating SNF.	Project		In Progress	06/01/2015	12/31/2017	06/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task Nursing home to hospital transfers reduced.	Provider	Nursing Home	In Progress	08/01/2015	12/31/2017	08/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task INTERACT 3.0 Toolkit used at each SNF.	Provider	Nursing Home	In Progress	08/01/2015	12/31/2017	08/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 1. Develop INTERACT budgets for participating partners	Project		Completed	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Identify INTERACT staff	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 3. Educate champion and staff on INTERACT principles	Project		In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 4. Form INTERACT oversight/implementation team at PPS level	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 5. Integrate INTERACT principles as part of daily workflow	Project		In Progress	09/01/2015	12/31/2017	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 6. Identify current nursing home to hospital transfer rate	Project		In Progress	08/01/2015	12/31/2015	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 7. Monitor nursing home to hospital transfer rate on a regular basis	Project		Not Started	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task 8. Engage hospital representatives to determine process for evaluating admissions	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 9. Develop Implementation plan for each participating SNF	Project		Completed	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task	Project		In Progress	09/01/2015	12/31/2017	09/01/2015	12/31/2017	12/31/2017	DY3 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
10. Identify data to be gathered for proof of INTERACT usage									
Milestone #2 Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	Project	N/A	In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Facility champion identified for each SNF.	Provider	Nursing Home	In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1. Develop job description and requirements for INTERACT champion	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2. Identify INTERACT champion	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 3. Train identified INTERACT champion in INTERACT Principles	Project		In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone #3 Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	Project	N/A	In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.	Project		In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
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	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1. Modify existing INTERACT pathways according to each participating SNF and utilize them	Project		In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 2. Monitor care pathways and adjust as needed	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3. Educate identified SNF staff on care pathways	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 4. Maintain training logs for each participating SNF	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone #4 Educate all staff on care pathways and INTERACT principles.	Project	N/A	In Progress	07/01/2015	12/31/2017	07/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task Training program for all SNF staff established encompassing care pathways and INTERACT principles.	Provider	Nursing Home	In Progress	07/01/2015	12/31/2017	07/01/2015	12/31/2017	12/31/2017	DY3 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 1. Identify sources of INTERACT training tools	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Develop training material for identified SNF staff	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3. Train identified SNF staff on care pathways and INTERACT principles	Project		In Progress	09/01/2015	12/31/2017	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
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.	Project	N/A	In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1. Evaluate current Advance Care Planning tools; validate usage is reflected in policies and procedures	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 2. Examine tools against requirements of INTERACT's advance care planning program, adjust as needed	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone #6 Create coaching program to facilitate and support implementation.	Project	N/A	In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task INTERACT coaching program established at each SNF.	Provider	Nursing Home	In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1. Identify goals of coaching program, staff needs	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Incorporate INTERACT training programs and refreshers into staff orientation and periodic staff meeting agendas	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	Project	N/A	In Progress	10/01/2015	12/31/2016	10/01/2015	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	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1. Develop patient/family education materials	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
2. Include INTERACT education at Annual Care Conferences at each SNF									
Task 3. Include INTERACT education material into admission materials provided to patient/family/caretakers	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone #8 Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Hospital	In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Nursing Home	In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1. Confirm if current EHRs for participating SNFs are meaningful use certified	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Implement MU Stage 2 certification for SNFs whose EHR does not currently meet these requirements	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 3. Obtain RHIO Attestation of connectivity	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4. Report (e.g., from Business Intelligence or Meaningful Use team) to show evidence of active sharing HIE info - transaction info, e.g,. of public health registries - NYSIS, lab to DOH for infectious conditions, etc.	Project		Not Started	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 5. Obtain QE (Qualified Entity)participant agreements	Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone #9 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Project	N/A	In Progress	07/01/2015	12/31/2017	07/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task Membership of quality committee is representative of PPS staff	Project		Completed	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
involved in quality improvement processes and other stakeholders.									
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.	Project		In Progress	07/01/2015	12/31/2017	07/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.	Project		Not Started	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task Service and quality outcome measures are reported to all stakeholders.	Project		Not Started	04/01/2017	12/31/2017	04/01/2017	12/31/2017	12/31/2017	DY3 Q3
Task 1. Ensure SNF representation in PPS quality committee	Project		Completed	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Identify role of quality committee and their oversight/development of quality improvement plans	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Reflect INTERACT quality improvement principles in overall quality improvement initiatives	Project		Not Started	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task 4. Identify metrics to be used (include Attachment J metrics)	Project		Not Started	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task 5. Identify how to measure; measure; monitor; adjust as needed	Project		Not Started	04/01/2016	12/31/2017	04/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task 6. Identify/build reporting method	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 7. Generate reports	Project		Not Started	07/01/2016	12/31/2017	07/01/2016	12/31/2017	12/31/2017	DY3 Q3
Milestone #10 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	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	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Determine criteria and metrics for counting/tracking patient engagement--EHR data, encounter data, INTERACT tool usage, etc.	Project		Completed	07/01/2015	08/15/2015	07/01/2015	08/15/2015	09/30/2015	DY1 Q2

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 2. Evaluate existing capability for EHR patient engagement tracking	Project		Completed	07/15/2015	08/31/2015	07/15/2015	08/31/2015	09/30/2015	DY1 Q2
Task 3. Identify technology enhancements/upgrades needed to count/track patient engagement	Project		In Progress	09/01/2015	12/31/2015	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4. Implement technology enhancements/upgrades needed to count/track patient engagement	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5. Identify workflow impact due to new technology, document new workflow	Project		Not Started	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 6. Train staff on technology and workflow	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.										
Task INTERACT principles implemented at each participating SNF.										
Task Nursing home to hospital transfers reduced.	0	0	0	0	0	0	0	0	1	1
Task INTERACT 3.0 Toolkit used at each SNF.	0	0	0	0	0	0	0	0	0	1
Task 1. Develop INTERACT budgets for participating partners										
Task 2. Identify INTERACT staff										
Task 3. Educate champion and staff on INTERACT principles										
Task 4. Form INTERACT oversight/implementation team at PPS level										
Task 5. Integrate INTERACT principles as part of daily workflow										
Task 6. Identify current nursing home to hospital transfer rate										
Task 7. Monitor nursing home to hospital transfer rate on a regular										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
basis										
Task 8. Engage hospital representatives to determine process for evaluating admissions										
Task 9. Develop Implementation plan for each participating SNF										
Task 10. Identify data to be gathered for proof of INTERACT usage										
Milestone #2 Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.										
Task Facility champion identified for each SNF.	0	0	0	3	9	9	9	9	9	9
Task 1. Develop job description and requirements for INTERACT champion										
Task 2. Identify INTERACT champion										
Task 3. Train identified INTERACT champion in INTERACT Principles										
Milestone #3 Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.										
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.										
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.										
Task 1. Modify existing INTERACT pathways according to each participating SNF and utilize them										
Task 2. Monitor care pathways and adjust as needed										
Task 3. Educate identified SNF staff on care pathways										
Task 4. Maintain training logs for each participating SNF										
Milestone #4 Educate all staff on care pathways and INTERACT principles.										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Training program for all SNF staff established encompassing care pathways and INTERACT principles.	0	0	0	0	0	0	1	1	2	2
Task 1. Identify sources of INTERACT training tools										
Task 2. Develop training material for identified SNF staff										
Task 3. Train identified SNF staff on care pathways and INTERACT principles										
Milestone #5 Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.										
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).										
Task 1. Evaluate current Advance Care Planning tools; validate usage is reflected in policies and procedures										
Task 2. Examine tools against requirements of INTERACT's advance care planning program, adjust as needed										
Milestone #6 Create coaching program to facilitate and support implementation.										
Task INTERACT coaching program established at each SNF.	0	0	2	4	4	4	9	9	9	9
Task 1. Identify goals of coaching program, staff needs										
Task 2. Incorporate INTERACT training programs and refreshers into staff orientation and periodic staff meeting agendas										
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.										
Task Patients and families educated and involved in planning of care using INTERACT principles.										
Task 1. Develop patient/family education materials										
Task 2. Include INTERACT education at Annual Care Conferences at each SNF										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 3. Include INTERACT education material into admission materials provided to patient/family/caretakers										
Milestone #8 Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task 1. Confirm if current EHRs for participating SNFs are meaningful use certified										
Task 2. Implement MU Stage 2 certification for SNFs whose EHR does not currently meet these requirements										
Task 3. Obtain RHIO Attestation of connectivity										
Task 4. Report (e.g., from Business Intelligence or Meaningful Use team) to show evidence of active sharing HIE info - transaction info, e.g,. of public health registries - NYSIS, lab to DOH for infectious conditions, etc.										
Task 5. Obtain QE (Qualified Entity)participant agreements										
Milestone #9 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.										
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.										
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.										
Task Service and quality outcome measures are reported to all stakeholders.										
Task 1. Ensure SNF representation in PPS quality committee										
Task 2. Identify role of quality committee and their oversight/development of quality improvement plans										
Task 3. Reflect INTERACT quality improvement principles in overall quality improvement initiatives										
Task 4. Identify metrics to be used (include Attachment J metrics)										
Task 5. Identify how to measure; measure; monitor; adjust as needed										
Task 6. Identify/build reporting method										
Task 7. Generate reports										
Milestone #10 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1. Determine criteria and metrics for counting/tracking patient engagement--EHR data, encounter data, INTERACT tool usage, etc.										
Task 2. Evaluate existing capability for EHR patient engagement tracking										
Task 3. Identify technology enhancements/upgrades needed to count/track patient engagement										
Task 4. Implement technology enhancements/upgrades needed to count/track patient engagement										
Task 5. Identify workflow impact due to new technology, document new workflow										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 6. Train staff on technology and workflow										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.										
Task INTERACT principles implemented at each participating SNF.										
Task Nursing home to hospital transfers reduced.	9	9	9	9	9	9	9	9	9	9
Task INTERACT 3.0 Toolkit used at each SNF.	9	9	9	9	9	9	9	9	9	9
Task 1. Develop INTERACT budgets for participating partners										
Task 2. Identify INTERACT staff										
Task 3. Educate champion and staff on INTERACT principles										
Task 4. Form INTERACT oversight/implementation team at PPS level										
Task 5. Integrate INTERACT principles as part of daily workflow										
Task 6. Identify current nursing home to hospital transfer rate										
Task 7. Monitor nursing home to hospital transfer rate on a regular basis										
Task 8. Engage hospital representatives to determine process for evaluating admissions										
Task 9. Develop Implementation plan for each participating SNF										
Task 10. Identify data to be gathered for proof of INTERACT usage										
Milestone #2 Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.										
Task Facility champion identified for each SNF.	9	9	9	9	9	9	9	9	9	9
Task 1. Develop job description and requirements for INTERACT										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
champion										
Task 2. Identify INTERACT champion										
Task 3. Train identified INTERACT champion in INTERACT Principles										
Milestone #3 Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.										
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.										
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.										
Task 1. Modify existing INTERACT pathways according to each participating SNF and utilize them										
Task 2. Monitor care pathways and adjust as needed										
Task 3. Educate identified SNF staff on care pathways										
Task 4. Maintain training logs for each participating SNF										
Milestone #4 Educate all staff on care pathways and INTERACT principles.										
Task Training program for all SNF staff established encompassing care pathways and INTERACT principles.	9	9	9	9	9	9	9	9	9	9
Task 1. Identify sources of INTERACT training tools										
Task 2. Develop training material for identified SNF staff										
Task 3. Train identified SNF staff on care pathways and INTERACT principles										
Milestone #5 Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.										
Task Advance Care Planning tools incorporated into program (as										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
evidenced by policies and procedures).										
Task 1. Evaluate current Advance Care Planning tools; validate usage is reflected in policies and procedures										
Task 2. Examine tools against requirements of INTERACT's advance care planning program, adjust as needed										
Milestone #6 Create coaching program to facilitate and support implementation.										
Task INTERACT coaching program established at each SNF.	9	9	9	9	9	9	9	9	9	9
Task 1. Identify goals of coaching program, staff needs										
Task 2. Incorporate INTERACT training programs and refreshers into staff orientation and periodic staff meeting agendas										
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.										
Task Patients and families educated and involved in planning of care using INTERACT principles.										
Task 1. Develop patient/family education materials										
Task 2. Include INTERACT education at Annual Care Conferences at each SNF										
Task 3. Include INTERACT education material into admission materials provided to patient/family/caretakers										
Milestone #8 Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	4	4	4	4	4	4	4	4	4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	9	9	9	9	9	9	9	9	9

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 1. Confirm if current EHRs for participating SNFs are meaningful use certified										
Task 2. Implement MU Stage 2 certification for SNFs whose EHR does not currently meet these requirements										
Task 3. Obtain RHIO Attestation of connectivity										
Task 4. Report (e.g., from Business Intelligence or Meaningful Use team) to show evidence of active sharing HIE info - transaction info, e.g,. of public health registries - NYSIS, lab to DOH for infectious conditions, etc.										
Task 5. Obtain QE (Qualified Entity)participant agreements										
Milestone #9 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.										
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.										
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.										
Task Service and quality outcome measures are reported to all stakeholders.										
Task 1. Ensure SNF representation in PPS quality committee										
Task 2. Identify role of quality committee and their oversight/development of quality improvement plans										
Task 3. Reflect INTERACT quality improvement principles in overall quality improvement initiatives										
Task 4. Identify metrics to be used (include Attachment J metrics)										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 5. Identify how to measure; measure; monitor; adjust as needed										
Task 6. Identify/build reporting method										
Task 7. Generate reports										
Milestone #10 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1. Determine criteria and metrics for counting/tracking patient engagement--EHR data, encounter data, INTERACT tool usage, etc.										
Task 2. Evaluate existing capability for EHR patient engagement tracking										
Task 3. Identify technology enhancements/upgrades needed to count/track patient engagement										
Task 4. Implement technology enhancements/upgrades needed to count/track patient engagement										
Task 5. Identify workflow impact due to new technology, document new workflow										
Task 6. Train staff on technology and workflow										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources	- Implementation plans were developed; initial budgets for INTERACT were created for each participating skilled nursing facility - Education of INTERACT Champion and staff under progress

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
available at http://interact2.net.	- Identified source of data for baseline information of nursing home to hospital transfer to be Salient; currently in the process of working with Salient to build this report for our PPS. Therefore Task 6 has been pushed out to 3/31/16. - Components of INTERACT Toolkit 4.0 are currently in use in all participating SNFs- for example Hospitalization tracking tool, while other tools are at various stages of implementation - The provider ramp up was updated to match the end dates of the metrics
Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	INTERACT Champion job description is developed by a few SNFs, while others are in the process of developing the job description. Therefore end date for task 1 has been pushed out to 3/31/16.
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.	
Educate all staff on care pathways and INTERACT principles.	- The provider ramp up was updated to match the end dates of the metrics
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.	Education on Advanced Care Planning Tools will begin in June 2016 according to the plan of the trainers. However, certain partner skilled nursing facilities (SNFs) participating in this project began this work.
Create coaching program to facilitate and support implementation.	- INTERACT Champions are coached; monthly touch points and quarterly meetings are planned to continue training INETRACT Champions - The provider ramp up was updated to match the end dates of the metrics
Educate patient and family/caretakers, to facilitate participation in planning of care.	
Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	- None of the current EMRs of participating Skilled Nursing Facilities (SNFs) are Meaningful Use certified. SNFs found out that there is no State/Federal requirement for long term care EMR vendors to meet meaningful use certification. Therefore they have no control on this project requirement. The team is in the process of finding a method to meet the metric.
Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	- Team identified nursing home to hospital transfer as a measure to be tracked under the oversight of quality committee. More analysis on measures to be tracked under progress.
Use EHRs and other technical platforms to track all patients engaged in the project.	- Identified a partially manual method to track actively engaged patients, which is applicable to most skilled nursing facilities - IT builds needed are in progress in a few participating SNFs. Therefore task 3 end date has been pushed out to 6/30/16

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

Bassett Medical Center (PPS ID:22)

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	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

Project 2.b.viii – Hospital-Home Care Collaboration Solutions

IPQR Module 2.b.viii.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:Pt engagement Mitigation:Education for pts to engage in their healthcare to identify & address social determinants. Referral tracking & pt follow-up in CBOs will be strategies used Risk:Physical Space Mitigation: Identify other projects that may have available space, consider overlapping needs to consolidate needs, and identify highest demand areas to be located. Risk:Partner Engagement Mitigation:Some LCHP Partners not engaged in project planning d/t uncertainty of projects/lack of designated resources to engage in planning/execution. LCHP Ops Team to confirm partner involvement in projects & complete funds flow model to inform their involvement. Updates to partners via email, project/all partner meetings, and utilization of tools such as website, Constant Contact/survey tools/Health Workforce NY are some strategies Risk:IT Technology including EHR interoperability/sharing of PHI/IT infrastructure Mitigation:Pt tracking & provider communications is challenged by variability of technology across LCHP project partners. Resources to acquire new technology to achieve interoperability are substantial. LCHP ITDAC will focus on standardization, assistance in joining partners to RHIOs, and developing electronic interfaces for HIE Risk:Transition planning w/medical professionals Mitigation:Build relationships among health providers in service area. LCHPs Ops Team w/Clinical Performance Committee (CPO), Collaborative Learning Committee(CLC), and ITDAC will engage home care agencies to develop/enhance relationships w/hospitals in and around PPS, w/goal of creating standardized clinical protocols and rapid guidance in the moment Risk:Funding for staff/training Mitigation:Request/align resources. Shared staffing and "train the trainer" method to be used to increase efficiency and avoid duplication Risk:Identifying/recruiting expertise in rural area Mitigation:LCHP will use creative regional recruitment/retention strategies to attract practitioners/nursing staff while emphasizing use of telemedicine to benefit patient care. LCHP PPS has engaged AHEC, workforce consultant. A global approach to staffing needs across LCHP and a creative approach for recruitment in a rural setting will be key to successful recruitment/retention of necessary staff Risk:Re-branding funding Mitigation:Project team will work w/LCHP PPS to request/resource re-branding plan. Dedicated marketing staff will assist DSRIP w/marketing needs across the PPS Risk:Standardized Protocols Mitigation:Care providers have various ways of addressing pt needs. Standardizing protocols across PPS may be a challenge due to large number of care providers/locations. Project team will collaborate with other teams on efforts, approach and implementation Risk:Capital Funding Mitigation:Involve sources like Robert Wood Johnson Foundation, PHIP (Population Health Improvement Program) team to assist in finding other funding Risk:Lack of mobile application Mitigation:Selection of tools to include off-line usage capabilities and increase mobility of home care Risk: Practitioner Engagement Mitigation:Detailed plan will be created by CPO to engage practitioners in DSRIP activities. Committee will have representation of various practitioners. LCHP will leverage existing practitioner groups such as Primary Care Council, Regional Medical Director Group and Clinical Leadership Group as models for clinical integration and practitioner engagement Risk:Contract negotiations Mitigation:In order to negotiate contracts with MCOs, efforts across project teams within LCHP PPS and other PPSs will be combined to strengthen and consolidate the message and make patient care in DSRIP projects sustainable, esp for services not reimbursed/under-reimbursed

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	786

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
53	189	125.17%	-38	24.05%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
amyvk	Rosters	22_PMDL3315_1_3_20160125160516_Roster_Hospital_Home_Care_Actively_Engaged_DY1Q3.pdf	Bassett Medical Center Project 2bviii Hosp Home Care Collaboration Patient Engagement Roster DY1Q3	01/25/2016 04:05 PM

Narrative Text :

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

Please note that there are several entries in the roster that do not contain DOB. Each line does contain the minimum required information of Medicaid ID#. Each line represents a unique patient. Total patients engaged 189.

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

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.	Project	N/A	In Progress	06/01/2015	06/30/2017	06/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for: - discharge planning - discharge facilitation - confirmation of home care services	Project		In Progress	06/01/2015	06/30/2017	06/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 1. Integrate Home Health Care services - possibly centralize for a single point of contact for rapid response - or, rapid referral to establish (all) services delivered in the home (home health, respiratory, DME, infusion, palliative care, hospice etc.)	Project		In Progress	10/01/2015	06/30/2017	10/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 2. Identify roles needed for rapid response team and staffing plan to include medical director, nurse practitioner, clinical and non-clinical navigators, home care nurse(s), care coordinator/manager(s), clinical pharmacist, respiratory therapist, MSW, nutritionist, etc.	Project		Completed	06/01/2015	12/31/2015	06/01/2015	10/20/2015	12/31/2015	DY1 Q3
Task 3. Recruit and hire rapid response team-- clinical and non-clinical navigators, home care nurse(s), care coordinator/manager(s), clinical pharmacist, respiratory therapist, MSW, nutritionist, etc.	Project		In Progress	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4. Recruit Medical Director(explore: sharing this role) - expedite access for MD for orders, intervention, etc.	Project		In Progress	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task	Project		In Progress	06/01/2015	06/30/2017	06/01/2015	06/30/2017	06/30/2017	DY3 Q1

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
5. Recruit Rapid Response NP. Evaluate the option to re-purpose and/or recruit (1 per quadrant)									
Task 6. Recruit Rapid Response Care Managers - re-deploy "discharge planner" or recruit; 24 / 7 on call	Project		In Progress	09/01/2015	06/30/2017	09/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 7. Recruit / hire RN Educator / Rapid Response Coordinator (home care)	Project		Completed	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 8. Develop 24-hour access plan to "Rapid Response Care Coordination Center - to include coordination same day visit, establish primary care and CBO linkages, home care services, interactive telehealth consultations, etc.--a single point of access	Project		In Progress	06/01/2015	06/30/2016	06/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 9. Train according to 24 hour access Rapid Response Care Coordination Center Plan	Project		Not Started	07/01/2016	12/30/2016	07/01/2016	12/30/2016	12/31/2016	DY2 Q3
Task 10. Implement 24 hour Rapid Response Care Coordination Center	Project		Not Started	01/17/2017	06/30/2017	01/17/2017	06/30/2017	06/30/2017	DY3 Q1
Task 11. Define Rapid Response care management workflows (referral procedure, protocols, PCMH communication etc.): ED to home, acute to home, acute to hospice and dispatch of clinical and supportive community resources	Project		In Progress	06/01/2015	03/31/2016	06/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #2 Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Staff trained on care model, specific to: - patient risks for readmission - evidence-based preventive medicine - chronic disease management	Provider	Home Care Facilities	In Progress	06/01/2015	12/31/2016	06/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Evidence-based guidelines for chronic-condition management implemented.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1. Select INETERACT-like tools.	Project		Completed	06/01/2015	06/30/2015	06/01/2015	06/30/2015	06/30/2015	DY1 Q1

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 2. Obtain / distribute INTERACT-like tools to all home care agency participants	Project		Completed	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Provide education on INTERACT-like tools to all home health, hospice, respiratory/ DME provider staff; and, to PCMH, ED and Case Management / Discharge Planning / Rapid Response staff	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4. Identify additional training needs (beyond INTERACT-like tools)--address various patient care settings, chronic and acute conditions, missed patient populations, adjustment to plan, staff turnover, etc.	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 6. Adopt and Implement existing evidence-based chronic condition guidelines	Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 7. Determine individuals most at risk for ED, Acute Care Readmission - Design a risk stratification / screening tool that is: (1) evidence-based, and (2) derived from (actual) home health care acute hospitalization (OASIS) data	Project		In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5. Identify and develop existing evidence-based chronic condition guidelines	Project		In Progress	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #3 Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	Project	N/A	In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
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.	Provider	Safety Net Hospital	Not Started	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 1. Determine patient monitoring requirements needed to invoke INTERACT-like or rapid intervention protocols; define baseline and metrics to achieve reduction in hospital transfers for	Project		In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
chronically ill patients.									
Task 2. Define workflow for Care Manager & Rapid Response Team for chronically ill patients -- obtaining home care and coordination of care plan in lieu of ED visit or hospitalization--expand on INTERACT-like guidelines	Project		Not Started	09/01/2016	12/31/2016	09/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 3. Identify evidence-based and technology (telehealth) supported chronic condition management stategies. Aligning with PCMH, establish education and plan to effectively and efficiently manage individuals with chronic and multiple comorbid conditions. Strategies tol address disease process education, behavioral health management, medication education / monitoring, dietary instruction, activities monitoring, advanced life planning, etc.	Project		Not Started	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 4. Build and implement evidence-based and technology (telehealth) supported chronic condition management stategies. Aligning with PCMH, establish education and plan to effectively and efficiently manage individuals with chronic and multiple comorbid conditions. Strategies tol address disease process education, behavioral health management, medication education / monitoring, dietary instruction, activities monitoring, advanced life planning, etc.	Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task 5. Concensus build: approval of pathway by collaborative experts	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. Develop a health status dashboard and algorythm - include "health alerts" to address specific referral / services need to mitigate risk for ED or readmission	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7. Monitor performance of care pathways for effectiveness and efficiency, adjust as needed	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Educate all staff on care pathways and INTERACT-like principles.	Project	N/A	In Progress	05/01/2015	09/30/2016	05/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task	Provider	Home Care Facilities	In Progress	05/01/2015	09/30/2016	05/01/2015	09/30/2016	09/30/2016	DY2 Q2

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Training program for all home care staff established, which encompasses care pathways and INTERACT-like principles.									
Task 1. Educate all staff involved in "rapid response" strategies using INTERACT-like principles.	Project		In Progress	05/01/2015	06/30/2016	05/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2. Develop staff training & competency program to educate on patient monitoring and management protocols	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Identify and educate multidisciplinary team (RT, RD, MSW, Clin Pharm, etc.) on techniques to effectively monitor and manage high risk patients	Project		In Progress	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #5 Develop 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.	Project	N/A	Completed	09/01/2015	12/31/2015	09/01/2015	12/28/2015	12/31/2015	DY1 Q3
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/28/2015	12/31/2015	DY1 Q3
Task 1. Evaluate INTERACT-like and Palliative Care (Project 3.g.i) Advanced Care planning tools. In collaboration with 3.g.i. adopt standard (staff, provider, patient) education, documentation and implemention plan	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/28/2015	12/31/2015	DY1 Q3
Task 2. Identify metrics to monitor effectiveness, review results and adjust protocols / workflows, as necessary	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/28/2015	12/31/2015	DY1 Q3
Milestone #6 Create coaching program to facilitate and support implementation.	Project	N/A	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task INTERACT-like coaching program has been established for all home care and Rapid Response Team staff.	Provider	Home Care Facilities	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 1. Develop the INTERACT-like coaching program with a team of rapid response experts	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 2. Identify liaison to partner home care agencies and to the Rapid Response Team(s) to coach partners and patients: or,	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
facilitate and oversight standardization of workflow, adjustments and progress									
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	Project	N/A	In Progress	05/01/2015	03/31/2017	05/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Patients and families educated and involved in planning of care using INTERACT-like principles.	Project		In Progress	05/01/2015	03/31/2017	05/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Identify methods to link patients and families with community resources and specialty services (e.g., pharmacists, diabetic educators)	Project		In Progress	09/30/2015	06/30/2016	09/30/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2. Identify educational guides / standardized resources to provide to patients / families to reinforce INTERACT-like principles	Project		In Progress	05/01/2015	06/30/2016	05/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3. Create community education programming and/or support groups that are health condition-specific. Collaborate with other PPS partners to conduct educational forums	Project		Not Started	03/30/2016	03/31/2017	03/30/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.	Project	N/A	Not Started	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task All relevant services (physical, behavioral, pharmacological) integrated into care and medication management model.	Project		Not Started	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task 1. Develop integrated care coordination models that incorporate strategies to mitigate risk of deteriorating condition(s) and necessity for ED or acute care hospitalization. Models will address of medication management, palliative care, address underlying behavioral health concerns, health risk(s) and need for community supports	Project		Not Started	03/30/2016	09/30/2017	03/30/2016	09/30/2017	09/30/2017	DY3 Q2
Task 2. To support integration, identify roles & recruit - to include Rapid Response NPs to deliver care/ services, as necessary, either remotely or direct in-person to homebound patients	Project		Not Started	03/30/2016	06/30/2017	03/30/2016	06/30/2017	06/30/2017	DY3 Q1
Task	Project		Not Started	01/01/2016	09/30/2016	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

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
3. Develop interactive telehealth methods to connect patient/family to clinical experts eg. (1.) pharmacist to address poly-pharmacy, medication duplication, medication reconciliation and medication education; (2) MSW to address behavioral health and community supports; (3.) RD to address nutritional issues, etc.									
Task 4. Explore further design of hi-risk patient interventions - to include rapid response collaboration with EMS - or, administration of medications in the home, stabilization and avoid transport pt to ED; MD/ NP home or remote visit(s); home care interventions, direct and remote visits, etc,	Project		Not Started	09/30/2016	06/30/2017	09/30/2016	06/30/2017	06/30/2017	DY3 Q1
Task 5. Engage in appropriate contracts with entities within PPS and cross PPS to manage clinical information (e.g.-patient is seen at a non LCHP PPS site for care, the expectation to share this information back to LCHP providers is present).	Project		Not Started	03/30/2016	09/30/2017	03/30/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #9 Utilize telehealth/telemedicine to enhance hospital-home care collaborations.	Project	N/A	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Telehealth/telemedicine program established to provide care transition services, prevent avoidable hospital use, and increase specialty expertise of PCPs and staff.	Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 1. Project partners evaluate (minimum three interactive video telehealth devices) and select technology most suited to attain interoperability and project goals	Project		Completed	04/01/2015	05/01/2015	04/01/2015	05/01/2015	06/30/2015	DY1 Q1
Task 2. Select telehealth devices, peripheral equipment and negotate lease with selected vendor	Project		In Progress	05/01/2015	12/31/2015	05/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3. Recruit telehealth RN project leader with responsibility for program implementation across care settings to include protocol / workflow development, provider education and outcomes monitoring / reporting	Project		Completed	01/01/2016	03/31/2016	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Develop a project hub, or expand on existing / mature	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
telehealth program in the rural region. Add interactive video with secure connectivity (PCs / laptops) across care settings (PCMH, home care) to enable remote interactive connection w/ patients for routine monitoring as well as provision of "face-to-face" specialty services (RPh, RT, RD, MSW) to monitor and manage care									
Task 5. Develop care protocols to enhance patient - specialty clinical providers - home care - and, physician collaborations	Project		Not Started	03/01/2016	12/31/2016	03/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 6. Establish interoperability between IT and telehealth devices	Project		Not Started	04/01/2016	09/30/2017	04/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #10 Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinical Interoperability System in place for all participating providers. Usage documented by the identified care coordinators.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Identify existing electronic health record interoperability capability	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Identify electronic health record interoperability needs to meet defined goals and ensure patient care across the network	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Identify technology that needs to be added to meet interoperability needs.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 4. Acquire and implement new technology/software as identified and needed.	Project		Not Started	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 5. Identify workflow impact due to new technology, to address patient safety and operational efficiencies; document new workflow	Project		Not Started	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 6. Train staff on new technology and workflow	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone #11 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Project	N/A	In Progress	07/01/2015	09/30/2017	07/01/2015	09/30/2017	09/30/2017	DY3 Q2

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.	Project		Not Started	03/01/2016	09/30/2017	03/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Service and quality outcome measures are reported to all stakeholders.	Project		Not Started	03/01/2016	09/30/2017	03/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task 1. Evaluate current EMR reporting capabilities and determine additional software/ Business Analytics tool need to collect and monitor information in real time	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Identify and appoint representative(s) from this Project to the Clinical Performance Committee	Project		Completed	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 3. Identify quality improvement goals and tools for all partners in project 2.b.viii that are consistent with desired and expected clinical and cost outcomes, particularly addressing the rural healthcare setting Overall, to impact policy; incentivize consumers to participate in their care; align a value-based payment with stated goals; and, to develop system-wide and enduring provider behavior expectations	Project		Not Started	03/01/2016	12/31/2016	03/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 4. Measure, trend and review quality improvement progress	Project		Not Started	03/01/2016	12/31/2016	03/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 5. Identify and implement root cause analysis methodology for metrics not achieved: Conduct concurrent review of patients (records) sent to ED or admitted to acute care - (1.) Verify best practices implemented; (2.) Avoidable? …and, based upon result(s), targeted review &	Project		Not Started	06/01/2016	09/30/2017	06/01/2016	09/30/2017	09/30/2017	DY3 Q2

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
adjustment to education, workflow and interventions, as necessary									
Task 6. Provide each project partner with metrics, targets and expected outcomes	Project		Not Started	01/01/2016	03/01/2016	01/01/2016	03/01/2016	03/31/2016	DY1 Q4
Task 7. Referencing organization-level and project-level plans of action, project partner(s) monitor progress and, per established timelines, provide report to PPS	Project		Not Started	03/01/2016	12/31/2016	03/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 8. Review (Attachment J) project results, adjust workflow and methods to achieve desired outcomes - avoidable ED and hospitalization -	Project		Not Started	03/01/2016	12/31/2016	03/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 9. Conduct root cause analyses of any result(s) not attained and implement corrective action plan - may include re-education, re-design of workflow(s), adjustment of partner action plan, provider engagement, etc.	Project		Not Started	03/01/2016	09/30/2017	03/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #12 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	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	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Determine criteria and metrics for counting/tracking patient engagement	Project		Completed	07/01/2015	08/15/2015	07/01/2015	08/15/2015	09/30/2015	DY1 Q2
Task 2. Evaluate existing capability for tracking patient engagement	Project		Completed	08/18/2015	08/30/2015	08/18/2015	08/30/2015	09/30/2015	DY1 Q2
Task 3. Identify technology enhancements/upgrades needed to count/track patient engagement	Project		Completed	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 4. Implement technology enhancements/upgrades needed to count/track patient engagement	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5. Identify workflow impact due to new technology; and, establish, as necessary, new workflow	Project		Not Started	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
6. Train staff on new technology and workflow									

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.										
Task Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for: - discharge planning - discharge facilitation - confirmation of home care services										
Task 1. Integrate Home Health Care services - possibly centralize for a single point of contact for rapid response - or, rapid referral to establish (all) services delivered in the home (home health, respiratory, DME, infusion, palliative care, hospice etc.)										
Task 2. Identify roles needed for rapid response team and staffing plan to include medical director, nurse practitioner, clinical and non-clinical navigators, home care nurse(s), care coordinator/manager(s), clinical pharmacist, respiratory therapist, MSW, nutritionist, etc.										
Task 3. Recruit and hire rapid response team-- clinical and non-clinical navigators, home care nurse(s), care coordinator/manager(s), clinical pharmacist, respiratory therapist, MSW, nutritionist, etc.										
Task 4. Recruit Medical Director(explore: sharing this role) - expedite access for MD for orders, intervention, etc.										
Task 5. Recruit Rapid Response NP. Evaluate the option to re-purpose and/or recruit (1 per quadrant)										
Task 6. Recruit Rapid Response Care Managers - re-deploy "discharge planner" or recruit; 24 / 7 on call										
Task 7. Recruit / hire RN Educator / Rapid Response Coordinator (home care)										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 8. Develop 24-hour access plan to "Rapid Response Care Coordination Center - to include coordination same day visit, establish primary care and CBO linkages, home care services, interactive telehealth consultations, etc.--a single point of access										
Task 9. Train according to 24 hour access Rapid Response Care Coordination Center Plan										
Task 10. Implement 24 hour Rapid Response Care Coordination Center										
Task 11. Define Rapid Response care management workflows (referral procedure, protocols, PCMH communication etc.): ED to home, acute to home, acute to hospice and dispatch of clinical and supportive community resources										
Milestone #2 Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.										
Task Staff trained on care model, specific to: - patient risks for readmission - evidence-based preventive medicine - chronic disease management	0	0	0	0	0	0	3	3	3	3
Task Evidence-based guidelines for chronic-condition management implemented.										
Task 1. Select INETERACT-like tools.										
Task 2. Obtain / distribute INTERACT-like tools to all home care agency participants										
Task 3. Provide education on INTERACT-like tools to all home health, hospice, respiratory/ DME provider staff; and, to PCMH, ED and Case Management / Discharge Planning / Rapid Response staff										
Task 4. Identify additional training needs (beyond INTERACT-like tools)--address various patient care settings, chronic and acute conditions, missed patient populations, adjustment to plan, staff turnover, etc.										
Task 6. Adopt and Implement existing evidence-based chronic condition guidelines										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 7. Determine individuals most at risk for ED, Acute Care Readmission - Design a risk stratification / screening tool that is: (1) evidence-based, and (2) derived from (actual) home health care acute hospitalization (OASIS) data										
Task 5. Identify and develop existing evidence-based chronic condition guidelines										
Milestone #3 Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.										
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.										
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.	0	0	0	0	0	0	6	6	6	6
Task 1. Determine patient monitoring requirements needed to invoke INTERACT-like or rapid intervention protocols; define baseline and metrics to achieve reduction in hospital transfers for chronically ill patients.										
Task 2. Define workflow for Care Manager & Rapid Response Team for chronically ill patients -- obtaining home care and coordination of care plan in lieu of ED visit or hospitalization--expand on INTERACT-like guidelines										
Task 3. Identify evidence-based and technology (telehealth) supported chronic condition management stategies. Aligning with PCMH, establish education and plan to effectively and efficiently manage individuals with chronic and multiple comorbid conditions. Strategies tol address disease process education, behavioral health management, medication education / monitoring, dietary instruction, activities monitoring, advanced life planning, etc.										
Task 4. Build and implement evidence-based and technology (telehealth) supported chronic condition management stategies. Aligning with PCMH, establish education and plan to effectively and efficiently manage individuals with chronic and multiple comorbid conditions. Strategies tol address disease process										

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
education, behavioral health management, medication education / monitoring, dietary instruction, activities monitoring, advanced life planning, etc.										
Task 5. Concensus build: approval of pathway by collaborative experts										
Task 6. Develop a health status dashboard and algorythm - include "health alerts" to address specific referral / services need to mitigate risk for ED or readmission										
Task 7. Monitor performance of care pathways for effectiveness and efficiency, adjust as needed										
Milestone #4 Educate all staff on care pathways and INTERACT-like principles.										
Task Training program for all home care staff established, which encompasses care pathways and INTERACT-like principles.	0	0	0	0	0	3	3	3	3	3
Task 1. Educate all staff involved in "rapid response" strategies using INTERACT-like principles.										
Task 2. Develop staff training & competency program to educate on patient monitoring and management protocols										
Task 3. Identify and educate multidisciplinary team (RT, RD, MSW, Clin Pharm, etc.) on techniques to effectively monitor and manage high risk patients										
Milestone #5 Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.										
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).										
Task 1. Evaluate INTERACT-like and Palliative Care (Project 3.g.i) Advanced Care planning tools. In collaboration with 3.g.i. adopt standard (staff, provider, patient) education, documentation and implemention plan										
Task 2. Identify metrics to monitor effectiveness, review results and adjust protocols / workflows, as necessary										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #6 Create coaching program to facilitate and support implementation.										
Task INTERACT-like coaching program has been established for all home care and Rapid Response Team staff.	0	0	0	0	0	0	0	3	3	3
Task 1. Develop the INTERACT-like coaching program with a team of rapid response experts										
Task 2. Identify liaison to partner home care agencies and to the Rapid Response Team(s) to coach partners and patients: or, facilitate and oversight standardization of workflow, adjustments and progress										
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.										
Task Patients and families educated and involved in planning of care using INTERACT-like principles.										
Task 1. Identify methods to link patients and families with community resources and specialty services (e.g., pharmacists, diabetic educators)										
Task 2. Identify educational guides / standardized resources to provide to patients / families to reinforce INTERACT-like principles										
Task 3. Create community education programming and/or support groups that are health condition-specific. Collaborate with other PPS partners to conduct educational forums										
Milestone #8 Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.										
Task All relevant services (physical, behavioral, pharmacological) integrated into care and medication management model.										
Task 1. Develop integrated care coordination models that incorporate strategies to mitigate risk of deteriorating condition(s) and necessity for ED or acute care hospitalization. Models will address of medication management, palliative care, address underlying behavioral health concerns, health risk(s) and need										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
for community supports										
Task 2. To support integration, identify roles & recruit - to include Rapid Response NPs to deliver care/ services, as necessary, either remotely or direct in-person to homebound patients										
Task 3. Develop interactive telehealth methods to connect patient/family to clinical experts eg. (1.) pharmacist to address poly-pharmacy, medication duplication, medication reconciliation and medication education; (2) MSW to address behavioral health and community supports; (3.) RD to address nutritional issues, etc.										
Task 4. Explore further design of hi-risk patient interventions - to include rapid response collaboration with EMS - or, administration of medications in the home, stabilization and avoid transport pt to ED; MD/ NP home or remote visit(s); home care interventions, direct and remote visits, etc,										
Task 5. Engage in appropriate contracts with entities within PPS and cross PPS to manage clinical information (e.g.-patient is seen at a non LCHP PPS site for care, the expectation to share this information back to LCHP providers is present).										
Milestone #9 Utilize telehealth/telemedicine to enhance hospital-home care collaborations.										
Task Telehealth/telemedicine program established to provide care transition services, prevent avoidable hospital use, and increase specialty expertise of PCPs and staff.										
Task 1. Project partners evaluate (minimum three interactive video telehealth devices) and select technology most suited to attain interoperability and project goals										
Task 2. Select telehealth devices, peripheral equipment and negotate lease with selected vendor										
Task 3. Recruit telehealth RN project leader with responsibility for program implementation across care settings to include protocol / workflow development, provider education and outcomes monitoring / reporting										
Task 4. Develop a project hub, or expand on existing / mature										

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
telehealth program in the rural region. Add interactive video with secure connectivity (PCs / laptops) across care settings (PCMH, home care) to enable remote interactive connection w/ patients for routine monitoring as well as provision of "face-to-face" specialty services (RPh, RT, RD, MSW) to monitor and manage care										
Task 5. Develop care protocols to enhance patient - specialty clinical providers - home care - and, physician collaborations										
Task 6. Establish interoperability between IT and telehealth devices										
Milestone #10 Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.										
Task Clinical Interoperability System in place for all participating providers. Usage documented by the identified care coordinators.										
Task 1. Identify existing electronic health record interoperability capability										
Task 2. Identify electronic health record interoperability needs to meet defined goals and ensure patient care across the network										
Task 3. Identify technology that needs to be added to meet interoperability needs.										
Task 4. Acquire and implement new technology/software as identified and needed.										
Task 5. Identify workflow impact due to new technology, to address patient safety and operational efficiencies; document new workflow										
Task 6. Train staff on new technology and workflow										
Milestone #11 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.										
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.										
Task										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.										
Task Service and quality outcome measures are reported to all stakeholders.										
Task 1. Evaluate current EMR reporting capabilities and determine additional software/ Business Analytics tool need to collect and monitor information in real time										
Task 2. Identify and appoint representative(s) from this Project to the Clinical Performance Committee										
Task 3. Identify quality improvement goals and tools for all partners in project 2.b.viii that are consistent with desired and expected clinical and cost outcomes, particularly addressing the rural healthcare setting Overall, to impact policy; incentivize consumers to participate in their care; align a value-based payment with stated goals; and, to develop system-wide and enduring provider behavior expectations										
Task 4. Measure, trend and review quality improvement progress										
Task 5. Identify and implement root cause analysis methodology for metrics not achieved: Conduct concurrent review of patients (records) sent to ED or admitted to acute care - (1.) Verify best practices implemented; (2.) Avoidable? …and, based upon result(s), targeted review & adjustment to education, workflow and interventions, as necessary										
Task 6. Provide each project partner with metrics, targets and expected outcomes										
Task 7. Referencing organization-level and project-level plans of action, project partner(s) monitor progress and, per established timelines, provide report to PPS										
Task 8. Review (Attachment J) project results, adjust workflow and										

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
methods to achieve desired outcomes - avoidable ED and hospitalization -										
Task 9. Conduct root cause analyses of any result(s) not attained and implement corrective action plan - may include re-education, re-design of workflow(s), adjustment of partner action plan, provider engagement, etc.										
Milestone #12 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1. Determine criteria and metrics for counting/tracking patient engagement										
Task 2. Evaluate existing capability for tracking patient engagement										
Task 3. Identify technology enhancements/upgrades needed to count/track patient engagement										
Task 4. Implement technology enhancements/upgrades needed to count/track patient engagement										
Task 5. Identify workflow impact due to new technology; and, establish, as necessary, new workflow										
Task 6. Train staff on new technology and workflow										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.										
Task Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for: - discharge planning - discharge facilitation - confirmation of home care services										
Task 1. Integrate Home Health Care services - possibly centralize for a										

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
single point of contact for rapid response - or, rapid referral to establish (all) services delivered in the home (home health, respiratory, DME, infusion, palliative care, hospice etc.)										
Task 2. Identify roles needed for rapid response team and staffing plan to include medical director, nurse practitioner, clinical and non-clinical navigators, home care nurse(s), care coordinator/manager(s), clinical pharmacist, respiratory therapist, MSW, nutritionist, etc.										
Task 3. Recruit and hire rapid response team-- clinical and non-clinical navigators, home care nurse(s), care coordinator/manager(s), clinical pharmacist, respiratory therapist, MSW, nutritionist, etc.										
Task 4. Recruit Medical Director(explore: sharing this role) - expedite access for MD for orders, intervention, etc.										
Task 5. Recruit Rapid Response NP. Evaluate the option to re-purpose and/or recruit (1 per quadrant)										
Task 6. Recruit Rapid Response Care Managers - re-deploy "discharge planner" or recruit; 24 / 7 on call										
Task 7. Recruit / hire RN Educator / Rapid Response Coordinator (home care)										
Task 8. Develop 24-hour access plan to "Rapid Response Care Coordination Center - to include coordination same day visit, establish primary care and CBO linkages, home care services, interactive telehealth consultations, etc.--a single point of access										
Task 9. Train according to 24 hour access Rapid Response Care Coordination Center Plan										
Task 10. Implement 24 hour Rapid Response Care Coordination Center										
Task 11. Define Rapid Response care management workflows (referral procedure, protocols, PCMH communication etc.): ED to home, acute to home, acute to hospice and dispatch of clinical and supportive community resources										
Milestone #2 Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
evidence-based medicine and chronic care management.										
Task Staff trained on care model, specific to: - patient risks for readmission - evidence-based preventive medicine - chronic disease management	3	3	3	3	3	3	3	3	3	3
Task Evidence-based guidelines for chronic-condition management implemented.										
Task 1. Select INETERACT-like tools.										
Task 2. Obtain / distribute INTERACT-like tools to all home care agency participants										
Task 3. Provide education on INTERACT-like tools to all home health, hospice, respiratory/ DME provider staff; and, to PCMH, ED and Case Management / Discharge Planning / Rapid Response staff										
Task 4. Identify additional training needs (beyond INTERACT-like tools)--address various patient care settings, chronic and acute conditions, missed patient populations, adjustment to plan, staff turnover, etc.										
Task 6. Adopt and Implement existing evidence-based chronic condition guidelines										
Task 7. Determine individuals most at risk for ED, Acute Care Readmission - Design a risk stratification / screening tool that is: (1) evidence-based, and (2) derived from (actual) home health care acute hospitalization (OASIS) data										
Task 5. Identify and develop existing evidence-based chronic condition guidelines										
Milestone #3 Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.										
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.										
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of	6	6	6	6	6	6	6	6	6	6

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.										
Task 1. Determine patient monitoring requirements needed to invoke INTERACT-like or rapid intervention protocols; define baseline and metrics to achieve reduction in hospital transfers for chronically ill patients.										
Task 2. Define workflow for Care Manager & Rapid Response Team for chronically ill patients -- obtaining home care and coordination of care plan in lieu of ED visit or hospitalization--expand on INTERACT-like guidelines										
Task 3. Identify evidence-based and technology (telehealth) supported chronic condition management stategies. Aligning with PCMH, establish education and plan to effectively and efficiently manage individuals with chronic and multiple comorbid conditions. Strategies tol address disease process education, behavioral health management, medication education / monitoring, dietary instruction, activities monitoring, advanced life planning, etc.										
Task 4. Build and implement evidence-based and technology (telehealth) supported chronic condition management stategies. Aligning with PCMH, establish education and plan to effectively and efficiently manage individuals with chronic and multiple comorbid conditions. Strategies tol address disease process education, behavioral health management, medication education / monitoring, dietary instruction, activities monitoring, advanced life planning, etc.										
Task 5. Concensus build: approval of pathway by collaborative experts										
Task 6. Develop a health status dashboard and algorythm - include "health alerts" to address specific referral / services need to mitigate risk for ED or readmission										
Task 7. Monitor performance of care pathways for effectiveness and efficiency, adjust as needed										
Milestone #4 Educate all staff on care pathways and INTERACT-like principles.										
Task Training program for all home care staff established, which	3	3	3	3	3	3	3	3	3	3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
encompasses care pathways and INTERACT-like principles.										
Task 1. Educate all staff involved in "rapid response" strategies using INTERACT-like principles.										
Task 2. Develop staff training & competency program to educate on patient monitoring and management protocols										
Task 3. Identify and educate multidisciplinary team (RT, RD, MSW, Clin Pharm, etc.) on techniques to effectively monitor and manage high risk patients										
Milestone #5 Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.										
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).										
Task 1. Evaluate INTERACT-like and Palliative Care (Project 3.g.i) Advanced Care planning tools. In collaboration with 3.g.i. adopt standard (staff, provider, patient) education, documentation and implemention plan										
Task 2. Identify metrics to monitor effectiveness, review results and adjust protocols / workflows, as necessary										
Milestone #6 Create coaching program to facilitate and support implementation.										
Task INTERACT-like coaching program has been established for all home care and Rapid Response Team staff.	3	3	3	3	3	3	3	3	3	3
Task 1. Develop the INTERACT-like coaching program with a team of rapid response experts										
Task 2. Identify liaison to partner home care agencies and to the Rapid Response Team(s) to coach partners and patients: or, facilitate and oversight standardization of workflow, adjustments and progress										
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Patients and families educated and involved in planning of care using INTERACT-like principles.										
Task 1. Identify methods to link patients and families with community resources and specialty services (e.g., pharmacists, diabetic educators)										
Task 2. Identify educational guides / standardized resources to provide to patients / families to reinforce INTERACT-like principles										
Task 3. Create community education programming and/or support groups that are health condition-specific. Collaborate with other PPS partners to conduct educational forums										
Milestone #8 Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.										
Task All relevant services (physical, behavioral, pharmacological) integrated into care and medication management model.										
Task 1. Develop integrated care coordination models that incorporate strategies to mitigate risk of deteriorating condition(s) and necessity for ED or acute care hospitalization. Models will address of medication management, palliative care, address underlying behavioral health concerns, health risk(s) and need for community supports										
Task 2. To support integration, identify roles & recruit - to include Rapid Response NPs to deliver care/ services, as necessary, either remotely or direct in-person to homebound patients										
Task 3. Develop interactive telehealth methods to connect patient/family to clinical experts eg. (1.) pharmacist to address poly-pharmacy, medication duplication, medication reconciliation and medication education; (2) MSW to address behavioral health and community supports; (3.) RD to address nutritional issues, etc.										
Task 4. Explore further design of hi-risk patient interventions - to include rapid response collaboration with EMS - or, administration of medications in the home, stabilization and avoid transport pt to ED; MD/ NP home or remote visit(s); home care										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
interventions, direct and remote visits, etc,										
Task 5. Engage in appropriate contracts with entities within PPS and cross PPS to manage clinical information (e.g.-patient is seen at a non LCHP PPS site for care, the expectation to share this information back to LCHP providers is present).										
Milestone #9 Utilize telehealth/telemedicine to enhance hospital-home care collaborations.										
Task Telehealth/telemedicine program established to provide care transition services, prevent avoidable hospital use, and increase specialty expertise of PCPs and staff.										
Task 1. Project partners evaluate (minimum three interactive video telehealth devices) and select technology most suited to attain interoperability and project goals										
Task 2. Select telehealth devices, peripheral equipment and negotate lease with selected vendor										
Task 3. Recruit telehealth RN project leader with responsibility for program implementation across care settings to include protocol / workflow development, provider education and outcomes monitoring / reporting										
Task 4. Develop a project hub, or expand on existing / mature telehealth program in the rural region. Add interactive video with secure connectivity (PCs / laptops) across care settings (PCMH, home care) to enable remote interactive connection w/ patients for routine monitoring as well as provision of "face-to-face" specialty services (RPh, RT, RD, MSW) to monitor and manage care										
Task 5. Develop care protocols to enhance patient - specialty clinical providers - home care - and, physician collaborations										
Task 6. Establish interoperability between IT and telehealth devices										
Milestone #10 Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.										
Task Clinical Interoperability System in place for all participating providers. Usage documented by the identified care										

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
coordinators.										
Task 1. Identify existing electronic health record interoperability capability										
Task 2. Identify electronic health record interoperability needs to meet defined goals and ensure patient care across the network										
Task 3. Identify technology that needs to be added to meet interoperability needs.										
Task 4. Acquire and implement new technology/software as identified and needed.										
Task 5. Identify workflow impact due to new technology, to address patient safety and operational efficiencies; document new workflow										
Task 6. Train staff on new technology and workflow										
Milestone #11 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.										
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.										
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.										
Task Service and quality outcome measures are reported to all stakeholders.										
Task 1. Evaluate current EMR reporting capabilities and determine additional software/ Business Analytics tool need to collect and monitor information in real time										
Task 2. Identify and appoint representative(s) from this Project to the Clinical Performance Committee										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 3. Identify quality improvement goals and tools for all partners in project 2.b.viii that are consistent with desired and expected clinical and cost outcomes, particularly addressing the rural healthcare setting Overall, to impact policy; incentivize consumers to participate in their care; align a value-based payment with stated goals; and, to develop system-wide and enduring provider behavior expectations										
Task 4. Measure, trend and review quality improvement progress										
Task 5. Identify and implement root cause analysis methodology for metrics not achieved: Conduct concurrent review of patients (records) sent to ED or admitted to acute care - (1.) Verify best practices implemented; (2.) Avoidable? …and, based upon result(s), targeted review & adjustment to education, workflow and interventions, as necessary										
Task 6. Provide each project partner with metrics, targets and expected outcomes										
Task 7. Referencing organization-level and project-level plans of action, project partner(s) monitor progress and, per established timelines, provide report to PPS										
Task 8. Review (Attachment J) project results, adjust workflow and methods to achieve desired outcomes - avoidable ED and hospitalization -										
Task 9. Conduct root cause analyses of any result(s) not attained and implement corrective action plan - may include re-education, re-design of workflow(s), adjustment of partner action plan, provider engagement, etc.										
Milestone #12 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1. Determine criteria and metrics for counting/tracking patient engagement										
Task										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
2. Evaluate existing capability for tracking patient engagement										
Task 3. Identify technology enhancements/upgrades needed to count/track patient engagement										
Task 4. Implement technology enhancements/upgrades needed to count/track patient engagement										
Task 5. Identify workflow impact due to new technology; and, establish, as necessary, new workflow										
Task 6. Train staff on new technology and workflow										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop 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.	amyvk	Other	22_PMDL3303_1_3_20160119134156_DSRIP_22_2bviii_HHCC_M5-1_MOLST_DD_Checklist_20151228.pdf	Best Practices - Developmental Disabilities Checklist	01/19/2016 01:41 PM
	amyvk	Other	22_PMDL3303_1_3_20160119134124_DSRIP_22_2bviii_HHCC_M5-1_DOH_MOLST_20151228.pdf	Best Practices - Molst	01/19/2016 01:41 PM
	amyvk	Other	22_PMDL3303_1_3_20160119134039_DSRIP_22_2bviii_HHCC_M5-1_DOH_HCP_20151228.pdf	Best Practices - Health Care Proxy	01/19/2016 01:40 PM
	amyvk	Other	22_PMDL3303_1_3_20160119133958_DSRIP_22_2bviii_HHCC_M5-1_DOH_DNR_20151228.pdf	Best Practices - DNR template	01/19/2016 01:39 PM
	amyvk	Other	22_PMDL3303_1_3_20160119133851_DSRIP_22_2bviii_HHCC_M5-1_AdvancedDirectivesBestPractices_20151228.pdf	Advanced Directives Best Practices	01/19/2016 01:38 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.	
Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop 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.	
Educate all staff on care pathways and INTERACT-like principles.	
Develop 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.	
Create coaching program to facilitate and support implementation.	
Educate patient and family/caretakers, to facilitate participation in planning of care.	
Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.	
Utilize telehealth/telemedicine to enhance hospital-home care collaborations.	DY1Q3 Narrative: although initial evlaluation of equipment was conducted per schedule, have not been able to move forward with device selection until source of capital funding is identified. This task has been pushed out until 12/31/16.
Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.	DY1Q3 Narrative: ITDAC IT inventory and focus has identified that HIE/RHIO and SHIN-NY will be the primary mechansims for clinical data exchange. ITDAC will be working with partners over the coming months to assist partners who do not currently participate with HIEs with developing those relationships.
Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	
Use EHRs and other technical platforms to track all patients engaged in the project.	

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

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #8	Pass & Ongoing	
Milestone #9	Pass & Ongoing	
Milestone #10	Pass & Ongoing	
Milestone #11	Pass & Ongoing	
Milestone #12	Pass & Ongoing	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

IPQR Module 2.b.viii.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

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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.

Risk:Non-Clinical ResourcesMitigation:Transportation, housing, food, etc will be relied upon for success.Social needs identified with participants & linked appropriately.Where demand for services is greater than what exists, PPS to assist CBOs to leverage non-clinical resources.(e.g.-transportation contracts across PPS to increase/expand services as identified)Risk:SpaceMitigation:New/repurposing space presents challenges in terms of cost. For efficiency, LCHP to combine projects 2.c.i. & 2.d.i. for navigators/support staff & deliver related services in shared spaceRisk:Rural geographic areaMitigation:Embed navigators in CBOs in high traffic areas/hotspots w/consideration that they may not always be available/accessible to patient. Work with participants to stay connected Risk:FundingMitigation:Involve sources like Robert Wood Johnson Foundation, PHIP (Population Health Improvement Program) team to assist in finding other funding sources for needed resources to be successful.Risk:Staff recruitment/retentionMitigation:Staffing poses challenge in rural area. Project committee will identify community leaders for assistance in recruiting former Medicaid consumers, who could be trained to fill positions for CBOs in their counties.Recruitment strategy would enhance the representativeness/diversity of LCHP workforce.LCHP will also avail of career fairs, external websites, CBOs and schools to advertise position openings.A workforce impact consultant, AHEC, will work closely with LCHPs Collaborative Learning Committee (CLC) & partners to employ creative workforce strategies. Utilizing expertise of workforce impact consultant, AHEC & CLC, online & in-person training will be offered to train/retrain employees. LCHP to leverage AHECs cross-PPS job opportunitiesRisk:Clinical ResourcesMitigation:Navigation is dependent on availability of clinical resources such as PCPs, Behavioral Health, etc. providers to accept/see patients in timeframe needed.Collaboration across projects especially with care coordinationMitigation:Low level of computer literacy among target population will be mitigated via simplified user interfaces/systemsRisk:Negotiate MCO contractsMitigation:Combine efforts across project teams in/across PPSs to negotiate MCO contracts esp for non-reimbursed/under-reimbursed services to strengthen/consolidate message and make pt care in DSRIP projects sustainable. Risk:Practitioner EngagementMitigation:Practitioners are not committed to the DSRIP activities.To address Comprehensive practitioner communication/engagement plan to be created by the Clinical Performance Committee (CPO) to engage practitioners in DSRIP activitiesRisk:Clinical InteroperabilityMitigation: To track actively engaged patients, an evaluation of IT reporting capability will be needed. ITDAC will assist partners with this activity.Patient registries will be required to track target patients and their care in the service area. Universal EHR connectivity is not present across service area providersRisk:Patient engagement Mitigation: Care coordinators, patient navigators, case managers, and health educators will be critical team members at CBO sites.Referral tracking and patient follow-up will be part of the ongoing strategies used to engage ptsRisk:Partner EngagementMitigation:Some LCHP Partners have not been engaged in planning projects due to ambiguity in funds flow, uncertainty of contribution to project requirements, lack of designated resources to engage in planning and execution, etc. LCHP Operations Team to confirm partner involvement, reach out to partners who are deemed essential, & complete a funds flow model to inform involvement.Regular updates to partners through email, project and all partner meetings, and utilization of tools such as website, Constant Contact, survey tools, Health Workforce NY, etc. are some strategies used currently

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	9,646

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
405	483	51.06%	463	5.01%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (946)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
amyvk	Rosters	22_PMDL3415_1_3_20160122125116_RosterNavigationActivelyEngagedDY1Q3.pdf	Bassett Medical Center PPS 2ci Navigation Patient Roster DY1Q3	01/22/2016 12:51 PM

Narrative Text :

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

Please note any items where name or date of birth (DOB) is blank means we do not have that information from that institution for that patient. We have at a minimum the CIN# as required by the State for each unique patient. List is de-duplicated (unique pts)

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

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.	Project	N/A	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Community-based health navigation services established.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1. Define Navigation Services and develop workflows	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2. Identify existing navigation job descriptions across PPS and develop standarized roles and duties.	Project		In Progress	08/01/2015	12/31/2015	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3. Define job standards (roles based) and tasks associated with role.	Project		In Progress	08/01/2015	12/31/2015	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4. Create contract to existing health home contracts;	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5. Seek out community based office space to accommodate Navigation projects	Project		In Progress	06/01/2015	03/31/2016	06/01/2015	03/31/2016	03/31/2016	DY1 Q4
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.	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Resource guide completed, detailing medical/behavioral/social community resources and care protocols developed by program oversight committee.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1. Gather resource information, including collaboration with	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
other resources such as 211									
Task 2. Discuss Netsmart capability to accommodate resource database	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3. Discuss marketing of resource database	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 4. Discuss making the resource database available on the DSRIP website and placement at resource locations	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone #3 Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.	Project	N/A	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Navigators recruited by residents in the targeted area, where possible.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1. Identify existing navigation resources available to determine gaps. Based on inventory of navigation resources, develop plan to ensure sufficient coverage of targetted populations.	Project		Completed	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Contracting CBO's will post job openings internally and externally with representation across PPS	Project		In Progress	09/01/2015	12/31/2015	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3. Develop roles based training curriculum that is standardized. Leverage agencies across PPS for shared resources.	Project		In Progress	09/01/2015	12/31/2015	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4. Recruit, hire, and train Navigators	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone #4 Resource appropriately for the community navigators, evaluating placement and service type.	Project	N/A	In Progress	06/01/2015	06/30/2016	06/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Navigator placement implemented based upon opportunity assessment.	Project		In Progress	06/01/2015	12/31/2015	06/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Telephonic and web-based health navigator services implemented by type.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 1. Identify existing resources to determine gaps and opportunities for navigator placement.	Project		Completed	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 2. Develop plan to address needs	Project		Completed	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Create list of community hot spots	Project		Completed	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Utilize "hotspot" list to determine navigator placement	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5. Identify existing telephonic and web-based health navigations services to determine gaps and opportunities	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 6. Develop strategic plan to incorporate/expand telephonic and web-based resources	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 7. Develop process and procedure for telephonic and web-based services, using existing technology	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone #5 Provide community navigators with access to non-clinical resources, such as transportation and housing services.	Project	N/A	In Progress	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Navigators have partnerships with transportation, housing, and other social services benefitting target population.	Project		In Progress	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1. Dispatch community educators to develop referral procedures with CBO's and Care Managers/Coordinators	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #6 Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.	Project	N/A	In Progress	09/01/2015	12/31/2015	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Case loads and discharge processes established for health navigators following patients longitudinally.	Project		In Progress	09/01/2015	12/31/2015	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1. Define standard caseloads appropriate to navigator role(s) with consideration given to case complexity/need.	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Develop policies and procedure	Project		In Progress	09/01/2015	12/31/2015	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #7 Market the availability of community-based navigation services.	Project	N/A	In Progress	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Health navigator personnel and services marketed within designated communities.									
Task 1, Using Community Needs Assessment, identify services to address identifed unmet needs, develop marketing plan in conjunction with the markerting department accordingly (including identification of educational needs for service providers and other resources)	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 2. Develop resource guide of non-clinical services and provide it to navigators by coordinating services known by community educators, outreach specialists, navigators, and others into one central repository.	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #8 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Determine criteria and metrics for counting/tracking patient engagement--EHR data, encounter data, INTERACT tool usage, etc.	Project		Completed	07/01/2015	08/15/2015	07/01/2015	08/15/2015	09/30/2015	DY1 Q2
Task 2. Evaluate existing capability for EHR patient engagement tracking	Project		Completed	08/15/2015	08/30/2015	08/15/2015	08/30/2015	09/30/2015	DY1 Q2
Task 3. Identify technology enhancements/upgrades needed to count/track patient engagement	Project		Completed	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 4. Implement technology enhancements/upgrades needed to count/track patient engagement	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5. Identify workflow impact due to new technology, document new workflow	Project		Not Started	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 6. Train staff on technology and workflow	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.										
Task Community-based health navigation services established.										
Task 1. Define Navigation Services and develop workflows										
Task 2. Identify existing navigation job descriptions across PPS and develop standarized roles and duties.										
Task 3. Define job standards (roles based) and tasks associated with role.										
Task 4. Create contract to existing health home contracts;										
Task 5. Seek out community based office space to accommodate Navigation projects										
Milestone #2 Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.										
Task Resource guide completed, detailing medical/behavioral/social community resources and care protocols developed by program oversight committee.										
Task 1. Gather resource information, including collaboration with other resources such as 211										
Task 2. Discuss Netsmart capability to accommodate resource database										
Task 3. Discuss marketing of resource database										
Task 4. Discuss making the resource database available on the DSRIP website and placement at resource locations										
Milestone #3 Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.										
Task										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Navigators recruited by residents in the targeted area, where possible.										
Task 1. Identify existing navigation resources available to determine gaps. Based on inventory of navigation resources, develop plan to ensure sufficient coverage of targetted populations.										
Task 2. Contracting CBO's will post job openings internally and externally with representation across PPS										
Task 3. Develop roles based training curriculum that is standardized. Leverage agencies across PPS for shared resources.										
Task 4. Recruit, hire, and train Navigators										
Milestone #4 Resource appropriately for the community navigators, evaluating placement and service type.										
Task Navigator placement implemented based upon opportunity assessment.										
Task Telephonic and web-based health navigator services implemented by type.										
Task 1. Identify existing resources to determine gaps and opportunities for navigator placement.										
Task 2. Develop plan to address needs										
Task 3. Create list of community hot spots										
Task 4. Utilize "hotspot" list to determine navigator placement										
Task 5. Identify existing telephonic and web-based health navigations services to determine gaps and opportunities										
Task 6. Develop strategic plan to incorporate/expand telephonic and web-based resources										
Task 7. Develop process and procedure for telephonic and web-based services, using existing technology										
Milestone #5 Provide community navigators with access to non-clinical resources, such as transportation and housing services.										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Navigators have partnerships with transportation, housing, and other social services benefitting target population.										
Task 1. Dispatch community educators to develop referral procedures with CBO's and Care Managers/Coordinators										
Milestone #6 Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.										
Task Case loads and discharge processes established for health navigators following patients longitudinally.										
Task 1. Define standard caseloads appropriate to navigator role(s) with consideration given to case complexity/need.										
Task 2. Develop policies and procedure										
Milestone #7 Market the availability of community-based navigation services.										
Task Health navigator personnel and services marketed within designated communities.										
Task 1, Using Community Needs Assessment, identify services to address identifed unmet needs, develop marketing plan in conjunction with the markerting department accordingly (including identification of educational needs for service providers and other resources)										
Task 2. Develop resource guide of non-clinical services and provide it to navigators by coordinating services known by community educators, outreach specialists, navigators, and others into one central repository.										
Milestone #8 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1. Determine criteria and metrics for counting/tracking patient engagement--EHR data, encounter data, INTERACT tool usage, etc.										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 2. Evaluate existing capability for EHR patient engagement tracking										
Task 3. Identify technology enhancements/upgrades needed to count/track patient engagement										
Task 4. Implement technology enhancements/upgrades needed to count/track patient engagement										
Task 5. Identify workflow impact due to new technology, document new workflow										
Task 6. Train staff on technology and workflow										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.										
Task Community-based health navigation services established.										
Task 1. Define Navigation Services and develop workflows										
Task 2. Identify existing navigation job descriptions across PPS and develop standarized roles and duties.										
Task 3. Define job standards (roles based) and tasks associated with role.										
Task 4. Create contract to existing health home contracts;										
Task 5. Seek out community based office space to accommodate Navigation projects										
Milestone #2 Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.										
Task Resource guide completed, detailing medical/behavioral/social										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
community resources and care protocols developed by program oversight committee.										
Task 1. Gather resource information, including collaboration with other resources such as 211										
Task 2. Discuss Netsmart capability to accommodate resource database										
Task 3. Discuss marketing of resource database										
Task 4. Discuss making the resource database available on the DSRIP website and placement at resource locations										
Milestone #3 Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.										
Task Navigators recruited by residents in the targeted area, where possible.										
Task 1. Identify existing navigation resources available to determine gaps. Based on inventory of navigation resources, develop plan to ensure sufficient coverage of targetted populations.										
Task 2. Contracting CBO's will post job openings internally and externally with representation across PPS										
Task 3. Develop roles based training curriculum that is standardized. Leverage agencies across PPS for shared resources.										
Task 4. Recruit, hire, and train Navigators										
Milestone #4 Resource appropriately for the community navigators, evaluating placement and service type.										
Task Navigator placement implemented based upon opportunity assessment.										
Task Telephonic and web-based health navigator services implemented by type.										
Task 1. Identify existing resources to determine gaps and opportunities for navigator placement.										
Task										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
2. Develop plan to address needs										
Task 3. Create list of community hot spots										
Task 4. Utilize "hotspot" list to determine navigator placement										
Task 5. Identify existing telephonic and web-based health navigations services to determine gaps and opportunities										
Task 6. Develop strategic plan to incorporate/expand telephonic and web-based resources										
Task 7. Develop process and procedure for telephonic and web-based services, using existing technology										
Milestone #5 Provide community navigators with access to non-clinical resources, such as transportation and housing services.										
Task Navigators have partnerships with transportation, housing, and other social services benefitting target population.										
Task 1. Dispatch community educators to develop referral procedures with CBO's and Care Managers/Coordinators										
Milestone #6 Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.										
Task Case loads and discharge processes established for health navigators following patients longitudinally.										
Task 1. Define standard caseloads appropriate to navigator role(s) with consideration given to case complexity/need.										
Task 2. Develop policies and procedure										
Milestone #7 Market the availability of community-based navigation services.										
Task Health navigator personnel and services marketed within designated communities.										
Task 1, Using Community Needs Assessment, identify services to address identifed unmet needs, develop marketing plan in conjunction with the markerting department accordingly										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
(including identification of educational needs for service providers and other resources)										
Task 2. Develop resource guide of non-clinical services and provide it to navigators by coordinating services known by community educators, outreach specialists, navigators, and others into one central repository.										
Milestone #8 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1. Determine criteria and metrics for counting/tracking patient engagement--EHR data, encounter data, INTERACT tool usage, etc.										
Task 2. Evaluate existing capability for EHR patient engagement tracking										
Task 3. Identify technology enhancements/upgrades needed to count/track patient engagement										
Task 4. Implement technology enhancements/upgrades needed to count/track patient engagement										
Task 5. Identify workflow impact due to new technology, document new workflow										
Task 6. Train staff on technology and workflow										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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.	DY1Q3-Contracts are in the final stages. Once these are executed, the Phase I agencies will have the workflows, job duties, job roles, etc. to expand. Workflows and screening tools are in the final stages of development. This task needs to be extended from 12/31/15 to 3/31/16.
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.	
Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.	DY1Q3 Narrative: Job descriptions for navigator positions are currently under Human Resource review so posting will not occur until end of first quarter 2016. Other tasks in this section are awaiting final signing of navigation services contracts with partner CBOs.
Resource appropriately for the community navigators, evaluating placement and service type.	
Provide community navigators with access to non-clinical resources, such as transportation and housing services.	DY1Q3-Workgroup has been assigned to develop referral procedures with CBO's and care managers/care coordinators. Modifying the task due date to match the milestone due date of 6/30/16 since the task drives the milestone completion.
Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.	DY1Q3-Caseloads for DSRIP Navigators is determined to be 100 at this time. This caseload was based on MHH Navigator (who has a caseload of 50). It is anticipated that the DSRIP Navigator will not have as high of a complexity of inidividuals to work with. The process and workflow work group have determined that they need time to test the caseloads and develop procedures for discharge over time. Task is being extended to 6/30/16 from 12/31/15 as a result.
Market the availability of community-based navigation services.	
Use EHRs and other technical platforms to track all patients engaged in the project.	

Milestone Review Status

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

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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:Patient EngagementMitigation:A key challenge will be to engage a culturally diverse population that does not usually seek care at the right time/place/location.Locating these individuals is a challenge.PPS engagement with AHEC will assist w/language needs/training materials appropriate to target populationsRisk:Funding Mitigation:Funding for staffing is limited.Consolidation of staff resources across projects like 2ci/2di will exist.Contracts among parnters to share staff will lower costsRisk:FundingMitigation:Insignia will contract with state on behalf of all PPSs to provide training on the PAM toolRisk:Practitioner EngagementMitigation:Practitioners are not yet committed to DSRIP goals. Comprehensive practitioner communication/engagement plan to be created by Clinical Performance Committee to engage practitioners in the DSRIP initiatives.LCHP will also leverage existing gatherings of practitioners within partners to create PPS-wide professional groupsRisk:Transportation Mitigation:Integrating diverse/segmented programs for critically important services such as transportation will be a challenge.Navigators will have timely access to these resources, will collect information on new resources and report this information back to LCHP.Leveraging PHIP with expanding 211 resource will be ideal. Transportation services are not as available as demand for them. CBOs will work with each other and w/transportation agencies to increase/expand services to serve patient populationsRisk:Varying to no IT systemsMitigation:Lack of a common IT platform can limit effectiveness of program.Integration of PAM assessment within Care Management system will aid in consistency of system and increase efficiencies by only having to use one system.Limited access to PCs and internet within population can pose a challenge.Leveraging libraries and other public access sites in the field may assist.Paper copies of screening/assessments can be loaded into a computerized system when availableRisk:Staff RecruitmentMitigation:It is important to engage representatives from service areas CBOs, LCHP Committees and beneficiaries from hot spot locations to strategize on ways to recruit target population.LCHP will explore use of community champions to distribute information regarding available services to area food pantries, religious organizations and other agencies that offer services to those facing financial hardships and to network with community residents to raise awareness of available servicesRisk:Contracts with insurance companiesMitigation:Sharing of patient registries to connect with UI/LU/NU will be essential to success DSRIP.CBOs are committed to working with recipients and insurance companies to connect patients to clinical service providersRisk:Contract negotiation with MCOsMitigation:In order to negotiate contracts with MCOs, there is a need to combine efforts across project teams within LCHP PPS and across PPSs to strengthen and consolidate message and make patient care in DSRIP projects Risk:Partner EngagementMitigation:Some LCHP Partners, who are deemed essential, have not been engaged in planning projects due to ambiguity in funds flow, uncertainty of contribution to project requirements, lack of designated resources to engage in planning and execution, etc. LCHP Operations Team will confirm current partner involvement in projects, reach out to partners who are deemed essential, and complete a funds flow model to better inform their involvement. Regular updates to partners through email, project and all partner meetings, and utilization of tools such as website, Constant Contact, survey tools, Health Workforce NY, etc. are some strategies

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	6,518

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
57	159	24.39%	493	2.44%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (652)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
amyvk	Rosters	22_PMDL3615_1_3_20160122131100_RosterPAMActivelyEngagedDY1Q3.pdf	Bassett Medical Center 2di (PAM) Actively Engaged Patient Roster DY1Q3	01/22/2016 01:11 PM

Narrative Text :

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

Please note any items where name or date of birth (DOB) is blank means we do not have that information from that institution for that patient. We have at a minimum the CIN# as required by the State for each unique patient. List is de-duplicated (unique pts)

Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its actively engaged commitments for DY1Q3. The documentation does not support the reported actively engaged numbers.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	Project	N/A	In Progress	06/01/2015	06/30/2016	06/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.	Project		In Progress	06/01/2015	06/30/2016	06/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1. Draft Intake Agency Contract	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2. Identify Phase I Agency Hot Spots to Pilot	Project		Completed	06/01/2015	03/31/2016	06/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Identify Phase II Agency Hot Spots	Project		In Progress	06/01/2015	06/30/2016	06/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Patient Activation Measure(R) (PAM(R)) training team established.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1. Identify trainer (Insignia)	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Identify staff to train	Project		Completed	04/01/2015	08/01/2015	04/01/2015	08/01/2015	09/30/2015	DY1 Q2
Task 3. Conduct training	Project		Completed	07/01/2015	08/30/2015	07/01/2015	08/30/2015	09/30/2015	DY1 Q2
Task 4. Develop training curriculum for train the trainer.	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task	Project		Not Started	03/31/2016	06/30/2016	03/31/2016	06/30/2016	06/30/2016	DY2 Q1

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
5. Roll out training to Phase II agencies									
Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	Project	N/A	In Progress	06/01/2015	06/30/2016	06/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.	Project		In Progress	06/01/2015	06/30/2016	06/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1. Create list of Phase I and Phase II hot spots - Herkimer, Otsego and Schoharie	Project		Completed	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Develop referral/intake contracts with CBO's to perform outreach at hot spot locations	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.	Project	N/A	Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Community engagement forums and other information-gathering mechanisms established and performed.	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 1. Develop subcommittee to develop survey tool	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task "2. Brainstorm with committee how to best meet this measure, based on a Community Needs Assessment. Based on brainstorming, develop a community engagement plan. Develop survey tool (barriers to healthcare, what do you need that you are lacking, etc.)"	Project		Not Started	03/31/2016	12/31/2016	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	Project	N/A	In Progress	09/01/2015	12/31/2015	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".	Project		In Progress	09/01/2015	12/31/2015	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1. Develop training schedule	Project		Completed	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Implement PAM Assessment and CFA	Project		In Progress	10/01/2015	12/31/2015	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

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.	Project	N/A	In Progress	09/21/2015	12/31/2016	09/21/2015	12/31/2016	12/31/2016	DY2 Q3
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	09/21/2015	12/31/2016	09/21/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1. Contracting with MCO's for information exchange across PPS (Fidelis, CDPHP, Excelllus) to obtain patient lists for NU and LU	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 2. Develop process and procedure to reconnect patients to their PCP's	Project		In Progress	09/21/2015	12/31/2015	09/21/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	Project	N/A	In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1. Develop cohort methodology and intervals as defined by state	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
(? Salient data)									
Milestone #8 Include beneficiaries in development team to promote preventive care.	Project	N/A	Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 1. Recruit beneficiaries to Committee by use of the survey	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 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.	Project	N/A	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement									
Task 1. Develop PAM reports	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 2. Run PAM reports for annual reports	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	Project	N/A	Not Started	06/30/2016	06/30/2017	06/30/2016	06/30/2017	06/30/2017	DY3 Q1
Task Volume of non-emergent visits for UI, NU, and LU populations increased.	Project		Not Started	06/30/2016	06/30/2017	06/30/2016	06/30/2017	06/30/2017	DY3 Q1
Task 1. Develop baseline of UI, NU, LU	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task 2. Develop relationships with primary care, behavioral and dental providers to increase the volume of non-emergent visits.	Project		Not Started	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 3. Provide support to patients where possible to receive preventitive services (encouraging the patient and PCP relationship)	Project		Not Started	10/01/2016	06/30/2017	10/01/2016	06/30/2017	06/30/2017	DY3 Q1
Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Community navigators identified and contracted.	Provider	PAM(R) Providers	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

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	Provider	PAM(R) Providers	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1. Connect with Health Insurance Navigator Services, collaborate with other resources such as 211--First Call for Help	Project		Not Started	03/28/2016	06/30/2016	03/28/2016	06/30/2016	06/30/2016	DY2 Q1
Task 2. Invite Health Insurance Navigators to sit on committee	Project		Not Started	03/28/2016	06/30/2016	03/28/2016	06/30/2016	06/30/2016	DY2 Q1
Task 3. Have Navigators trained in Health Insurance enrollment	Project		In Progress	04/01/2015	12/30/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4. Develop master list of navigators trained in health insurance enrollment to add to resource guide.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	Project	N/A	In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Policies and procedures for customer service complaints and appeals developed.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1. Create a greviance policy for providers and participants	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	Project	N/A	In Progress	06/01/2015	06/30/2016	06/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task List of community navigators formally trained in the PAM(R).	Provider	PAM(R) Providers	In Progress	08/20/2015	06/30/2016	08/20/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1. Conduct PAM training using external consultant (Insignia)	Project		Completed	06/01/2015	08/30/2015	06/01/2015	08/30/2015	09/30/2015	DY1 Q2
Task 2. Develop workflow, process and procedure	Project		In Progress	08/20/2015	12/31/2015	08/20/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3. Train navigators in PAM	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
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	Project	N/A	In Progress	06/01/2015	12/30/2015	06/01/2015	06/30/2016	06/30/2016	DY2 Q1

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	06/01/2015	12/30/2015	06/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1. Create list of hot spots - Herkimer, Otsego and Schoharie	Project		Completed	06/01/2015	12/30/2015	06/01/2015	12/30/2015	12/31/2015	DY1 Q3
Task 2. Develop workflow, process and procedure	Project		In Progress	08/20/2015	12/30/2015	08/20/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3. Develop referral/intake form	Project		In Progress	09/01/2015	12/30/2015	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
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	06/30/2016	06/30/2016	DY2 Q1
Task 1. Identify existing navigator resources to determine additional needs.	Project		Completed	04/01/2015	12/30/2015	04/01/2015	12/30/2015	12/31/2015	DY1 Q3
Task 2. Train/Certify Navigator to enroll through the NYS of Health Marketplace	Project		In Progress	11/02/2015	06/30/2016	11/02/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3. Utilize Navigators already trained (Bassett Health Insurance Navigators, Partnering Agency Navigators)	Project		In Progress	04/01/2015	12/30/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Timely access for navigator when connecting members to services.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1. Develop relationships with primary care, behavioral and dental providers.	Project		In Progress	11/01/2015	06/30/2016	11/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2. Add PCP to committee roster	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #17 Perform population health management by actively using EHRs	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

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.									
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Work with Health Home vendor (Netsmart) to build out Care Manager to accommodate DSRIP needs	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2. Determine criteria and metrics for counting/tracking patient engagement--EHR data, encounter data, INTERACT tool usage, etc.	Project		Completed	07/01/2015	08/15/2015	07/01/2015	08/15/2015	09/30/2015	DY1 Q2
Task 3. Evaluate existing capability for EHR patient engagement tracking	Project		Completed	08/15/2015	08/30/2015	08/15/2015	08/30/2015	09/30/2015	DY1 Q2
Task 4. Identify technology enhancements/upgrades needed to count/track patient engagement	Project		Completed	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 5. Implement technology enhancements/upgrades needed to count/track patient engagement	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 6. Identify workflow impact due to new technology, document new workflow	Project		Not Started	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 7. Train staff on technology and workflow	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.										
Task Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 1. Draft Intake Agency Contract										
Task 2. Identify Phase I Agency Hot Spots to Pilot										
Task 3. Identify Phase II Agency Hot Spots										
Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.										
Task Patient Activation Measure(R) (PAM(R)) training team established.										
Task 1. Identify trainer (Insignia)										
Task 2. Identify staff to train										
Task 3. Conduct training										
Task 4. Develop training curriculum for train the trainer.										
Task 5. Roll out training to Phase II agencies										
Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.										
Task Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.										
Task 1. Create list of Phase I and Phase II hot spots - Herkimer, Otsego and Schoharie										
Task 2. Develop referral/intake contracts with CBO's to perform outreach at hot spot locations										
Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.										
Task Community engagement forums and other information-gathering mechanisms established and performed.										
Task 1. Develop subcommittee to develop survey tool										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task "2. Brainstorm with committee how to best meet this measure, based on a Community Needs Assessment. Based on brainstorming, develop a community engagement plan. Develop survey tool (barriers to healthcare, what do you need that you are lacking, etc.)"										
Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.										
Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".										
Task 1. Develop training schedule										
Task 2. Implement PAM Assessment and CFA										
Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.										
Task Procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.										
Task 1. Contracting with MCO's for information exchange across PPS (Fidelis, CDPHP, Excelllus) to obtain patient lists for NU and LU										
Task 2. Develop process and procedure to reconnect patients to their PCP's										
Milestone #7										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.										
Task For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).										
Task 1. Develop cohort methodology and intervals as defined by state (? Salient data)										
Milestone #8 Include beneficiaries in development team to promote preventive care.										
Task Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.										
Task 1. Recruit beneficiaries to Committee by use of the survey										
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										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.										
Task Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement										
Task 1. Develop PAM reports										
Task 2. Run PAM reports for annual reports										
Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.										
Task Volume of non-emergent visits for UI, NU, and LU populations increased.										
Task 1. Develop baseline of UI, NU, LU										
Task 2. Develop relationships with primary care, behavioral and dental providers to increase the volume of non-emergent visits.										
Task 3. Provide support to patients where possible to receive preventitive services (encouraging the patient and PCP relationship)										
Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.										
Task Community navigators identified and contracted.	0	0	0	0	27	27	27	27	27	27

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	0	0	0	0	27	27	27	27	27	27
Task 1. Connect with Health Insurance Navigator Services, collaborate with other resources such as 211--First Call for Help										
Task 2. Invite Health Insurance Navigators to sit on committee										
Task 3. Have Navigators trained in Health Insurance enrollment										
Task 4. Develop master list of navigators trained in health insurance enrollment to add to resource guide.										
Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.										
Task Policies and procedures for customer service complaints and appeals developed.										
Task 1. Create a greviance policy for providers and participants										
Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).										
Task List of community navigators formally trained in the PAM(R).	0	0	0	0	27	27	27	27	27	27
Task 1. Conduct PAM training using external consultant (Insignia)										
Task 2. Develop workflow, process and procedure										
Task 3. Train navigators in PAM										
Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.										
Task Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.	0	0	0	0	27	27	27	27	27	27
Task										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
1. Create list of hot spots - Herkimer, Otsego and Schoharie										
Task 2. Develop workflow, process and procedure										
Task 3. Develop referral/intake form										
Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.										
Task Navigators educated about insurance options and healthcare resources available to populations in this project.										
Task 1. Identify existing navigator resources to determine additional needs.										
Task 2. Train/Certify Navigator to enroll through the NYS of Health Marketplace										
Task 3. Utilize Navigators already trained (Bassett Health Insurance Navigators, Partnering Agency Navigators)										
Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.										
Task Timely access for navigator when connecting members to services.										
Task 1. Develop relationships with primary care, behavioral and dental providers.										
Task 2. Add PCP to committee roster										
Milestone #17 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task 1. Work with Health Home vendor (Netsmart) to build out Care Manager to accommodate DSRIP needs										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 2. Determine criteria and metrics for counting/tracking patient engagement--EHR data, encounter data, INTERACT tool usage, etc.										
Task 3. Evaluate existing capability for EHR patient engagement tracking										
Task 4. Identify technology enhancements/upgrades needed to count/track patient engagement										
Task 5. Implement technology enhancements/upgrades needed to count/track patient engagement										
Task 6. Identify workflow impact due to new technology, document new workflow										
Task 7. Train staff on technology and workflow										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.										
Task Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.										
Task 1. Draft Intake Agency Contract										
Task 2. Identify Phase I Agency Hot Spots to Pilot										
Task 3. Identify Phase II Agency Hot Spots										
Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.										
Task Patient Activation Measure(R) (PAM(R)) training team established.										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 1. Identify trainer (Insignia)										
Task 2. Identify staff to train										
Task 3. Conduct training										
Task 4. Develop training curriculum for train the trainer.										
Task 5. Roll out training to Phase II agencies										
Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.										
Task Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.										
Task 1. Create list of Phase I and Phase II hot spots - Herkimer, Otsego and Schoharie										
Task 2. Develop referral/intake contracts with CBO's to perform outreach at hot spot locations										
Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.										
Task Community engagement forums and other information-gathering mechanisms established and performed.										
Task 1. Develop subcommittee to develop survey tool										
Task "2. Brainstorm with committee how to best meet this measure, based on a Community Needs Assessment. Based on brainstorming, develop a community engagement plan. Develop survey tool (barriers to healthcare, what do you need that you are lacking, etc.)"										
Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.										
Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 1. Develop training schedule										
Task 2. Implement PAM Assessment and CFA										
Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.										
Task Procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.										
Task 1. Contracting with MCO's for information exchange across PPS (Fidelis, CDPHP, Excelllus) to obtain patient lists for NU and LU										
Task 2. Develop process and procedure to reconnect patients to their PCP's										
Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.										
Task For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).										
Task 1. Develop cohort methodology and intervals as defined by state (? Salient data)										
Milestone #8										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Include beneficiaries in development team to promote preventive care.										
Task Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.										
Task 1. Recruit beneficiaries to Committee by use of the survey										
Milestone #9 Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.										
Task Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
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 1. Develop PAM reports										
Task 2. Run PAM reports for annual reports										
Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.										
Task Volume of non-emergent visits for UI, NU, and LU populations increased.										
Task 1. Develop baseline of UI, NU, LU										
Task 2. Develop relationships with primary care, behavioral and dental providers to increase the volume of non-emergent visits.										
Task 3. Provide support to patients where possible to receive preventitive services (encouraging the patient and PCP relationship)										
Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.										
Task Community navigators identified and contracted.	27	27	27	27	27	27	27	27	27	27
Task Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	27	27	27	27	27	27	27	27	27	27
Task 1. Connect with Health Insurance Navigator Services, collaborate with other resources such as 211--First Call for Help										
Task 2. Invite Health Insurance Navigators to sit on committee										
Task 3. Have Navigators trained in Health Insurance enrollment										
Task 4. Develop master list of navigators trained in health insurance										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
enrollment to add to resource guide.										
Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.										
Task Policies and procedures for customer service complaints and appeals developed.										
Task 1. Create a greviance policy for providers and participants										
Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).										
Task List of community navigators formally trained in the PAM(R).	27	27	27	27	27	27	27	27	27	27
Task 1. Conduct PAM training using external consultant (Insignia)										
Task 2. Develop workflow, process and procedure										
Task 3. Train navigators in PAM										
Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.										
Task Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.	27	27	27	27	27	27	27	27	27	27
Task 1. Create list of hot spots - Herkimer, Otsego and Schoharie										
Task 2. Develop workflow, process and procedure										
Task 3. Develop referral/intake form										
Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.										
Task Navigators educated about insurance options and healthcare resources available to populations in this project.										
Task 1. Identify existing navigator resources to determine additional										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
needs.										
Task 2. Train/Certify Navigator to enroll through the NYS of Health Marketplace										
Task 3. Utilize Navigators already trained (Bassett Health Insurance Navigators, Partnering Agency Navigators)										
Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.										
Task Timely access for navigator when connecting members to services.										
Task 1. Develop relationships with primary care, behavioral and dental providers.										
Task 2. Add PCP to committee roster										
Milestone #17 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task 1. Work with Health Home vendor (Netsmart) to build out Care Manager to accommodate DSRIP needs										
Task 2. Determine criteria and metrics for counting/tracking patient engagement--EHR data, encounter data, INTERACT tool usage, etc.										
Task 3. Evaluate existing capability for EHR patient engagement tracking										
Task 4. Identify technology enhancements/upgrades needed to count/track patient engagement										
Task 5. Implement technology enhancements/upgrades needed to count/track patient engagement										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 6. Identify workflow impact due to new technology, document new workflow										
Task 7. Train staff on technology and workflow										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	
Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	
Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	
Survey the targeted population about healthcare needs in the PPS' region.	
Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	DY1Q3-Initial training was completed for 20+ individuals, and PAM assessment have begun at one agency thus far. This agency is trialing work flows to roll out to other Phase I agencies. 5 additional Phase I agencies will begin to conduct PAM assessments after they have been trained via train the trainer method. Due to delays in development of workflow developed and contracts not being executed with CBO's, this milestone will be pushed out from 12/31/15 to 6/30/16. This will allow the Phase I agencies to trial the workflows, test the caseloads and develop standardized train the trainer curriculum.
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	DY1Q3-NU and LU lists have not yet been obtained. This requirement indicates that we will be receiving a list of NU and LU by MCO's; however, there has been no indication from MCO's that they are planning to do this. Work around will be to ask individuals if they have a PCP. If yes, then re-connect that individual to their PCP. If not, then establish with a PCP. As a result, the estimated completion date of some tasks in this section will need to be extended.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	
Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	
Include beneficiaries in development team to promote preventive care.	
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.	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
• 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.	
Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	
Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	DY1Q3-Staffing and Training work group have been established. Some navigators have been trained in health insurance enrollment, but this task will be ongoing until 3/31/2016.
Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	
Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	DY1Q3-Insignia trained initial individuals from agencies. Staffing/Training work group is developing standardized training for train the trainer. Process work group is developing screening and workflows processes to use with Phase I agencies initially. This task needs to be pushed out from 12/31/15 to 6/30/16 in order to have ample time to trial workflows.
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.	DY1Q3-Workflows will be trialed with Phase I agencies and will not be fully rolled out until at least 6/30/16. There was an error in estimated completion date for several tasks in this section so the milestone needs to be pushed from 12/31/15 to 6/30/16.
Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	DY1Q3-Full utilization of already trained navigators has not yet occurred so that task date will be extended until 3/31/2016.
Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	

Milestone Review Status

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

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
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	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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.

Risk: LCHP considers staff recruitment to be its main challenge in implementing Project 3.a.i. Under the integrated care model, licensed behavioral health professionals (NPs, RNs, and LCSWs) and behavioral health navigators will share many patient care responsibilities with physicians as team members. Recruitment of RNs and LCSWs is currently an obstacle; behavioral health navigator is a new position.
Mitigation: A Workforce Committee has been assembled to identify all project workforce requirements, develop recruitment and retention strategies, develop certificate programs with local colleges, and provide staff training programs. LCHP partners are experienced in effectively responding to rural workforce challenges and will work collectively to develop innovative regional strategies.

Risk: Smaller organizations do not have IT staff available to accomplish needed requirements.
Mitigation: LCHP is assessing IT needs for all projects to meet all requirements, and performing a gap analysis not only for functionality but for staffing as well, and expects to provide needed support for these organizations.

Risk: Technology analysis includes identifying interconnectivity gaps as well as ensuring HIPAA privacy requirements for mental/behavioral health and PHI are in full compliance while still meeting information-sharing needs. Because there is not a common IT platform across LCHP partners, the challenge presented by this will be identified in the gap analysis and addressed with specific plans to fill the gap. In addition, information sharing continues to be a logistical challenge, as regulations preclude primary care and behavioral health providers being able to share essential information, with a need to "break the glass". There is also a need to identify specific information to be shared, such as historical or just forward, to include medications, documentation of visit being completed and/or more. This challenge presents a barrier to fully completing project requirements.
Mitigation: We continue to pursue resolution through collaboration in a voice with other PPSs and with appropriate government representatives. A corresponding need will be to educate patients about inappropriate information sharing as an essential part of their care.

Risk: The costs and amount of time to achieve PCMH recognition and interoperability at all sites will be challenging. Many primary care practices will be implementing EHRs, pursuing PCMH recognition, and implementing the project concurrently. Fortunately, most of these are affiliated with Bassett, which has implemented an EHR and achieved 2011 level 3 PCMH recognition at its sites. The County mental health clinics utilize different EHRs, which will make it difficult to electronically exchange data with PCPs.
Mitigation: Bassett will provide the necessary IT and clinical support to practices implementing an EHR and pursuing PCMH. Most project sites currently submit patient-level data to a RHIO. The LCHP ITDAC Committee will assist the remaining sites to join a RHIO and work with them to develop interconnectivity and HIE.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	13,009

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
2,608	3,372	60.28%	2,222	25.92%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (5,594)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
amyvk	Rosters	22_PMDL3715_1_3_20160120085247_BassettPPS3aiActivelyEngagedRosterDY1Q3.pdf	Bassett PPS 3ai Actively Engaged Patient Roster DY1Q3	01/20/2016 08:53 AM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Model 1	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Behavioral health services are co-located within PCMH/APC practices and are available.		Provider	Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Identify existing co-location models within and outside the PPS to serve PPS population		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 2. Identify primary care practices who are potential for co-locating (and who are Level 3 certified/in process of being certified by DY3); include mental health clinics for mental health screening or co-locating mental health practices		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 3. Develop a readiness/interest survey for identified primary care practices and mental health sites, and the behavioral health services that can be integrated		Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 4. Identify site prospects and negotiate agreements with interested primary care practices and mental health sites, to determine co-location services and other arrangements		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 5. Research regulations to ensure behavioral health		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

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
services can be provided/billed within primary care practice sites; identify where waivers are needed										
Task 6. Develop staffing model (including recruitment and retention) for co-located behavioral health services		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 7. Recruit behavioral health staff for co-location sites; monitor staffing and adjust as needed		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 8. Design and develop warm handoff processes, including technical solutions		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 1	Project	N/A	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 1. Identify stakeholders and subject matter experts (SMEs) to participate in standards of care development (include education on DSRIP initiative for primary care providers)		Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 2. Meet with primary care providers to determine what works best for them		Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 3. Identify existing models of care within the PPS (to leverage them)		Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 4. Meet with stakeholders/SMEs to develop an implementation plan for the desired evidence-based approach		Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 5. Identify existing evidence-based standards of care and		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
models										
Task 6. Meet with stakeholders/SMEs to develop an implementation plan for the desired evidence-based approach		Project		Not Started	06/01/2016	03/31/2017	06/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7. Select a standard evidence-based protocol (including med mgmt and care engt) for all Partners to use; reflect ambulatory detox referral protocols where appropriate		Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 8. Identify metrics to monitor effectiveness of protocol		Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 9. Each Partner customized implementation plan for the desired evidence-based approach		Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 10. Monitor protocol implementation, adjust as needed, to achieve desired outcomes		Project		Not Started	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	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	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Screenings are documented in Electronic Health Record.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 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	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Identify screeners in identified sites for co-location		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

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 2. Train trainers at selected sites on SBIRT and availability of ambulatory detox and hospice programs		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3. Train screeners at all sites/providers on PHQ and availability of ambulatory detox and hospice programs		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4. Identify tools (EHR, etc.) to track screening data		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5. Identify screening frequency, identify customized screenings for special patient populations		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6. Develop/update procedures related to conducting preventive care screenings		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 7. Examine EHR for SBIRT screening documentation current capability		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 8. Identify SBIRT screening requirements		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 9. Identify technology additions/updates needed to accommodate SBIRT screenings (includes hardware such as Tablets)		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 10. Examine EHR for PHQ screening documentation current capability		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 11. Identify PHQ screening requirements		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 12. Identify technology additions/updates needed to accommodate PHQ screenings (includes hardware such as Tablets)		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 13. Develop/update method to identify patients eligible for screenings (e.g., reports to filter for patients meeting criteria that indicates need for screening; flag chart if needed)		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task		Project		Not Started	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
14. Develop reporting tools and report results										
Task 15. Identify criteria for "positive screening", alert provider (nurse/Care Coordinator and Patient Navigator) (develop an alert mechanism); identify criteria for ""warm transfer"" to begin withdrawal treatment Is Health-home referral 'warm hand-off'?		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 16. Define "warm transfer" process based on location; define process accordingly		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 17. Define communication/ technology to achieve "warm transfer"		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 18. Case Manager reaches out and sets up appointments, works with Care Navigators if available, assists with breaking down barriers such as lack of patient transportation		Project		Not Started	06/01/2016	03/31/2018	06/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 19. Partner develops a referral tracking process to monitor follow-up activity and consult notes returned to Partner; if not followed-up on, Partner develops a process to reach out to service provider and patient as needed, referring to Navigator services if available		Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 1	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		In Progress	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Survey Partners to determine current capability of integrating medical and behavioral health records		Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2. For Partners with potential capability to integrate		Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
medical and behavioral health records, identify where systems need to be enhanced to adequately integrate										
Task 3. Determine criteria and metrics for counting/tracking patient engagement		Project		Completed	07/01/2015	08/15/2015	07/01/2015	08/15/2015	09/30/2015	DY1 Q2
Task 4. Evaluate existing capability for EHR patient engagement tracking		Project		Completed	08/15/2015	08/31/2015	08/15/2015	08/31/2015	09/30/2015	DY1 Q2
Task 5. Identify technology enhancements/upgrades needed to count/track patient engagement		Project		Completed	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 6. Implement technology enhancements/upgrades needed to count/track patient engagement		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 7. Identify workflow impact due to new technology, document new workflow		Project		Not Started	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 8. Train staff on technology and workflow		Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Co-locate primary care services at behavioral health sites.	Model 2	Project	N/A	In Progress	09/01/2015	06/30/2017	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	09/01/2015	06/30/2016	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Practitioner - Primary Care Provider (PCP)	Not Started	07/01/2016	06/30/2017	07/01/2016	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	Not Started	07/01/2016	06/30/2017	07/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task 1. Identify existing co-location models within and outside the PPS to serve PPS population		Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Identify primary care practices who are potential for co-locating; include mental health clinics for mental health screening or co-locating mental health practices		Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 3. Develop a readiness/interest survey for identified primary care practices and mental health sites, and the behavioral health services that can be integrated		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 4. Negotiate agreements with interested primary care practices and mental health sites, to determine co-location services and other arrangements		Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 5. Research regulations to ensure primary care services can be provided/billed within mental health practice sites		Project		Not Started	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 6. Develop staffing model (including recruitment and retention) for co-located primary care services		Project		Not Started	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 7. Recruit primary care health staff for co-location sites; monitor staffing and adjust as needed		Project		Not Started	10/01/2016	06/30/2017	10/01/2016	06/30/2017	06/30/2017	DY3 Q1
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 2	Project	N/A	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 1. Identify stakeholders and subject matter experts (SMEs) to participate in standards of care development (include education on DSRIP initiative for primary care providers)		Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 2. Meet with primary care providers to determine what works best for them		Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 3. Identify existing models of care within the PPS (to leverage them)		Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 4. Meet with stakeholders/SMEs to develop an implementation plan for the desired evidence-based approach		Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 5. Identify existing evidence-based standards of care and models		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. Meet with stakeholders/SMEs to develop an implementation plan for the desired evidence-based approach		Project		Not Started	06/01/2016	03/31/2017	06/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7. Select a standard evidence-based protocol (including med mgmt and care engt) for all Partners to use; reflect ambulatory detox referral protocols where appropriate		Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 8. Identify metrics to monitor effectiveness of protocol		Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 9. Each Partner customized implementation plan for the desired evidence-based approach		Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 10. Monitor protocol implementation, adjust as needed, to achieve desired outcomes		Project		Not Started	12/31/2016	03/31/2017	12/31/2016	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.	Model 2	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 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	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Screenings are documented in Electronic Health Record.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as		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

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Identify screeners in identified sites for co-location		Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 2. Train trainers at selected sites on SBIRT and availability of ambulatory detox and hospice programs		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3. Train screeners at all sites/providers on PHQ and availability of ambulatory detox and hospice programs		Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 4. Identify tools (EHR, etc.) to track screening data		Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 5. Identify screening frequency, identify customized screenings for special patient populations		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6. Develop/update procedures related to conducting preventive care screenings		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 7. Examine EHR for SBIRT screening documentation current capability		Project		Not Started	10/01/2015	06/30/2016	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 8. Identify SBIRT screening requirements		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 9. Identify technology additions/updates needed to accommodate SBIRT screenings (includes hardware such as Tablets)		Project		Not Started	10/01/2015	06/30/2016	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 10. Examine EHR for PHQ screening documentation current capability		Project		Not Started	10/01/2015	12/31/2015	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 11. Identify PHQ screening requirements		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 12. Identify technology additions/updates needed to		Project		Not Started	10/01/2015	12/31/2015	07/01/2016	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
accommodate PHQ screenings (includes hardware such as Tablets)										
Task 13. Develop/update method to identify patients eligible for screenings (e.g., reports to filter for patients meeting criteria that indicates need for screening; flag chart if needed)		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 14. Develop reporting tools and report results		Project		Not Started	01/01/2016	12/31/2017	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 15. Identify criteria for ""positive screening"", alert provider (nurse/Care Coordinator and Patient Navigator) (develop an alert mechanism); identify criteria for ""warm transfer"" to begin withdrawal treatment Is Health-home referral 'warm hand-off'?		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 16. Define "warm transfer" process based on location; define process accordingly		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 17. Define communication/technology to achieve "warm transfer"		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 18. Case Manager reaches out and sets up appointments, works with Care Navigators if available, assists with breaking down barriers such as lack of patient transportation		Project		Not Started	06/01/2016	03/31/2018	06/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 19. Partner develops a referral tracking process to monitor follow-up activity and consult notes returned to Partner; if not followed-up on, Partner develops a process to reach out to service provider and patient as needed, referring to Navigator services if available		Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 2	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral		Project		In Progress	09/01/2015	06/30/2016	09/01/2015	03/31/2017	03/31/2017	DY2 Q4

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Survey Partners to determine current capability of integrating medical and behavioral health records		Project		In Progress	09/01/2015	03/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 2. For Partners with potential capability to integrate medical and behavioral health records, identify where systems need to be enhanced to adequately integrate		Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 3. Determine criteria and metrics for counting/tracking patient engagement		Project		Completed	07/01/2015	08/15/2015	07/01/2015	08/15/2015	09/30/2015	DY1 Q2
Task 4. Evaluate existing capability for EHR patient engagement tracking		Project		Not Started	10/01/2015	06/30/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 5. Identify technology enhancements/upgrades needed to count/track patient engagement		Project		Not Started	10/01/2015	06/30/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 6. Implement technology enhancements/upgrades needed to count/track patient engagement		Project		Not Started	10/01/2015	12/31/2016	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task 7. Identify workflow impact due to new technology, document new workflow		Project		Not Started	10/01/2016	12/31/2016	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task 8. Train staff on technology and workflow		Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Implement IMPACT Model at Primary Care Sites.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has implemented IMPACT Model at Primary Care Sites.		Provider	Practitioner - Primary Care Provider (PCP)	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Policies and procedures include process for consulting with Psychiatrist.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a 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.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task All IMPACT participants in PPS have a designated Psychiatrist.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #13 Measure outcomes as required in the IMPACT Model.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #14 Provide "stepped care" as required by the IMPACT Model.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task In alignment with the IMPACT model, treatment is adjusted		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.										
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.	0	0	0	0	0	0	0	12	12	12
Task Behavioral health services are co-located within PCMH/APC practices and are available.	0	0	0	0	0	0	0	1	1	1
Task 1. Identify existing co-location models within and outside the PPS to serve PPS population										
Task 2. Identify primary care practices who are potential for co-locating (and who are Level 3 certified/in process of being certified by DY3); include mental health clinics for mental health screening or co-locating mental health practices										
Task 3. Develop a readiness/interest survey for identified primary care practices and mental health sites, and the behavioral health services that can be integrated										
Task 4. Identify site prospects and negotiate agreements with										

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
interested primary care practices and mental health sites, to determine co-location services and other arrangements										
Task 5. Research regulations to ensure behavioral health services can be provided/billed within primary care practice sites; identify where waivers are needed										
Task 6. Develop staffing model (including recruitment and retention) for co-located behavioral health services										
Task 7. Recruit behavioral health staff for co-location sites; monitor staffing and adjust as needed										
Task 8. Design and develop warm handoff processes, including technical solutions										
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices.										
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.										
Task 1. Identify stakeholders and subject matter experts (SMEs) to participate in standards of care development (include education on DSRIP initiative for primary care providers)										
Task 2. Meet with primary care providers to determine what works best for them										
Task 3. Identify existing models of care within the PPS (to leverage them)										
Task 4. Meet with stakeholders/SMEs to develop an implementation plan for the desired evidence-based approach										
Task 5. Identify existing evidence-based standards of care and models										
Task 6. Meet with stakeholders/SMEs to develop an implementation										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
plan for the desired evidence-based approach										
Task 7. Select a standard evidence-based protocol (including med mgmt and care engt) for all Partners to use; reflect ambulatory detox referral protocols where appropriate										
Task 8. Identify metrics to monitor effectiveness of protocol										
Task 9. Each Partner customized implementation plan for the desired evidence-based approach										
Task 10. Monitor protocol implementation, adjust as needed, to achieve desired outcomes										
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.										
Task Policies and procedures are in place to facilitate and document completion of screenings.										
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	0	0	0	0	0	0	0	12	12	12
Task 1. Identify screeners in identified sites for co-location										
Task 2. Train trainers at selected sites on SBIRT and availability of ambulatory detox and hospice programs										
Task 3. Train screeners at all sites/providers on PHQ and availability of ambulatory detox and hospice programs										
Task 4. Identify tools (EHR, etc.) to track screening data										
Task 5. Identify screening frequency, identify customized screenings for special patient populations										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 6. Develop/update procedures related to conducting preventive care screenings										
Task 7. Examine EHR for SBIRT screening documentation current capability										
Task 8. Identify SBIRT screening requirements										
Task 9. Identify technology additions/updates needed to accommodate SBIRT screenings (includes hardware such as Tablets)										
Task 10. Examine EHR for PHQ screening documentation current capability										
Task 11. Identify PHQ screening requirements										
Task 12. Identify technology additions/updates needed to accommodate PHQ screenings (includes hardware such as Tablets)										
Task 13. Develop/update method to identify patients eligible for screenings (e.g., reports to filter for patients meeting criteria that indicates need for screening; flag chart if needed)										
Task 14. Develop reporting tools and report results										
Task 15. Identify criteria for "positive screening", alert provider (nurse/Care Coordinator and Patient Navigator) (develop an alert mechanism); identify criteria for ""warm transfer"" to begin withdrawal treatment Is Health-home referral 'warm hand-off'?										
Task 16. Define "warm transfer" process based on location; define process accordingly										
Task 17. Define communication/ technology to achieve "warm transfer"										
Task 18. Case Manager reaches out and sets up appointments, works with Care Navigators if available, assists with breaking down barriers such as lack of patient transportation										
Task										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
19. Partner develops a referral tracking process to monitor follow-up activity and consult notes returned to Partner; if not followed-up on, Partner develops a process to reach out to service provider and patient as needed, referring to Navigator services if available										
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1. Survey Partners to determine current capability of integrating medical and behavioral health records										
Task 2. For Partners with potential capability to integrate medical and behavioral health records, identify where systems need to be enhanced to adequately integrate										
Task 3. Determine criteria and metrics for counting/tracking patient engagement										
Task 4. Evaluate existing capability for EHR patient engagement tracking										
Task 5. Identify technology enhancements/upgrades needed to count/track patient engagement										
Task 6. Implement technology enhancements/upgrades needed to count/track patient engagement										
Task 7. Identify workflow impact due to new technology, document new workflow										
Task 8. Train staff on technology and workflow										
Milestone #5 Co-locate primary care services at behavioral health sites.										
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.	0	0	0	0	174	174	174	174	174	174
Task	0	0	0	0	0	0	36	36	174	174

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Primary care services are co-located within behavioral Health practices and are available.										
Task Primary care services are co-located within behavioral Health practices and are available.	0	0	0	0	0	0	4	4	26	26
Task 1. Identify existing co-location models within and outside the PPS to serve PPS population										
Task 2. Identify primary care practices who are potential for co-locating; include mental health clinics for mental health screening or co-locating mental health practices										
Task 3. Develop a readiness/interest survey for identified primary care practices and mental health sites, and the behavioral health services that can be integrated										
Task 4. Negotiate agreements with interested primary care practices and mental health sites, to determine co-location services and other arrangements										
Task 5. Research regulations to ensure primary care services can be provided/billed within mental health practice sites										
Task 6. Develop staffing model (including recruitment and retention) for co-located primary care services										
Task 7. Recruit primary care health staff for co-location sites; monitor staffing and adjust as needed										
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.										
Task 1. Identify stakeholders and subject matter experts (SMEs) to participate in standards of care development (include education on DSRIP initiative for primary care providers)										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 2. Meet with primary care providers to determine what works best for them										
Task 3. Identify existing models of care within the PPS (to leverage them)										
Task 4. Meet with stakeholders/SMEs to develop an implementation plan for the desired evidence-based approach										
Task 5. Identify existing evidence-based standards of care and models										
Task 6. Meet with stakeholders/SMEs to develop an implementation plan for the desired evidence-based approach										
Task 7. Select a standard evidence-based protocol (including med mgmt and care engt) for all Partners to use; reflect ambulatory detox referral protocols where appropriate										
Task 8. Identify metrics to monitor effectiveness of protocol										
Task 9. Each Partner customized implementation plan for the desired evidence-based approach										
Task 10. Monitor protocol implementation, adjust as needed, to achieve desired outcomes										
Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.										
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.										
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task	0	0	0	0	0	0	0	12	31	31

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.										
Task 1. Identify screeners in identified sites for co-location										
Task 2. Train trainers at selected sites on SBIRT and availability of ambulatory detox and hospice programs										
Task 3. Train screeners at all sites/providers on PHQ and availability of ambulatory detox and hospice programs										
Task 4. Identify tools (EHR, etc.) to track screening data										
Task 5. Identify screening frequency, identify customized screenings for special patient populations										
Task 6. Develop/update procedures related to conducting preventive care screenings										
Task 7. Examine EHR for SBIRT screening documentation current capability										
Task 8. Identify SBIRT screening requirements										
Task 9. Identify technology additions/updates needed to accommodate SBIRT screenings (includes hardware such as Tablets)										
Task 10. Examine EHR for PHQ screening documentation current capability										
Task 11. Identify PHQ screening requirements										
Task 12. Identify technology additions/updates needed to accommodate PHQ screenings (includes hardware such as Tablets)										
Task 13. Develop/update method to identify patients eligible for screenings (e.g., reports to filter for patients meeting criteria that indicates need for screening; flag chart if needed)										
Task 14. Develop reporting tools and report results										
Task										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
15. Identify criteria for ""positive screening"", alert provider (nurse/Care Coordinator and Patient Navigator) (develop an alert mechanism); identify criteria for ""warm transfer"" to begin withdrawal treatment Is Health-home referral 'warm hand-off'?										
Task 16. Define "warm transfer" process based on location; define process accordingly										
Task 17. Define communication/technology to achieve "warm transfer"										
Task 18. Case Manager reaches out and sets up appointments, works with Care Navigators if available, assists with breaking down barriers such as lack of patient transportation										
Task 19. Partner develops a referral tracking process to monitor follow-up activity and consult notes returned to Partner; if not followed-up on, Partner develops a process to reach out to service provider and patient as needed, referring to Navigator services if available										
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1. Survey Partners to determine current capability of integrating medical and behavioral health records										
Task 2. For Partners with potential capability to integrate medical and behavioral health records, identify where systems need to be enhanced to adequately integrate										
Task 3. Determine criteria and metrics for counting/tracking patient engagement										
Task 4. Evaluate existing capability for EHR patient engagement tracking										
Task 5. Identify technology enhancements/upgrades needed to count/track patient engagement										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 6. Implement technology enhancements/upgrades needed to count/track patient engagement										
Task 7. Identify workflow impact due to new technology, document new workflow										
Task 8. Train staff on technology and workflow										
Milestone #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	0	0	0	0	0	0	0	0	0	0
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.										
Task Policies and procedures include process for consulting with Psychiatrist.										
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.										
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.										
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Milestone #13 Measure outcomes as required in the IMPACT Model.										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Milestone #14 Provide "stepped care" as required by the IMPACT Model.										
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.										
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.	150	174	174	174	174	174	174	174	174	174
Task Behavioral health services are co-located within PCMH/APC practices and are available.	1	26	26	26	26	26	26	26	26	26
Task 1. Identify existing co-location models within and outside the PPS to serve PPS population										
Task 2. Identify primary care practices who are potential for co-locating (and who are Level 3 certified/in process of being certified by DY3); include mental health clinics for mental health screening or co-locating mental health practices										
Task 3. Develop a readiness/interest survey for identified primary care										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
practices and mental health sites, and the behavioral health services that can be integrated										
Task 4. Identify site prospects and negotiate agreements with interested primary care practices and mental health sites, to determine co-location services and other arrangements										
Task 5. Research regulations to ensure behavioral health services can be provided/billed within primary care practice sites; identify where waivers are needed										
Task 6. Develop staffing model (including recruitment and retention) for co-located behavioral health services										
Task 7. Recruit behavioral health staff for co-location sites; monitor staffing and adjust as needed										
Task 8. Design and develop warm handoff processes, including technical solutions										
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices.										
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.										
Task 1. Identify stakeholders and subject matter experts (SMEs) to participate in standards of care development (include education on DSRIP initiative for primary care providers)										
Task 2. Meet with primary care providers to determine what works best for them										
Task 3. Identify existing models of care within the PPS (to leverage them)										
Task 4. Meet with stakeholders/SMEs to develop an implementation plan for the desired evidence-based approach										
Task										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
5. Identify existing evidence-based standards of care and models										
Task 6. Meet with stakeholders/SMEs to develop an implementation plan for the desired evidence-based approach										
Task 7. Select a standard evidence-based protocol (including med mgmt and care engt) for all Partners to use; reflect ambulatory detox referral protocols where appropriate										
Task 8. Identify metrics to monitor effectiveness of protocol										
Task 9. Each Partner customized implementation plan for the desired evidence-based approach										
Task 10. Monitor protocol implementation, adjust as needed, to achieve desired outcomes										
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.										
Task Policies and procedures are in place to facilitate and document completion of screenings.										
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	150	174	174	174	174	174	174	174	174	174
Task 1. Identify screeners in identified sites for co-location										
Task 2. Train trainers at selected sites on SBIRT and availability of ambulatory detox and hospice programs										
Task 3. Train screeners at all sites/providers on PHQ and availability of ambulatory detox and hospice programs										
Task										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
4. Identify tools (EHR, etc.) to track screening data										
Task 5. Identify screening frequency, identify customized screenings for special patient populations										
Task 6. Develop/update procedures related to conducting preventive care screenings										
Task 7. Examine EHR for SBIRT screening documentation current capability										
Task 8. Identify SBIRT screening requirements										
Task 9. Identify technology additions/updates needed to accommodate SBIRT screenings (includes hardware such as Tablets)										
Task 10. Examine EHR for PHQ screening documentation current capability										
Task 11. Identify PHQ screening requirements										
Task 12. Identify technology additions/updates needed to accommodate PHQ screenings (includes hardware such as Tablets)										
Task 13. Develop/update method to identify patients eligible for screenings (e.g., reports to filter for patients meeting criteria that indicates need for screening; flag chart if needed)										
Task 14. Develop reporting tools and report results										
Task 15. Identify criteria for "positive screening", alert provider (nurse/Care Coordinator and Patient Navigator) (develop an alert mechanism); identify criteria for ""warm transfer"" to begin withdrawal treatment Is Health-home referral 'warm hand-off'?										
Task 16. Define "warm transfer" process based on location; define process accordingly										
Task 17. Define communication/ technology to achieve "warm transfer"										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 18. Case Manager reaches out and sets up appointments, works with Care Navigators if available, assists with breaking down barriers such as lack of patient transportation										
Task 19. Partner develops a referral tracking process to monitor follow-up activity and consult notes returned to Partner; if not followed-up on, Partner develops a process to reach out to service provider and patient as needed, referring to Navigator services if available										
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1. Survey Partners to determine current capability of integrating medical and behavioral health records										
Task 2. For Partners with potential capability to integrate medical and behavioral health records, identify where systems need to be enhanced to adequately integrate										
Task 3. Determine criteria and metrics for counting/tracking patient engagement										
Task 4. Evaluate existing capability for EHR patient engagement tracking										
Task 5. Identify technology enhancements/upgrades needed to count/track patient engagement										
Task 6. Implement technology enhancements/upgrades needed to count/track patient engagement										
Task 7. Identify workflow impact due to new technology, document new workflow										
Task 8. Train staff on technology and workflow										
Milestone #5										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Co-locate primary care services at behavioral health sites.										
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.	174	174	174	174	174	174	174	174	174	174
Task Primary care services are co-located within behavioral Health practices and are available.	174	174	174	174	174	174	174	174	174	174
Task Primary care services are co-located within behavioral Health practices and are available.	26	26	26	26	26	26	26	26	26	26
Task 1. Identify existing co-location models within and outside the PPS to serve PPS population										
Task 2. Identify primary care practices who are potential for co-locating; include mental health clinics for mental health screening or co-locating mental health practices										
Task 3. Develop a readiness/interest survey for identified primary care practices and mental health sites, and the behavioral health services that can be integrated										
Task 4. Negotiate agreements with interested primary care practices and mental health sites, to determine co-location services and other arrangements										
Task 5. Research regulations to ensure primary care services can be provided/billed within mental health practice sites										
Task 6. Develop staffing model (including recruitment and retention) for co-located primary care services										
Task 7. Recruit primary care health staff for co-location sites; monitor staffing and adjust as needed										
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement										

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
process.										
Task 1. Identify stakeholders and subject matter experts (SMEs) to participate in standards of care development (include education on DSRIP initiative for primary care providers)										
Task 2. Meet with primary care providers to determine what works best for them										
Task 3. Identify existing models of care within the PPS (to leverage them)										
Task 4. Meet with stakeholders/SMEs to develop an implementation plan for the desired evidence-based approach										
Task 5. Identify existing evidence-based standards of care and models										
Task 6. Meet with stakeholders/SMEs to develop an implementation plan for the desired evidence-based approach										
Task 7. Select a standard evidence-based protocol (including med mgmt and care engt) for all Partners to use; reflect ambulatory detox referral protocols where appropriate										
Task 8. Identify metrics to monitor effectiveness of protocol										
Task 9. Each Partner customized implementation plan for the desired evidence-based approach										
Task 10. Monitor protocol implementation, adjust as needed, to achieve desired outcomes										
Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.										
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.										
Task Screenings are documented in Electronic Health Record.										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	31	174	174	174	174	174	174	174	174	174
Task 1. Identify screeners in identified sites for co-location										
Task 2. Train trainers at selected sites on SBIRT and availability of ambulatory detox and hospice programs										
Task 3. Train screeners at all sites/providers on PHQ and availability of ambulatory detox and hospice programs										
Task 4. Identify tools (EHR, etc.) to track screening data										
Task 5. Identify screening frequency, identify customized screenings for special patient populations										
Task 6. Develop/update procedures related to conducting preventive care screenings										
Task 7. Examine EHR for SBIRT screening documentation current capability										
Task 8. Identify SBIRT screening requirements										
Task 9. Identify technology additions/updates needed to accommodate SBIRT screenings (includes hardware such as Tablets)										
Task 10. Examine EHR for PHQ screening documentation current capability										
Task 11. Identify PHQ screening requirements										
Task 12. Identify technology additions/updates needed to accommodate PHQ screenings (includes hardware such as Tablets)										
Task										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
13. Develop/update method to identify patients eligible for screenings (e.g., reports to filter for patients meeting criteria that indicates need for screening; flag chart if needed)										
Task 14. Develop reporting tools and report results										
Task 15. Identify criteria for ""positive screening"", alert provider (nurse/Care Coordinator and Patient Navigator) (develop an alert mechanism); identify criteria for ""warm transfer"" to begin withdrawal treatment Is Health-home referral 'warm hand-off'?										
Task 16. Define "warm transfer" process based on location; define process accordingly										
Task 17. Define communication/technology to achieve "warm transfer"										
Task 18. Case Manager reaches out and sets up appointments, works with Care Navigators if available, assists with breaking down barriers such as lack of patient transportation										
Task 19. Partner develops a referral tracking process to monitor follow-up activity and consult notes returned to Partner; if not followed-up on, Partner develops a process to reach out to service provider and patient as needed, referring to Navigator services if available										
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1. Survey Partners to determine current capability of integrating medical and behavioral health records										
Task 2. For Partners with potential capability to integrate medical and behavioral health records, identify where systems need to be enhanced to adequately integrate										
Task 3. Determine criteria and metrics for counting/tracking patient engagement										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 4. Evaluate existing capability for EHR patient engagement tracking										
Task 5. Identify technology enhancements/upgrades needed to count/track patient engagement										
Task 6. Implement technology enhancements/upgrades needed to count/track patient engagement										
Task 7. Identify workflow impact due to new technology, document new workflow										
Task 8. Train staff on technology and workflow										
Milestone #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	0	0	0	0	0	0	0	0	0	0
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.										
Task Policies and procedures include process for consulting with Psychiatrist.										
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.										
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.										
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.										
Milestone #12										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Designate a Psychiatrist meeting requirements of the IMPACT Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Milestone #13 Measure outcomes as required in the IMPACT Model.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Milestone #14 Provide "stepped care" as required by the IMPACT Model.										
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.										
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	
Develop collaborative evidence-based standards of care including medication management and care engagement process.	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	
Use EHRs or other technical platforms to track all patients engaged in this project.	
Co-locate primary care services at behavioral health sites.	Metric relating to achievement of NCQA Level 3 2014 standards is due end of DY3. Therefore the milestone date is pushed out to end of DY3.
Develop collaborative evidence-based standards of care including medication management and care engagement process.	
Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Task 7,9,10,12,13,14,15,16 some of the dates for determining EHR capabilities, technology additions, has been pushed out due to delay of determination of the Behavioral Health Sites. Tasks 13, 14,15,16 some of these dates to identify eligible patients, criteria for positive screening, and definitions of process has been pushed out due to a delay in determination of Behavioral Health Sites. Overall, this has created a disruption in the work flow for these specific sites processes.
Use EHRs or other technical platforms to track all patients engaged in this project.	Task 1 dates have been pushed out due to Behavioral Health Sites determination being delayed, survey template is currently being created, Task 4,5,6,7 dates have been pushed out for evaluating EHR capability, technology needs and implementation, as well as work flow impact and staff training on technology due to delay of choosing Behavioral Health Sites.
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 & Ongoing	
Milestone #3	Pass & Ongoing	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone Review Status

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

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project 3.a.iv – Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs

IPQR Module 3.a.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.

Risk: Not all partners have functioning EHRs, EHRs vary, or cannot inter-communicate; timing of EHR connectivity requirement to RHIO/HIE/SHIN-NY depends on SHIN-NY activation.
Mitigation: Standardize interoperability and data collection methods. Examine alternatives such as modifying strategy to accommodate SHIN-NY timeline changes. For partners without an EHR, IT/Data Analytics Committee to offer expertise, with primary focus on standardizing IT platform. For partners not currently submitting patient-level data to HIXNY or RHIO, ITDAC to share expertise to join RHIOs

Risk: Recruiting qualified substance abuse professionals is difficult in our rural region; currently, few physicians are board-certified as addictionologists in the region; is difficult to recruit other clinical and non-clinical staff.
Mitigation: Seek credentialed physician board-certified in addictionology to treat opiate and other substances; contract to serve our PPS counties until one can be recruited. Also encourage primary care physicians to become ex-license to prescribe buprenorphine in order to spread heavy volumes across more providers & reduce ER visits. Collaborative Learning Committee to develop staff recruitment & retention solutions to include collaboration with Conifer Park (recently opened ambulatory detox program, extensive staff recruitment network). Use Mohawk Valley Community College CASAC certificate program to increase CASAC supply, consolidate recruitment with 2 other DSRIP projects requiring substance abuse staff (3ai & 4aiii), use creative recruitment/retention strategies, e.g., incentives, to attract providers. Workforce impact consultant to work with Collaborative Learning Committee & partners, such as AHEC, for creative workforce strategies and for online and in-person training to retrain employees. Leverage AHEC's cross-PPS job opportunities. If needed, identify new/existing partners having needed resources so participating partners can contract with them instead of hiring new staff

Risk: Clinical decisions not based on research, data and best practice guidelines; training not clinically-focused.
Mitigation: Develop appropriate protocols, train staff.

Risk: Medical record systems do not reflect all data on patients or treatments; data not available to providers
Mitigation: Strengthen communication and reporting among providers to share essential information

Risk: Limited resources for developing materials and conducting training
Mitigation: Uuse economies of scale when training PPS staff using train-the-trainer model; will explore with other PPSs the possibility of shared training resources

Risk: Need to negotiate contracts w/ MCOs since many services are not reimbursed/under-reimbursed
Mitigation: To negotiate contracts with MCOs, need to combine efforts across project teams within the PPS and across PPSs to

strengthen/consolidate the message & sustain patient care in DSRIP projects

Risk: Practitioner Engagement—individual practitioners not committed to DSRIP activities
Mitigation: Clinical Performance Committee, with representation of different practitioner types, will create a comprehensive practitioner communication & engagement plan to engage practitioners in program initiatives. Leverage existing practitioner gatherings such as Primary Care Council, Regional Medical Director Group, Clinical Leadership Group as models for clinical integration & practitioner engagement in creating PPS-wide professional groups. Develop referral protocols; engage early adopters to engage additional practitioners; address physician capacity to handle volume of Suboxone pts.

Risk: Insufficient funds, especially for smaller organizations
Mitigation: Engage funding sources like Robert Wood Johnson Foundation; leverage PHIP (Pop Hlth Improvement Program) to assist in finding other funding sources; share work collaboratively w/ other organizations

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	4,243

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
30	120	96.00%	5	2.83%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (125)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
amyvk	Rosters	22_PMDL4015_1_3_20160125082552_Roster_3aiv_Ambulatory_Withdrawal_Mgmt_Actively_Engaged_DY1Q3.pdf	Bassett Medical Center Actively Engaged Roster 3aiv Ambulatory Withdrawal Management	01/25/2016 08:26 AM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Develop community-based addiction treatment programs that include outpatient SUD sites with PCP integrated teams, and stabilization services including social services.	Project	N/A	In Progress	07/01/2015	12/31/2017	07/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task PPS has developed community-based addiction treatment programs that include outpatient SUD sites, PCP integrated teams, and stabilization services.	Project		In Progress	07/01/2015	12/31/2017	07/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 1. Determine needs utilizing committee brainstorming and review of Community Needs Assessment	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Perform current state assessment re existing programs/scope	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Assess potential sites for ability to develop full program scope	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 4. For sites willing/able to expand or develop programs, identify sites where addictionologists are needed within the program at clinics	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 5. Reach out to Finger Lakes PPS and any other PPS who chose Ambulatory detox project for guidance on program development	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6. Adopt policies and protocols to support diagnoses and referrals by and to PCPs, including education	Project		In Progress	09/01/2015	12/31/2017	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 7. Engage primary care sites to adopt protocols for withdrawal management	Project		In Progress	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 8. Leverage Care Navigators to work with patients to support	Project		Not Started	01/01/2017	12/31/2017	01/01/2017	12/31/2017	12/31/2017	DY3 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
program follow-ups									
Milestone #2 Establish referral relationships between community treatment programs and inpatient detoxification services with development of referral protocols.	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 established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	Provider	Hospital	In Progress	07/01/2015	12/31/2015	10/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	Provider	Mental Health	In Progress	07/01/2015	12/31/2015	10/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	Provider	Substance Abuse	In Progress	07/01/2015	12/31/2015	10/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task Regularly scheduled formal meetings are held to develop collaborative care practices among community treatment programs as well as between community treatment programs and inpatient detoxification facilities.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Coordinated evidence-based care protocols are in place for community withdrawal management services. Protocols include referral procedures.	Project		In Progress	10/01/2015	12/31/2017	10/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 1. Identify existing community treatment programs inpatient detoxification service providers	Project		In Progress	07/01/2015	12/31/2015	10/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 2. Identify leader for collaboration program	Project		Completed	04/01/2015	04/30/2015	04/01/2015	04/30/2015	06/30/2015	DY1 Q1
Task 3. Establish group membership and charter, meeting schedule and agenda	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4. See #1 re adopt policies and protocols to support diagnoses	Project		In Progress	10/01/2015	12/31/2017	10/01/2015	12/31/2017	12/31/2017	DY3 Q3

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
and referrals by and to PCPs, including education; reflect referrals to Behavioral Health in protocols									
Task 5. Establish an integrated model for PCPs to refer patients	Project		In Progress	10/01/2015	12/31/2017	10/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 6. Collaborate on developing referral protocols per Medicaid reimbursement guidelines	Project		In Progress	10/01/2015	12/31/2017	10/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 7. Identify existing referral patterns from inpatient, ED, and community based organizations (department of mental health and LEAF) to ambulatory detox programs.	Project		In Progress	10/01/2015	12/31/2017	10/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 8. Develop work flows for referral process.	Project		In Progress	10/01/2015	12/31/2017	10/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 9. Working with collaborating partners, determine opportunities to transition detox treatment from "ED to inpatient" to "ED to outpatient" detox.	Project		In Progress	10/01/2015	12/31/2017	10/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 10. Provide education on ambulatory detox options and pathways to community agencies (e.g.-law enforcement, ED providers, and first responders)	Project		In Progress	10/01/2015	12/31/2017	10/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 11. Develop ED discharge plan that includes ambulatory detox referral where appropriate and warm hand off when possible.	Project		In Progress	10/01/2015	12/31/2017	10/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 12. Develop written agreements amongst collaborating partners where appropriate.	Project		In Progress	10/01/2015	12/31/2017	10/01/2015	12/31/2017	12/31/2017	DY3 Q3
Milestone #3 Include a project medical director, board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/naltrexone as well as familiarity with other withdrawal management agents.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has designated at least one qualified and certified physician with training and privileges for use of buprenorphine/Naltrexone and other withdrawal agents.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Create job description for Project Medical Director/Addictionologist (include input from Physician Recruiters	Project		Completed	09/01/2015	10/31/2015	09/01/2015	10/31/2015	12/31/2015	DY1 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
within the PPS as well as subject matter experts									
Task 2. Recruit addictionologist	Project		In Progress	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3. Contract for addictionologist services while recruitment of full time provider is occurring	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Recruit candidates and hire successful candidate as Medical Director	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #4 Identify and link to providers approved for outpatient medication management of opioid addiction who agree to provide continued maintenance therapy and collaborate with the treatment program and care manager. These may include practices with collocated behavioral health services, opioid treatment programs or outpatient SUD clinics.	Project	N/A	Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	Provider	Practitioner - Primary Care Provider (PCP)	Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	Provider	Practitioner - Non-Primary Care Provider (PCP)	Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	Provider	Hospital	Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	Provider	Mental Health	Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task PPS has established relationships between inpatient detoxification services and community treatment programs that	Provider	Substance Abuse	Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
have the capacity to provide withdrawal management services to target patients.									
Task 1. Identify existing candidates (including addictionologists) and incentive package	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 2. Identify roles to support providers (e.g., Care Coordinator to handle referrals, Navigators)	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 3. Enter into agreements with interested providers meeting criteria	Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone #5 Develop community-based withdrawal management (ambulatory detoxification) protocols based upon evidence based best practices and staff training.	Project	N/A	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place for community withdrawal management services.	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Staff are trained on community-based withdrawal management protocols and care coordination procedures.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 1. Research for existing evidence-based protocols, agree to and adopt guidelines that best meet program requirements for medication-assisted treatments; reflect referrals to Behavioral Health in protocols	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 2. Structure training program (trainee targets, (e.g., Nurses, Recovery Coaches), expected outcomes), conduct training, measure competency; reflect Behavioral Health in training content	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 3. Hire/contract trainer, they develop training program based on identified care management protocols (collaborate with other PPSs or others demonstrating success, e.g., CASA at Columbia University); reflect Behavioral Health in training content	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 4. Conduct Training	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #6	Project	N/A	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

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Develop care management services within the SUD treatment program.									
Task Coordinated evidence-based care protocols are in place for care management services within SUD treatment program.	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task Staff are trained to provide care management services within SUD treatment program.	Project		Not Started	01/01/2016	03/31/2019	01/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task 1. Collaborate with Health Home to identify Care Managers and Recovery Coaches needing trained in addiction care management to ensure this expertise is available within Health Home; reflect Behavioral Health in training content	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 2. Research for existing evidence-based protocols, agree to and adopt guidelines that best meet program requirements for care management services within SUD treatment programs	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 3. Hire/contract trainer, they develop training program based on identified care management protocols (collaborate with other PPSs or others demonstrating success, e.g., CASA at Columbia University); reflect Behavioral Health in training content	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 4. Structure training program (trainee targets, (e.g., Nurses, Recovery Coaches), expected outcomes), conduct training, measure competency; reflect Behavioral Health in training content	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 5. Conduct Training	Project		Not Started	07/01/2016	03/31/2019	07/01/2016	03/31/2019	03/31/2019	DY4 Q4
Milestone #7 Form agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.	Project	N/A	In Progress	10/01/2015	03/31/2019	10/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS has engaged MCO to develop protocols for coordination of services under this project.	Project		In Progress	10/01/2015	03/31/2019	10/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 1. Identify potential MCOs with which to form agreements (e.g., Excellus, CDPHP, Value Options)	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 2. Negotiate efficient and immediate access to services, within service coverage negotiations	Project		Not Started	01/01/2016	03/31/2019	01/01/2016	03/31/2019	03/31/2019	DY4 Q4
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	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	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Determine criteria and metrics for counting/tracking patient engagement	Project		Completed	07/01/2015	08/15/2015	07/01/2015	08/15/2015	09/30/2015	DY1 Q2
Task 2. Evaluate existing capability for EHR patient engagement tracking	Project		Completed	07/15/2015	08/31/2015	07/15/2015	08/31/2015	09/30/2015	DY1 Q2
Task 3. Identify technology enhancements/upgrades needed to count/track patient engagement	Project		Completed	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 4. Implement technology enhancements/upgrades needed to count/track patient engagement	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5. Identify workflow impact due to new technology, document new workflow	Project		Not Started	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 6. Train staff on technology and workflow	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Develop community-based addiction treatment programs that include outpatient SUD sites with PCP integrated teams, and stabilization services including social services.										
Task PPS has developed community-based addiction treatment programs that include outpatient SUD sites, PCP integrated teams, and stabilization services.										
Task 1. Determine needs utilizing committee brainstorming and review of Community Needs Assessment										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 2. Perform current state assessment re existing programs/scope										
Task 3. Assess potential sites for ability to develop full program scope										
Task 4. For sites willing/able to expand or develop programs, identify sites where addictionologists are needed within the program at clinics										
Task 5. Reach out to Finger Lakes PPS and any other PPS who chose Ambulatory detox project for guidance on program development										
Task 6. Adopt policies and protocols to support diagnoses and referrals by and to PCPs, including education										
Task 7. Engage primary care sites to adopt protocols for withdrawal management										
Task 8. Leverage Care Navigators to work with patients to support program follow-ups										
Milestone #2 Establish referral relationships between community treatment programs and inpatient detoxification services with development of referral protocols.										
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	0	0	0	0	0	0	0	0	0	1
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	0	0	0	0	0	0	0	0	0	1
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	0	0	0	0	0	0	0	0	0	1
Task Regularly scheduled formal meetings are held to develop collaborative care practices among community treatment programs as well as between community treatment programs and inpatient detoxification facilities.										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Coordinated evidence-based care protocols are in place for community withdrawal management services. Protocols include referral procedures.										
Task 1. Identify existing community treatment programs inpatient detoxification service providers										
Task 2. Identify leader for collaboration program										
Task 3. Establish group membership and charter, meeting schedule and agenda										
Task 4. See #1 re adopt policies and protocols to support diagnoses and referrals by and to PCPs, including education; reflect referrals to Behavioral Health in protocols										
Task 5. Establish an integrated model for PCPs to refer patients										
Task 6. Collaborate on developing referral protocols per Medicaid reimbursement guidelines										
Task 7. Identify existing referral patterns from inpatient, ED, and community based organizations (department of mental health and LEAF) to ambulatory detox programs.										
Task 8. Develop work flows for referral process.										
Task 9. Working with collaborating partners, determine opportunities to transition detox treatment from "ED to inpatient" to "ED to outpatient" detox.										
Task 10. Provide education on ambulatory detox options and pathways to community agencies (e.g.-law enforcement, ED providers, and first responders)										
Task 11. Develop ED discharge plan that includes ambulatory detox referral where appropriate and warm hand off when possible.										
Task 12. Develop written agreements amongst collaborating partners where appropriate.										
Milestone #3 Include a project medical director, board certified in addiction medicine, with training and privileges for use of buprenorphine										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
and buprenorphine/naltrexone as well as familiarity with other withdrawal management agents.										
Task PPS has designated at least one qualified and certified physician with training and privileges for use of buprenorphine/Naltrexone and other withdrawal agents.										
Task 1. Create job description for Project Medical Director/Addictionologist (include input from Physician Recruiters within the PPS as well as subject matter experts										
Task 2. Recruit addictionologist										
Task 3. Contract for addictionologist services while recruitment of full time provider is occurring										
Task 4. Recruit candidates and hire successful candidate as Medical Director										
Milestone #4 Identify and link to providers approved for outpatient medication management of opioid addiction who agree to provide continued maintenance therapy and collaborate with the treatment program and care manager. These may include practices with collocated behavioral health services, opioid treatment programs or outpatient SUD clinics.										
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	0	0	0	0	0	19	162	162	162	162
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	0	0	0	0	0	26	530	530	530	530
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	0	0	0	0	0	2	7	7	7	7
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	0	0	0	0	0	3	23	23	23	23

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	0	0	0	0	0	0	4	4	4	4
Task 1. Identify existing candidates (including addictionologists) and incentive package										
Task 2. Identify roles to support providers (e.g., Care Coordinator to handle referrals, Navigators)										
Task 3. Enter into agreements with interested providers meeting criteria										
Milestone #5 Develop community-based withdrawal management (ambulatory detoxification) protocols based upon evidence based best practices and staff training.										
Task Coordinated evidence-based care protocols are in place for community withdrawal management services.										
Task Staff are trained on community-based withdrawal management protocols and care coordination procedures.										
Task 1. Research for existing evidence-based protocols, agree to and adopt guidelines that best meet program requirements for medication-assisted treatments; reflect referrals to Behavioral Health in protocols										
Task 2. Structure training program (trainee targets, (e.g., Nurses, Recovery Coaches), expected outcomes), conduct training, measure competency; reflect Behavioral Health in training content										
Task 3. Hire/contract trainer, they develop training program based on identified care management protocols (collaborate with other PPSs or others demonstrating success, e.g., CASA at Columbia University); reflect Behavioral Health in training content										
Task 4. Conduct Training										
Milestone #6 Develop care management services within the SUD treatment program.										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Coordinated evidence-based care protocols are in place for care management services within SUD treatment program.										
Task Staff are trained to provide care management services within SUD treatment program.										
Task 1. Collaborate with Health Home to identify Care Managers and Recovery Coaches needing trained in addiction care management to ensure this expertise is available within Health Home; reflect Behavioral Health in training content										
Task 2. Research for existing evidence-based protocols, agree to and adopt guidelines that best meet program requirements for care management services within SUD treatment programs										
Task 3. Hire/contract trainer, they develop training program based on identified care management protocols (collaborate with other PPSs or others demonstrating success, e.g., CASA at Columbia University); reflect Behavioral Health in training content										
Task 4. Structure training program (trainee targets, (e.g., Nurses, Recovery Coaches), expected outcomes), conduct training, measure competency; reflect Behavioral Health in training content										
Task 5. Conduct Training										
Milestone #7 Form agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.										
Task PPS has engaged MCO to develop protocols for coordination of services under this project.										
Task 1. Identify potential MCOs with which to form agreements (e.g., Excellus, CDPHP, Value Options)										
Task 2. Negotiate efficient and immediate access to services, within service coverage negotiations										
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
engaged patients for project milestone reporting.										
Task 1. Determine criteria and metrics for counting/tracking patient engagement										
Task 2. Evaluate existing capability for EHR patient engagement tracking										
Task 3. Identify technology enhancements/upgrades needed to count/track patient engagement										
Task 4. Implement technology enhancements/upgrades needed to count/track patient engagement										
Task 5. Identify workflow impact due to new technology, document new workflow										
Task 6. Train staff on technology and workflow										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Develop community-based addiction treatment programs that include outpatient SUD sites with PCP integrated teams, and stabilization services including social services.										
Task PPS has developed community-based addiction treatment programs that include outpatient SUD sites, PCP integrated teams, and stabilization services.										
Task 1. Determine needs utilizing committee brainstorming and review of Community Needs Assessment										
Task 2. Perform current state assessment re existing programs/scope										
Task 3. Assess potential sites for ability to develop full program scope										
Task 4. For sites willing/able to expand or develop programs, identify sites where addictionologists are needed within the program at clinics										
Task 5. Reach out to Finger Lakes PPS and any other PPS who chose Ambulatory detox project for guidance on program										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
development										
Task 6. Adopt policies and protocols to support diagnoses and referrals by and to PCPs, including education										
Task 7. Engage primary care sites to adopt protocols for withdrawal management										
Task 8. Leverage Care Navigators to work with patients to support program follow-ups										
Milestone #2 Establish referral relationships between community treatment programs and inpatient detoxification services with development of referral protocols.										
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	7	7	7	7	7	7	7	7	7	7
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	23	23	23	23	23	23	23	23	23	23
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	4	4	4	4	4	4	4	4	4	4
Task Regularly scheduled formal meetings are held to develop collaborative care practices among community treatment programs as well as between community treatment programs and inpatient detoxification facilities.										
Task Coordinated evidence-based care protocols are in place for community withdrawal management services. Protocols include referral procedures.										
Task 1. Identify existing community treatment programs inpatient detoxification service providers										
Task 2. Identify leader for collaboration program										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 3. Establish group membership and charter, meeting schedule and agenda										
Task 4. See #1 re adopt policies and protocols to support diagnoses and referrals by and to PCPs, including education; reflect referrals to Behavioral Health in protocols										
Task 5. Establish an integrated model for PCPs to refer patients										
Task 6. Collaborate on developing referral protocols per Medicaid reimbursement guidelines										
Task 7. Identify existing referral patterns from inpatient, ED, and community based organizations (department of mental health and LEAF) to ambulatory detox programs.										
Task 8. Develop work flows for referral process.										
Task 9. Working with collaborating partners, determine opportunities to transition detox treatment from "ED to inpatient" to "ED to outpatient" detox.										
Task 10. Provide education on ambulatory detox options and pathways to community agencies (e.g.-law enforcement, ED providers, and first responders)										
Task 11. Develop ED discharge plan that includes ambulatory detox referral where appropriate and warm hand off when possible.										
Task 12. Develop written agreements amongst collaborating partners where appropriate.										
Milestone #3 Include a project medical director, board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/naltrexone as well as familiarity with other withdrawal management agents.										
Task PPS has designated at least one qualified and certified physician with training and privileges for use of buprenorphine/Naltrexone and other withdrawal agents.										
Task 1. Create job description for Project Medical Director/Addictionologist (include input from Physician Recruiters within the PPS as well as subject matter experts										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 2. Recruit addictionologist										
Task 3. Contract for addictionologist services while recruitment of full time provider is occurring										
Task 4. Recruit candidates and hire successful candidate as Medical Director										
Milestone #4 Identify and link to providers approved for outpatient medication management of opioid addiction who agree to provide continued maintenance therapy and collaborate with the treatment program and care manager. These may include practices with collocated behavioral health services, opioid treatment programs or outpatient SUD clinics.										
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	162	162	162	162	162	162	162	162	162	162
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	530	530	530	530	530	530	530	530	530	530
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	7	7	7	7	7	7	7	7	7	7
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	23	23	23	23	23	23	23	23	23	23
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	4	4	4	4	4	4	4	4	4	4
Task 1. Identify existing candidates (including addictionologists) and incentive package										
Task 2. Identify roles to support providers (e.g., Care Coordinator to										

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
handle referrals, Navigators)										
Task 3. Enter into agreements with interested providers meeting criteria										
Milestone #5 Develop community-based withdrawal management (ambulatory detoxification) protocols based upon evidence based best practices and staff training.										
Task Coordinated evidence-based care protocols are in place for community withdrawal management services.										
Task Staff are trained on community-based withdrawal management protocols and care coordination procedures.										
Task 1. Research for existing evidence-based protocols, agree to and adopt guidelines that best meet program requirements for medication-assisted treatments; reflect referrals to Behavioral Health in protocols										
Task 2. Structure training program (trainee targets, (e.g., Nurses, Recovery Coaches), expected outcomes), conduct training, measure competency; reflect Behavioral Health in training content										
Task 3. Hire/contract trainer, they develop training program based on identified care management protocols (collaborate with other PPSs or others demonstrating success, e.g., CASA at Columbia University); reflect Behavioral Health in training content										
Task 4. Conduct Training										
Milestone #6 Develop care management services within the SUD treatment program.										
Task Coordinated evidence-based care protocols are in place for care management services within SUD treatment program.										
Task Staff are trained to provide care management services within SUD treatment program.										
Task 1. Collaborate with Health Home to identify Care Managers and Recovery Coaches needing trained in addiction care management to ensure this expertise is available within Health										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Home; reflect Behavioral Health in training content										
Task 2. Research for existing evidence-based protocols, agree to and adopt guidelines that best meet program requirements for care management services within SUD treatment programs										
Task 3. Hire/contract trainer, they develop training program based on identified care management protocols (collaborate with other PPSs or others demonstrating success, e.g., CASA at Columbia University); reflect Behavioral Health in training content										
Task 4. Structure training program (trainee targets, (e.g., Nurses, Recovery Coaches), expected outcomes), conduct training, measure competency; reflect Behavioral Health in training content										
Task 5. Conduct Training										
Milestone #7 Form agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.										
Task PPS has engaged MCO to develop protocols for coordination of services under this project.										
Task 1. Identify potential MCOs with which to form agreements (e.g., Excellus, CDPHP, Value Options)										
Task 2. Negotiate efficient and immediate access to services, within service coverage negotiations										
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1. Determine criteria and metrics for counting/tracking patient engagement										
Task 2. Evaluate existing capability for EHR patient engagement tracking										
Task 3. Identify technology enhancements/upgrades needed to										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
count/track patient engagement										
Task 4. Implement technology enhancements/upgrades needed to count/track patient engagement										
Task 5. Identify workflow impact due to new technology, document new workflow										
Task 6. Train staff on technology and workflow										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop community-based addiction treatment programs that include outpatient SUD sites with PCP integrated teams, and stabilization services including social services.	
Establish referral relationships between community treatment programs and inpatient detoxification services with development of referral protocols.	- The provider ramp up was updated to match the end dates of metrics
Include a project medical director, board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/naltrexone as well as familiarity with other withdrawal management agents.	
Identify and link to providers approved for outpatient medication management of opioid addiction who agree to provide continued maintenance therapy and collaborate with the treatment program and care manager. These may include practices with collocated behavioral health services, opioid treatment programs or outpatient SUD clinics.	- The provider ramp up was updated to match the end dates of metrics
Develop community-based withdrawal management (ambulatory detoxification) protocols based upon evidence based best practices and staff training.	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop care management services within the SUD treatment program.	
Form agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.	
Use EHRs or other technical platforms to track all patients engaged in this project.	

Milestone Review Status

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

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

IPQR Module 3.a.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

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project 3.d.iii – Implementation of evidence-based medicine guidelines for asthma management

IPQR Module 3.d.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.

Risk: Recruitment of clinical and non-clinical staff.
Mitigation: LCHP will use creative regional recruitment and retention strategies, such as incentives, telemedicine for patient/provider access to attract providers, engaging a workforce impact consultant like AHEC, LCHP's Collaborative Learning Committee and partners. The PPS will leverage Bassett's relationship with local colleges, as well as nationally recognized universities, to create programs necessary to serve the population

Risk: Patient engagement
Mitigation: Care coordinators, patient navigators, case managers, and health educators will be critical team members at community- based provider sites. These staff will engage patients in care, facilitate implementation of asthma action plans, and champion patient self-management for better asthma control. Referral tracking and patient follow-up will be part of the ongoing strategies used to engage and re-engage patients in care

Risk: Practitioner Engagement
Mitigation: A comprehensive practitioner communication and engagement plan will be created by the Clinical Performance Committee to engage practitioners in the initiatives under DSRIP Program. This committee will have representation of different types of practitioners. LCHP will also leverage existing gatherings of practitioners within partners such as Grand Rounds, Primary Care Council, Regional Medical Director Group and Clinical Leadership Group as models for clinical integration and practitioner engagement in creating PPS-wide professional groups

Risk: Partner Engagement
Mitigation: Some essential LCHP Partners are not engaged in planning projects due to ambiguity in funds flow, contribution to project requirements, lack of designated resources to engage in planning and execution, etc. LCHP Operations Team will confirm current partner involvement in projects, reach out to partners who are deemed essential, and complete a funds flow model to better inform their involvement. LCHP will regularly update partners through by using various tools

Risk: Clinical Interoperability - varying EHRs among partners present a challenge in interconnectivity. Additionally, involving new partners with varied EHRs later on in the process will add risk for clinically interoperability in the required timeline
Mitigation: Patient registries will be required to track target patients and their care in the service area. Universal EHR connectivity is not present across service area providers. LCHP Operations Team will collaborate with partners since several proposed DSRIP projects will also rely on EHR systems and other technical platforms to track patient engagement. To address addition of new partners later on, LCHP Operations Team will confirm current partner involvement in this project, reach out to partners who are deemed essential, and complete a funds flow model to comfort partners on their participation

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Risk: EHR meeting connectivity to RHIOs HIE and SHIN-NY requirements on time is contingent on SHIN-NY activation date Mitigation: In case SHIN-NY activation's timeline varies from our commitment, we will not be able to meet this metric. LCHP will work on alternate possibilities such as plan modification to our strategy to accommodate any change in SHIN-NY roll-out timeline. For agencies without an EHR, the LCHP IT/Data Analytics Committee will offer its expertise, with a primary focus on standardization of IT products. For project participants who do not currently submit patient- level data to HIXNY or another RHIO, the IT/Data Analytics Committee will share expertise with appropriate partners to join RHIOs

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	3,099

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
107	170	36.80%	292	5.49%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (462)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
amyvk	Rosters	22_PMDL4815_1_3_20160125135848_Bassett_3diiiAsthmaActivelyEngagedPtRegistryDY1Q3.pdf	Bassett Medical Center 3diii Asthma Actively Engaged Pt Roster DY1Q3	01/25/2016 01:59 PM

Narrative Text :

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

Please note that within the patient roster, any entries where Last Name, First name or DOB are blank mean we did not receive that information from the reporting institution. Each line represents a unique patient - total 170 patients for DY1Q3 reporting period.

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

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement evidence-based asthma management guidelines between primary care practitioners, specialists, and community-based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population based approach to asthma management.	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 agreements from participating providers and community programs to support a evidence-based asthma management guidelines.	Project		In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task All participating practices have a Clinical Interoperability System in place for all participating providers.	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 All participating practices have a Clinical Interoperability System in place for all participating providers.	Provider	Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1. Identify clinicians to participate in program, execute program agreements	Project		In Progress	09/01/2015	12/31/2015	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2. Distribute NHLBI guidelines to participants and partners/collaborators, and other identified participants	Project		In Progress	09/01/2015	12/31/2015	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3. Customize pathways to reflect specific EHR functionality; reflect best practices demonstration projects	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 4. Provide patient education materials to support guidelines adherence	Project		In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5. Partner with interdisciplinary team comprised of IT, EMR, Clinicians, etc. to create information exchange workflow (eg.	Project		In Progress	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

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
EPIC CareEverywhere, Healthy Connections, RHIOs like HIXNY)									
Task 6. Add "Care everywhere, Care Link, etc " for partners to pilot	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 7. Map workflows once defined	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 8. Educate providers and staff on the workflow	Project		Not Started	04/01/2015	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone #2 Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.	Project	N/A	In Progress	04/01/2015	12/31/2018	04/01/2015	12/31/2018	12/31/2018	DY4 Q3
Task Agreements with asthma specialists and asthma educators are established.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Telemedicine service implemented, based on evaluation of impact to underserved areas including, but not limited to: - analysis of the availability of broadband access in the geographic area being served - gaps in services - geographic areas where PPS lacks resources and telemedicine will be used to increase the reach of these patients - why telemedicine is the best alternative to provide these services - challenges expected and plan to pro-actively resolve - plan for long term sustainability	Project		In Progress	10/01/2015	12/31/2018	10/01/2015	12/31/2018	12/31/2018	DY4 Q3
Task 1. Identify specialists meeting this criteria, with whom we would establish an agreement	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Enter into agreements with selected specialists	Project		In Progress	12/31/2015	12/31/2016	12/31/2015	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 3. Describe referral process algorithm	Project		In Progress	12/31/2015	12/31/2016	12/31/2015	12/31/2016	12/31/2016	DY2 Q3
Task 4. Obtain RHIO Attestation of connectivity	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5. Report (e.g., from Business Intelligence or Meaningful Use team) to show evidence of active sharing HIE info - transaction info, e.g,. of public health registries - NYSIS, lab to DOH for infectious conditions, etc.	Project		Not Started	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 6. Obtain QE (Qualified Entity)participant agreements	Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 7. Identify selection criteria and targeted patients who are candidates for telemedicine services	Project		Not Started	10/01/2015	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 8. Identify sites for telemedicine use; Refer to sites with already existing telemedicine	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 9. As applicable, identify/select telemedicine vendor; acquire technology; coordinate technology with Bassett's to ensure compatibility	Project		Not Started	10/01/2015	12/31/2018	01/01/2016	12/31/2018	12/31/2018	DY4 Q3
Task 10. Implement Telemedicine and plan for long term sustainability	Project		Not Started	09/01/2016	12/31/2018	09/01/2016	12/31/2018	12/31/2018	DY4 Q3
Milestone #3 Deliver educational activities addressing asthma management to participating primary care providers.	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Participating providers receive training in evidence-based asthma management.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1. Identify primary care providers to be educated	Project		Completed	09/01/2015	10/01/2015	09/01/2015	10/01/2015	12/31/2015	DY1 Q3
Task 2. Educate on guidelines with grand rounds, other Rounds; includes staff education	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3. Reinforce guidelines with grand rounds, other Rounds; includes staff education	Project		Not Started	09/01/2016	12/31/2016	09/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 4. Establish distance-learning mechanism to deliver education,	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
track participants (Meaing: Webinar or archived grand rounds)									
Milestone #4 Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.	Project	N/A	In Progress	10/01/2015	03/31/2019	10/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with participating health home care managers, PCPs, and specialty providers.	Project		In Progress	10/01/2015	03/31/2019	10/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 1. Identify existing Medicaid Managed Care organizations having asthma coverage (some arrangements in place, some to be added)	Project		In Progress	10/01/2015	04/30/2016	10/01/2015	04/30/2016	06/30/2016	DY2 Q1
Task 2. Identify participating health home care managers, PCPs, and specialty providers.	Project		Not Started	01/01/2016	08/31/2016	01/01/2016	08/31/2016	09/30/2016	DY2 Q2
Task 3. Establish agreements with MCOs that address asthma coverage	Project		Not Started	09/01/2016	03/31/2019	09/01/2016	03/31/2019	03/31/2019	DY4 Q4
Milestone #5 Use EHRs or other technical platforms to track all patients engaged in this project.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	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	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Determine criteria and metrics for counting/tracking patient engagement--EHR data, encounter data, INTERACT tool usage, etc.	Project		Completed	07/01/2015	08/15/2015	07/01/2015	08/15/2015	09/30/2015	DY1 Q2
Task 2. Evaluate existing capability for EHR patient engagement tracking	Project		Completed	07/15/2015	08/31/2015	07/15/2015	08/31/2015	09/30/2015	DY1 Q2
Task 3. Identify technology enhancements/upgrades needed to count/track patient engagement	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Implement technology enhancements/upgrades needed to count/track patient engagement	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task	Project		Not Started	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
5. Identify workflow impact due to new technology, document new workflow									
Task 6. Train staff on technology and workflow	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Implement evidence-based asthma management guidelines between primary care practitioners, specialists, and community-based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population based approach to asthma management.										
Task PPS has agreements from participating providers and community programs to support a evidence-based asthma management guidelines.										
Task All participating practices have a Clinical Interoperability System in place for all participating providers.	0	0	0	0	0	0	0	0	0	0
Task All participating practices have a Clinical Interoperability System in place for all participating providers.	0	0	0	0	0	0	0	0	0	0
Task 1. Identify clinicians to participate in program, execute program agreements										
Task 2. Distribute NHLBI guidelines to participants and partners/collaborators, and other identified participants										
Task 3. Customize pathways to reflect specific EHR functionality; reflect best practices demonstration projects										
Task 4. Provide patient education materials to support guidelines adherence										
Task 5. Partner with interdisciplinary team comprised of IT, EMR, Clinicians, etc. to create information exchange workflow (eg. EPIC CareEverywhere, Healthy Connections, RHIOs like HIXNY)										
Task 6. Add "Care everywhere, Care Link, etc " for partners to pilot										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 7. Map workflows once defined										
Task 8. Educate providers and staff on the workflow										
Milestone #2 Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.										
Task Agreements with asthma specialists and asthma educators are established.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task Telemedicine service implemented, based on evaluation of impact to underserved areas including, but not limited to: - analysis of the availability of broadband access in the geographic area being served - gaps in services - geographic areas where PPS lacks resources and telemedicine will be used to increase the reach of these patients - why telemedicine is the best alternative to provide these services - challenges expected and plan to pro-actively resolve - plan for long term sustainability										
Task 1. Identify specialists meeting this criteria, with whom we would establish an agreement										
Task 2. Enter into agreements with selected specialists										
Task 3. Describe referral process algorithm										
Task 4. Obtain RHIO Attestation of connectivity										
Task 5. Report (e.g., from Business Intelligence or Meaningful Use team) to show evidence of active sharing HIE info - transaction info, e.g,. of public health registries - NYSIS, lab to DOH for infectious conditions, etc.										
Task 6. Obtain QE (Qualified Entity)participant agreements										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 7. Identify selection criteria and targeted patients who are candidates for telemedicine services										
Task 8. Identify sites for telemedicine use; Refer to sites with already existing telemedicine										
Task 9. As applicable, identify/select telemedicine vendor; acquire technology; coordinate technology with Bassett's to ensure compatibility										
Task 10. Implement Telemedicine and plan for long term sustainability										
Milestone #3 Deliver educational activities addressing asthma management to participating primary care providers.										
Task Participating providers receive training in evidence-based asthma management.										
Task 1. Identify primary care providers to be educated										
Task 2. Educate on guidelines with grand rounds, other Rounds; includes staff education										
Task 3. Reinforce guidelines with grand rounds, other Rounds; includes staff education										
Task 4. Establish distance-learning mechanism to deliver education, track participants (Meaing: Webinar or archived grand rounds)										
Milestone #4 Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.										
Task PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with participating health home care managers, PCPs, and specialty providers.										
Task 1. Identify existing Medicaid Managed Care organizations having asthma coverage (some arrangements in place, some to be added)										
Task 2. Identify participating health home care managers, PCPs, and specialty providers.										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 3. Establish agreements with MCOs that address asthma coverage										
Milestone #5 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1. Determine criteria and metrics for counting/tracking patient engagement--EHR data, encounter data, INTERACT tool usage, etc.										
Task 2. Evaluate existing capability for EHR patient engagement tracking										
Task 3. Identify technology enhancements/upgrades needed to count/track patient engagement										
Task 4. Implement technology enhancements/upgrades needed to count/track patient engagement										
Task 5. Identify workflow impact due to new technology, document new workflow										
Task 6. Train staff on technology and workflow										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Implement evidence-based asthma management guidelines between primary care practitioners, specialists, and community-based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population based approach to asthma management.										
Task PPS has agreements from participating providers and community programs to support a evidence-based asthma management guidelines.										
Task All participating practices have a Clinical Interoperability System in place for all participating providers.	0	0	0	19	174	174	174	174	174	174

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task All participating practices have a Clinical Interoperability System in place for all participating providers.	0	0	0	5	5	533	533	533	533	533
Task 1. Identify clinicians to participate in program, execute program agreements										
Task 2. Distribute NHLBI guidelines to participants and partners/collaborators, and other identified participants										
Task 3. Customize pathways to reflect specific EHR functionality; reflect best practices demonstration projects										
Task 4. Provide patient education materials to support guidelines adherence										
Task 5. Partner with interdisciplinary team comprised of IT, EMR, Clinicians, etc. to create information exchange workflow (eg. EPIC CareEverywhere, Healthy Connections, RHIOs like HIXNY)										
Task 6. Add "Care everywhere, Care Link, etc " for partners to pilot										
Task 7. Map workflows once defined										
Task 8. Educate providers and staff on the workflow										
Milestone #2 Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.										
Task Agreements with asthma specialists and asthma educators are established.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	1	1	17	17	17	17	17
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	2	2	24	24	24	24	24
Task Telemedicine service implemented, based on evaluation of impact to underserved areas including, but not limited to: - analysis of the availability of broadband access in the geographic area being served										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
- gaps in services - geographic areas where PPS lacks resources and telemedicine will be used to increase the reach of these patients - why telemedicine is the best alternative to provide these services - challenges expected and plan to pro-actively resolve - plan for long term sustainability										
Task 1. Identify specialists meeting this criteria, with whom we would establish an agreement										
Task 2. Enter into agreements with selected specialists										
Task 3. Describe referral process algorithm										
Task 4. Obtain RHIO Attestation of connectivity										
Task 5. Report (e.g., from Business Intelligence or Meaningful Use team) to show evidence of active sharing HIE info - transaction info, e.g,. of public health registries - NYSIS, lab to DOH for infectious conditions, etc.										
Task 6. Obtain QE (Qualified Entity)participant agreements										
Task 7. Identify selection criteria and targeted patients who are candidates for telemedicine services										
Task 8. Identify sites for telemedicine use; Refer to sites with already existing telemedicine										
Task 9. As applicable, identify/select telemedicine vendor; acquire technology; coordinate technology with Bassett's to ensure compatibility										
Task 10. Implement Telemedicine and plan for long term sustainability										
Milestone #3 Deliver educational activities addressing asthma management to participating primary care providers.										
Task Participating providers receive training in evidence-based asthma management.										
Task 1. Identify primary care providers to be educated										
Task										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
2. Educate on guidelines with grand rounds, other Rounds; includes staff education										
Task 3. Reinforce guidelines with grand rounds, other Rounds; includes staff education										
Task 4. Establish distance-learning mechanism to deliver education, track participants (Meaing: Webinar or archived grand rounds)										
Milestone #4 Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.										
Task PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with participating health home care managers, PCPs, and specialty providers.										
Task 1. Identify existing Medicaid Managed Care organizations having asthma coverage (some arrangements in place, some to be added)										
Task 2. Identify participating health home care managers, PCPs, and specialty providers.										
Task 3. Establish agreements with MCOs that address asthma coverage										
Milestone #5 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1. Determine criteria and metrics for counting/tracking patient engagement--EHR data, encounter data, INTERACT tool usage, etc.										
Task 2. Evaluate existing capability for EHR patient engagement tracking										
Task 3. Identify technology enhancements/upgrades needed to count/track patient engagement										
Task 4. Implement technology enhancements/upgrades needed to										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
count/track patient engagement										
Task 5. Identify workflow impact due to new technology, document new workflow										
Task 6. Train staff on technology and workflow										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement evidence-based asthma management guidelines between primary care practitioners, specialists, and community-based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population based approach to asthma management.	- Method of agreement under assessment based on current structure of clinicians within partners. Eg. clinicians as employees, contractors, etc. - Identified Clinical inter-operability definition; current capabilities under evaluation. - Initial Training on NHLBI Guidelines Completed - In the process of engaging clinical specialist stakeholders to customize pathways/workflows - The provider ramp up was updated to match the end dates of metrics
Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.	- Identified the specialists to mainly be pulmonologists. Method of meeting this metric varies by partner. Some have physicians as employees while others may contract. Based on the type of current structure of organizations participating in the project, the mode of agreement varies. Currently under the process of evaluation. - Under the process of involving a pulmonologist to assess telemedicine need and method of incorporating the equipment. Therefore start dates for tasks 7 and 9 have been pushed out. - The provider ramp up was updated to match the end dates of metrics
Deliver educational activities addressing asthma management to participating primary care providers.	- Clinicians to be trained identified - Initial training completed with 3 sessions of grand rounds. - In the process of training all identified clinicians. Therefore end date of task 2 has been pushed out to 6/30/16
Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.	
Use EHRs or other technical platforms to track all patients engaged in this project.	- Criteria for tracking engagement of patients were identified. - IT build needed to capture patient engagement currently under process for majority of participating partners.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

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

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

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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.

Risk: The wide differences in acquisition of EMRs and achieving PCMH recognition throughout the LCHP service region Mitigation: LCHP PPS in conjunction with PCMH project team plans to engaged PCMH consultant w/the NCQA/PCMH expertise needed for success Risk: Recruitment/funding of staff Mitigation: Project team will conduct a pilot program to test their approach, develop buy in and measure success. Team will use existing staff to test their model & further develop short and long term needs. LCHP will use creative regional recruitment and retention strategies, such as incentives, to attract providers and will use telemedicine to increase patient access to care and increase provider education and training. A workforce impact consultant will work closely with LCHPs Collaborative Learning Committee (CLC) and partners, such as AHEC, to employ creative workforce strategies. Utilizing the expertise of the workforce impact consultant, AHEC and the CLC, online and in-person training will be offered to retrain existing employees. LCHP also intends to leverage AHEC's cross-PPS job opportunities. The PPS will leverage Bassett's relationship with local colleges, as well as nationally recognized universities, to create programs necessary to serve the population. If needed, LCHP will identify new/existing partners needing resources so participating partners can contract with them instead of hiring new staff Risk: Negotiating contracts w/MCOs Mitigation: In order to negotiate contracts with MCOs, there is a need to leverage across project teams within LCHP/across PPSs to benefit all parties Risk: PCP Education Mitigation: Palliative Care team will develop a training curriculum that encompasses knowledge base, resources, and how to have the difficult conversations with patients when referring to Palliative Care as PCPs do not have a good understanding of Palliative Care. Risk: Insufficient funds, especially for smaller organizations Mitigation: Involve sources like Robert Wood Johnson Foundation, PHIP (Population Health Improvement Program) team to assist in finding other funding sources for needed resources to be successful in project Risk: Resources for developing training materials and conducting training Mitigation: Economies of scale will be implemented when training staff across the PPS, sometimes utilizing a "train the trainer" model for sharing learning and/or providing onsite training for multiple partners. It is expected that RNs will be hired without care coordination experience, trained with intent to become certified. LCHP will identify partners who can train other partners. LCHP will engage with other PPSs for exploring possibilities of shared training resources Risk: Clinical Interoperability Mitigation: Patient registries will be required to track target patients and their care in service area. Universal EHR connectivity is not present across service area providers. LCHP Operations Team will collaborate with partners since several proposed DSRIP projects will also rely on EHR systems and other technical platforms to track patient engagement. To address addition of new partners later on, LCHP Operations Team will confirm current partner involvement in this project, reach out to partners who are deemed essential, and complete a funds flow model to comfort partners on their participation.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	4,236

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
0	0	0.00%	424	0.00%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (424)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
amyvk	Other	22_PMDL5115_1_3_20160122132626_Palliative_Care_Actively_Engaged.docx	Bassett Medical Center 3gi Palliative Care Patient Engagement Update	01/22/2016 01:26 PM

Narrative Text :

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

PPS has not yet achieved any actively engaged patients for this project so no roster is being uploaded this quarter.

Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its actively engaged commitments for DY1Q3. The documentation does not support the reported actively engaged numbers.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.	Project	N/A	In Progress	06/01/2015	03/31/2018	06/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH and/or APCM have been included. The PPS has received agreement from those PCPs not PCMH and/or APCM certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	06/01/2015	03/31/2018	06/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Identify NCQA level 1 2011 PCMH certified *PCP / PCMHs in Region. Select at least one per quadrant to participate in pilot	Project		Completed	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Select at least one practice in each quadrant to participate in pilot.	Project		Completed	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 3 Conduct and evaluate the pilot	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4. Select practices to integrate Palliative Care services into PCP practices based on results of pilots in quadrants	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 5. All sites inegrating Palliaitve Care services into their practices will achieve NCQA of at least the level 1 of 2014 PCMH recognition. The Patient Centered Medical Home Project is aiming to achieve level 3 NCQA 2014 standards at all participating sites by 12/31/17.	Project		In Progress	06/01/2015	03/31/2018	06/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Develop partnerships with community and provider resources	Project	N/A	In Progress	06/01/2015	03/31/2017	06/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
including Hospice to bring the palliative care supports and services into the practice.									
Task The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice.	Project		In Progress	06/01/2015	03/31/2017	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Inventory existing staffing resources to conduct pilot program	Project		Completed	08/01/2015	09/01/2015	08/01/2015	09/01/2015	09/30/2015	DY1 Q2
Task 2. Create collaborative agreements with identified partners; and, add new, as needed	Project		In Progress	06/01/2015	06/30/2016	06/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3. Expand existing palliative care agreements to identify and include (new) community partners - eg. disabled community - and, as circumstances warrant, continue to identify additional partners	Project		Not Started	01/01/2016	12/30/2016	01/01/2016	12/30/2016	12/31/2016	DY2 Q3
Task 4. With consideration to re-allocation of existing personnel, recruit and orient staff required to successfully launch PC program - to include a staff educator	Project		Not Started	01/01/2016	12/30/2016	01/01/2016	12/30/2016	12/31/2016	DY2 Q3
Task 5. Assess current status of, and need for additional, Palliative Care certified staff credentialing	Project		Completed	08/01/2015	09/01/2015	08/01/2015	09/01/2015	09/30/2015	DY1 Q2
Task 6. Apply for and attain certification for provider/practitioner staff-identified areas / personnel	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	Project	N/A	In Progress	09/01/2015	03/31/2017	09/01/2015	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	09/01/2015	06/30/2016	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Leverage existing Palliative Care standards among partners to adopt service and eligibility standards - including adoption of	Project		Completed	09/01/2015	06/30/2016	09/01/2015	10/21/2015	12/31/2015	DY1 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
MOLST, at all identified practice locations, for all Palliative Care patients									
Task 2. Those providing Palliative Care Services will guide the use of the best tools to use to standardize approach. The pilot program will yield best use of tools across PPS region to best meet the needs of patients and care providers.	Project		In Progress	09/01/2015	06/30/2016	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	Project	N/A	In Progress	06/01/2015	03/31/2017	06/01/2015	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	06/01/2015	03/31/2017	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Referencing evidence-based guidelines, design a program to educate PCPs and NPs	Project		Completed	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Educate pilot group of PCPs and NPs to regional practices	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Develop and provide staff educational program(s) for all selected practice locations -- disseminate palliative care clinical guidelines	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Visit and seek consultative advice form an established PC program directed at care of the developmentally disabled and other under-served populations: Center for Hospice and Palliative Care and Aspire of WNY, Buffalo NY	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 5. Include Developmental Disability providers and community partners in training and awareness programs	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.	Project	N/A	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Identify gaps in coverage for Palliative Care services to	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
determine which MCO's to develop agreements with and communicate gaps/barriers to LCHP PPS.									
Task 2. Policy and Payment Shift: Negotiate agreements by leveraging the existing Hospice toolkit to develop palliative care coverage or, expansion of Home Care / Hospice benefit to include a specific palliative care benefit that includes telehealth and carves out specific needs of the underserved populations (e.g.-disabled and LTC)	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	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	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Determine criteria and metrics for counting/ tracking patient engagement-- EHR data, encounter data, INTERACT tool usage, etc.	Project		Completed	07/01/2015	08/15/2015	07/01/2015	08/15/2015	09/30/2015	DY1 Q2
Task 2. Evaluate existing capability for EHR patient engagement tracking	Project		Completed	08/15/2015	08/30/2015	08/15/2015	08/30/2015	09/30/2015	DY1 Q2
Task 3. Identify technology enhancements/upgrades needed to count/track patient engagement	Project		Completed	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 4. Implement technology enhancements/upgrades needed to count/track patient engagement	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5. Identify workflow impact due to technology enhancements. Document new workflow.	Project		Not Started	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 6. Train staff on technology and workflow	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM										

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
certification.										
Task PPS has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH and/or APCM have been included. The PPS has received agreement from those PCPs not PCMH and/or APCM certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3.	0	0	0	0	0	0	0	0	0	0
Task 1. Identify NCQA level 1 2011 PCMH certified *PCP / PCMHs in Region. Select at least one per quadrant to participate in pilot										
Task 2. Select at least one practice in each quadrant to participate in pilot.										
Task 3 Conduct and evaluate the pilot										
Task 4. Select practices to integrate Palliative Care services into PCP practices based on results of pilots in quadrants										
Task 5. All sites inegrating Palliaitve Care services into their practices will achieve NCQA of at least the level 1 of 2014 PCMH recognition. The Patient Centered Medical Home Project is aiming to achieve level 3 NCQA 2014 standards at all participating sites by 12/31/17.										
Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.										
Task The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice.										
Task 1. Inventory existing staffing resources to conduct pilot program										
Task 2. Create collaborative agreements with identified partners; and, add new, as needed										
Task 3. Expand existing palliative care agreements to identify and include (new) community partners - eg. disabled community - and, as circumstances warrant, continue to identify additional partners										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 4. With consideration to re-allocation of existing personnel, recruit and orient staff required to successfully launch PC program - to include a staff educator										
Task 5. Assess current status of, and need for additional, Palliative Care certified staff credentialing										
Task 6. Apply for and attain certification for provider/practitioner staff-identified areas / personnel										
Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.										
Task PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form. PPS has trained staff addressing role-appropriate competence in palliative care skills.										
Task 1. Leverage existing Palliative Care standards among partners to adopt service and eligibility standards - including adoption of MOLST, at all identified practice locations, for all Palliative Care patients										
Task 2. Those providing Palliative Care Services will guide the use of the best tools to use to standardize approach. The pilot program will yield best use of tools across PPS region to best meet the needs of patients and care providers.										
Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.										
Task Staff has received appropriate palliative care skills training, including training on PPS care protocols.										
Task 1. Referencing evidence-based guidelines, design a program to educate PCPs and NPs										
Task 2. Educate pilot group of PCPs and NPs to regional practices										
Task 3. Develop and provide staff educational program(s) for all selected practice locations -- disseminate palliative care clinical										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
guidelines										
Task 4. Visit and seek consultative advice form an established PC program directed at care of the developmentally disabled and other under-served populations: Center for Hospice and Palliative Care and Aspire of WNY, Buffalo NY										
Task 5. Include Developmental Disability providers and community partners in training and awareness programs										
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.										
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.										
Task 1. Identify gaps in coverage for Palliative Care services to determine which MCO's to develop agreements with and communicate gaps/barriers to LCHP PPS.										
Task 2. Policy and Payment Shift: Negotiate agreements by leveraging the existing Hospice toolkit to develop palliative care coverage or, expansion of Home Care / Hospice benefit to include a specific palliative care benefit that includes telehealth and carves out specific needs of the underserved populations (e.g.-disabled and LTC)										
Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1. Determine criteria and metrics for counting/ tracking patient engagement-- EHR data, encounter data, INTERACT tool usage, etc.										
Task 2. Evaluate existing capability for EHR patient engagement tracking										
Task 3. Identify technology enhancements/upgrades needed to count/track patient engagement										
Task 4. Implement technology enhancements/upgrades needed to										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
count/track patient engagement										
Task 5. Identify workflow impact due to technology enhancements. Document new workflow.										
Task 6. Train staff on technology and workflow										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.										
Task PPS has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH and/or APCM have been included. The PPS has received agreement from those PCPs not PCMH and/or APCM certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3.	4	162	162	162	162	162	162	162	162	162
Task 1. Identify NCQA level 1 2011 PCMH certified *PCP / PCMHs in Region. Select at least one per quadrant to participate in pilot										
Task 2. Select at least one practice in each quadrant to participate in pilot.										
Task 3 Conduct and evaluate the pilot										
Task 4. Select practices to integrate Palliative Care services into PCP practices based on results of pilots in quadrants										
Task 5. All sites inegrating Palliaitve Care services into their practices will achieve NCQA of at least the level 1 of 2014 PCMH recognition. The Patient Centered Medical Home Project is aiming to achieve level 3 NCQA 2014 standards at all participating sites by 12/31/17.										
Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice.										
Task 1. Inventory existing staffing resources to conduct pilot program										
Task 2. Create collaborative agreements with identified partners; and, add new, as needed										
Task 3. Expand existing palliative care agreements to identify and include (new) community partners - eg. disabled community - and, as circumstances warrant, continue to identify additional partners										
Task 4. With consideration to re-allocation of existing personnel, recruit and orient staff required to successfully launch PC program - to include a staff educator										
Task 5. Assess current status of, and need for additional, Palliative Care certified staff credentialing										
Task 6. Apply for and attain certification for provider/practitioner staff-identified areas / personnel										
Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.										
Task PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form. PPS has trained staff addressing role-appropriate competence in palliative care skills.										
Task 1. Leverage existing Palliative Care standards among partners to adopt service and eligibility standards - including adoption of MOLST, at all identified practice locations, for all Palliative Care patients										
Task 2. Those providing Palliative Care Services will guide the use of the best tools to use to standardize approach. The pilot program will yield best use of tools across PPS region to best meet the needs of patients and care providers.										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.										
Task Staff has received appropriate palliative care skills training, including training on PPS care protocols.										
Task 1. Referencing evidence-based guidelines, design a program to educate PCPs and NPs										
Task 2. Educate pilot group of PCPs and NPs to regional practices										
Task 3. Develop and provide staff educational program(s) for all selected practice locations -- disseminate palliative care clinical guidelines										
Task 4. Visit and seek consultative advice form an established PC program directed at care of the developmentally disabled and other under-served populations: Center for Hospice and Palliative Care and Aspire of WNY, Buffalo NY										
Task 5. Include Developmental Disability providers and community partners in training and awareness programs										
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.										
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.										
Task 1. Identify gaps in coverage for Palliative Care services to determine which MCO's to develop agreements with and communicate gaps/barriers to LCHP PPS.										
Task 2. Policy and Payment Shift: Negotiate agreements by leveraging the existing Hospice toolkit to develop palliative care coverage or, expansion of Home Care / Hospice benefit to include a specific palliative care benefit that includes telehealth and carves out specific needs of the underserved populations (e.g.-disabled and LTC)										
Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.										

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1. Determine criteria and metrics for counting/ tracking patient engagement-- EHR data, encounter data, INTERACT tool usage, etc.										
Task 2. Evaluate existing capability for EHR patient engagement tracking										
Task 3. Identify technology enhancements/upgrades needed to count/track patient engagement										
Task 4. Implement technology enhancements/upgrades needed to count/track patient engagement										
Task 5. Identify workflow impact due to technology enhancements. Document new workflow.										
Task 6. Train staff on technology and workflow										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.	
Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	
Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	
Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Engage with Medicaid Managed Care to address coverage of services.	
Use EHRs or other IT platforms to track all patients engaged in this project.	

Milestone Review Status

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

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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.

Significant Project Milestones
- Expand implementation of "collaborative care" in primary care settings, for adults and children.
- Develop models for integrated prevention interventions.

Risk: Insufficient staff at partners to execute project tasks
Mitigation: Flow funds to discrete activities (e.g., training, research of best practices)

Risk: The recruitment of qualified mental health staff professionals is difficult in our rural region.
Mitigation: Collaborative Learning Committee will develop staff recruitment and retention solutions. Mohawk Valley Community College offers a CASAC certificate program, which will be a resource to increase CASAC supply. Will implement two other DSRIP projects that require substance abuse staff (Projects 3ai and 3aiv) and consolidate recruitment efforts as needed. Will use creative regional recruitment/retention strategies, e.g., incentives, to attract providers. A workforce impact consultant will work closely with the Collaborative Learning Committee and partners, such as AHEC, to employ creative workforce strategies. Utilizing expertise of workforce impact consultant, AHEC and Collaborative Learning Committee, will offer online and in-person training to retrain existing employees. We intend to leverage AHEC's cross-PPS job opportunities. If needed, LCHP will identify new/existing partners having needed resources so participating partners can contract with them instead of hiring new staff. LCHP plans to redeploy or retrain existing staff for clinical roles or positions in outreach or in education as patient volume shifts from acute care to primary care settings over the life of the DSRIP program. Additionally, telemedicine will be incorporated into the collaborative care model, currently in use at Bassett, if psychiatrists are not readily available to consult with the multidisciplinary teams.

Risk: Cultural and linguistic differences within the rural service area are a challenge.
Mitigation: LCHP will leverage its well-established relationships with CBOs & providers serving diverse patient groups (e.g., residential services for developmentally disabled) to tailor treatment approaches to populations. Will leverage expertise and network relationships to identify culturally and linguistically competent strategies.

Risk: Stigma and fear of arrest or loss of control/embarrassment are challenges that individuals who have MEB issues or seeking MEB treatment problems face that may prevent them from seeking help for themselves or others.
Mitigation: LCHP will design public health campaigns to address these challenges, including raising awareness of the 911 Good Samaritan law. The pilot program will provide high school students with culturally salient support from coaches who are close in age to their peer group and who have similar lived experiences, thus decreasing feelings of stigma and isolation in adolescents screened to be at risk for MEB disorders.

Risk: HIPAA privacy requirements for mental/behavior health will impose an additional burden on IT for securing PHI. These analyses include

identifying interconnectivity gaps as well as ensuring HIPAA privacy requirements for mental/behavioral health and PHI are in full compliance while still meeting sharing needs. This presents a challenge due to not having a common IT platform across all LCHP partners.
Mitigation : We continue to pursue resolution through collaboration with all partners. A corresponding need will be to educate patients about information sharing needs as an essential part of their continuity of care.

Risk: Lack of transportation will be a challenge for LCHP patients.
Mitigation: To meet this challenge, LCHP will develop a program using care coordinators/navigators to provide follow-up and coordinate transportation using strategies developed by the project team.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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 1-Participate in MEB health promotion and MEB disorder prevention partnerships.	In Progress	Participate in MEB health promotion and MEB disorder prevention partnerships.	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1. Connect with Community Based Organizations to identify MEB services and programs currently available; identify partnership opportunities within the PPS by identifying who the Counties connect to (use survey tool to obtain information)	Completed	Connect with County Directors to identify MEB services and programs currently available; identify partnership opportunities within the PPS by identifying who the Counties connect to (use survey tool to obtain information)	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Identify participation criteria, structure, purpose (including rationale, assets, challenges, goals, objectives, baseline data for tracking, specific issues to be addressed, interventions to be implemented to address issues); also include projects selected from State's list of options	Completed	Announcement to community partners on intention to take action on this project and invitation for regional alliance	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Invite and clarify roles of community partners, Local Health Departments, and Local Government Units to strengthen MEB infrastructure; reflect areas that need strengthening per Community Need Assessments obtained from community partners/other stakeholders	Completed	Invite and clarify roles of community partners, Local Health Departments, and Local Government Units to strengthen MEB infrastructure; reflect areas that need strengthening per Community Need Assessments obtained from community partners/other stakeholders	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Invite prospective partners to collaborate on overseeing MEB health promotion activities; Identify key representatives from	Completed	Invite prospective partners to collaborate on overseeing MEB health promotion activities; Identify key representatives from multi-system governmental agencies, health care and community based organizations, schools, etc., to serve on an inter-agency team to	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
multi-system governmental agencies, health care and community based organizations, schools, etc., to serve on an inter-agency team to address the specific MEB issues in the community that includes an approach balancing promotion, prevention, treatment and maintenance		address the specific MEB issues in the community that includes an approach balancing promotion, prevention, treatment and maintenance						
Task 5. Using data from community needs assessment and engagement with community partners, identify specific MEB issues to be addressed; perform a gap analysis to identify where existing programs need to be expanded or where new programs are needed	Not Started	Using data from community needs assessment and engagement with community partners, identify specific MEB issues to be addressed; perform a gap analysis to identify where existing programs need to be expanded or where new programs are needed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 6. Establish partnership arrangements	Not Started	Number of organizations that enter into formal inter/intra organizational agreement to develop and implement interventions to support MEB efforts that balance promotion, prevention, treatment and maintenance	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Milestone 2-Expand efforts with DOH, OMH and OASAS to implement 'Collaborative Care in primary care settings throughout NYS, for adults and children.	In Progress	Expand efforts with DOH, OMH and OASAS to implement 'Collaborative Care in primary care settings throughout NYS, for adults and children.	09/01/2015	12/31/2017	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 1. Identify primary care partners willing to participate in adult and youth screenings beyond those identified in project 3.a.i--Integration of Behavioral Health and Primary Care	Not Started	Number of screenings by primary care providers and the % of total # patients this represents; number of positive screenings that result in a referral; number of referrals	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 2. Identify opportunities to work with adults,youth and parents of children/younger populations in various settings, e.g., Head Start, parent programs, AARP, Senior Groups, service organizations, non-traditional settings.	Not Started	Identify opportunities to work with adults,youth and parents of children/younger populations in various settings, e.g., Head Start, parent programs, AARP, Senior Groups, service organizations, non-traditional settings.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 3. Identify opportuities for adult and child	Not Started	Identify opportuities for adult and child telemedicine.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
telemedicine.								
Task 4. Identify schools willing to participate in screenings	Not Started	Identify schools willing to participate in screenings	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 5. Identify collaboration opportunities with school-based health clinics for collaborative care models	Not Started	Identify collaboration opportunities with school-based health clinics for collaborative care models	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. Train-the-trainer for children/youth and adults settings on SBIRT screening interventions (train on OASAS methods)	Not Started	Train-the-trainer for children/youth and adults settings on SBIRT screening interventions (train on OASAS methods)	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7. Integrate performance-based early recognition screening program for adults and children (e.g., de-stigmatizing through early identification)	Not Started	Integrate performance-based early recognition screening program for adults and children (e.g., de-stigmatizing through early identification)	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 8. Develop methods and data sources to track patient progress and make improvements as needed (per project 3.a.i--Behavioral Health/Primary Care Integration)	Not Started	Develop methods and data sources to track patient progress and make improvements as needed (per project 3.a.i--Behavioral Health/Primary Care Integration)	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 9. Identify screening/ assessment tools that are evidenced based	In Progress	Identify screening/ assessment tools that are evidenced based	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 10. Train collaborative partners in evidenced based screening/assessment tools	Not Started	Train collaborative partners in evidenced based screening/assessment tools	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 11. Monitor interventions, track progress, and make improvements as needed	Not Started	Identification of data set and baseline data for tracking implementation progress	04/01/2016	12/31/2017	04/01/2016	12/31/2017	12/31/2017	DY3 Q3
Milestone 3-Provide cultural and linguistic training to providers on MEB health promotion, prevention and treatment.	In Progress	Provide cultural and linguistic training to providers on MEB health promotion, prevention and treatment.	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1. Update/analyze Community Needs Assessment to assess level of cultural and	Not Started	Update/analyze Community Needs Assessment to assess level of cultural and linguisic needs, and understand community and provider	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
linguisic needs, and understand community and provider characteristics, including an understanding of MEB promotion		characteristics, including an understanding of MEB promotion						
Task 2. Conduct an assessment of providers' cultural competency, including an understanding of community culture, comfort working with diverse segments, proficiency in treating community members, and participation in cultural competency training	Not Started	Use validated surveys where possible to assess cultural competency	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 3. Identify currently available cultural and linguistic services	Not Started	Identify currently available cultural and linguistic services	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 4. Perform a gap analysis between cultural/linguistic service needs and available services; identify training program(s) to fill the gap	Not Started	Perform a gap analysis between cultural/linguistic service needs and available services; identify training program(s) to fill the gap	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 5. Identify individuals who can train on cultural/linguistic programs (e.g., recruit from college campuses)	Not Started	Identify individuals who can train on cultural/linguistic programs (e.g., recruit from college campuses)	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 6. Identify cultural and linguistic training needs (e.g., farming/NYCAHM/Cornell Cooperative Extension, Amish, impoverished, disabled, religious)	Not Started	Identify cultural and linguistic training needs (e.g., farming/NYCAHM/Cornell Cooperative Extension, Amish, impoverished, disabled, religious)	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 7. Develop targeted cultural training on MEB health promotion, prevention, treatment	Not Started	Develop targeted cultural training on MEB health promotion, prevention, treatment	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 8. Train providers on cultural and linguistic approach to ensure services are provided in a culturally and linguistically appropriate manner	Not Started	Number of organizations conducting a specific behavioral health promotion or disorder prevention cultural competency training; number of participants who completed a specific training; number of participants who gained knowledge and/or skills from a specific training via a post-test	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone 4-Identify model prevention interventions and	Not Started	Identify model prevention interventions and lessons in integrating prevention and treatment.	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
lessons in integrating prevention and treatment.								
Task 1. Identify evidenced-based models for intregrated prevention, develop method and treatment approach to tie them all together	Not Started	Identify evidenced-based models for intregrated prevention, develop method and treatment approach to tie them all together	09/01/2016	12/31/2016	09/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 2. Collect resources to support the model (e.g., evidence-based practices and interventions delivered)	Not Started	Collect resources to support the model (e.g., evidence-based practices and interventions delivered)	09/01/2016	12/31/2016	09/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 3. Identify and deliver training programs for adults,children and youth to enhance protected factors.	Not Started	Identify and deliver training programs for adults,children and youth to enhance protected factors.	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task 4. Identify and deliver curricula to members of partnership on MEB health promotion, prevention, and treatment, using the Institute of Medicine Intervention Spectrum framework	Not Started	Identify and deliver curricula to members of partnership on MEB health promotion, prevention, and treatment, using the Institute of Medicine Intervention Spectrum framework	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone 5-Identify opportunities to collaborate on efficiencies in care delivery.	Not Started	Identify opportunities to collaborate on efficiencies in care delivery.	01/01/2016	06/30/2017	01/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task 1. Analyze service providers and patient populations (in collaboration with Health Home), to identify ways to reduce duplication, improve efficiencies, share services, co-locate, merge services	Not Started	Analyze service providers and patient populations (in collaboration with Health Home), to identify ways to reduce duplication, improve efficiencies, share services, co-locate, merge services	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 2. Develop service agreements and MOUs to implement reductions/efficiencies where negotiated	Not Started	Develop service agreements and MOUs to implement reductions/efficiencies where negotiated	01/01/2017	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1
Milestone 6-Identify population MHSA needs and methods to measure outcomes.	In Progress	Identify population MHSA needs and methods to measure outcomes.	09/01/2015	12/31/2017	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 1. Engage PHIP to source data, analyze it,	Not Started	Engage PHIP to source data, analyze it, establish a baseline of behavioral health needs in the region; examine results against	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
establish a baseline of behavioral health needs in the region; examine results against baseline; adjust approach as needed		baseline; adjust approach as needed						
Task 2. Identify barriers to success of existing and potential programs	In Progress	Identify barriers to success of existing and potential programs	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3. Conduct root cause analysis on reasons for existing barriers (e.g., high no-show rate may be due to lack of transportation)	Not Started	Conduct root cause analysis on reasons for existing barriers (e.g., high no-show rate may be due to lack of transportation)	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 4. Educate primary and acute care providers (and others) to incorporate MHSA protocols and practices on policies/programs (e.g., discharge protocols to reflect recognition of MHSA conditions)	Not Started	Educate primary and acute care providers (and others) to incorporate MHSA protocols and practices on policies/programs (e.g., discharge protocols to reflect recognition of MHSA conditions)	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 5. Identify methods to monitor and adjust practices and collaboration as needed to continually improve communications and outcomes	Not Started	Number of referrals; number of patients engaged in treatment	01/01/2017	12/31/2017	01/01/2017	12/31/2017	12/31/2017	DY3 Q3
Milestone 7-Share data and information with providers on MEB health promotion and MEB disorder prevention and treatment.	In Progress	Share data and information with providers on MEB health promotion and MEB disorder prevention and treatment.	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1. Develop communication plan to include tasks, methods (e.g., NY-211, phone calls, hot lines/MCAT/warmline, NY-Connect, county coordinating councils/agencies), expected results	In Progress	Develop communication plan to include tasks, methods (e.g., NY-211, phone calls, hot lines/MCAT/warmline, NY-Connect, county coordinating councils/agencies), expected results	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2. Develop a communication mechanism among providers re patient services, treatments (primary care, agencies, behavioral health, substance abuse treatment facilities, Health Homes, etc.)	In Progress	Develop a communication mechanism among providers re patient services, treatments (primary care, agencies, behavioral health, substance abuse treatment facilities, Health Homes, etc.)	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 3. Collaborate with local health departments and local government units (LGUs), providers, payers (Insurance companies) to identify data sources that can be used to share information on MEB issues within the community	In Progress	"Assess the feasibility of incorporating and sharing data on standard measures recommended by the Institute of Medicine committee for eight social and behavioral domains: educational attainment – financial resource strain – stress depression – physical activity social isolation – intimate partner violence (for women of reproductive age) neighborhood median-household income"	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
1-Participate in MEB health promotion and MEB disorder prevention partnerships.	
2-Expand efforts with DOH, OMH and OASAS to implement 'Collaborative Care in primary care settings throughout NYS, for adults and children.	
3-Provide cultural and linguistic training to providers on MEB health promotion, prevention and treatment.	
4-Identify model prevention interventions and lessons in integrating prevention and treatment.	
5-Identify opportunities to collaborate on efficiencies in care delivery.	
6-Identify population MHSA needs and methods to measure outcomes.	
7-Share data and information with providers on MEB health promotion and MEB disorder prevention and treatment.	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

Project 4.b.i – Promote tobacco use cessation, especially among low SES populations and those with poor mental health.

IPQR Module 4.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.

Significant Project Milestones
- Ongoing—train health care providers to ask the 5 As (Ask, Assess, Advise, Assist, and Arrange), and track follow-ups/results
- Pursue reimbursement for Smoking Cessation counseling by all provider types

Risk: Insufficient staff at partners to execute project tasks
Mitigation: Flow funds to discrete activities (e.g., training, research of best practices)

Risk: The higher prevalence of smoking among low SES populations indicates that they still consider smoking to be a "normal" part of life, posing a large barrier to cessation.
Mitigation: LCHP will promote smoke-free lifestyles through education, advocacy and social marketing. LCHP will target teachers and other school workers who smoke with cessation messages so that they may be cessation role models for youth.

Risk: Achieving smoker buy-in and monitoring compliance with policies.
Mitigation: Develop a method to obtain good baseline data on number of current smokers in target population, track success in smoking cessation efforts, correlate success rates with techniques used, and flag individuals who quit and then start smoking again

Risk: Risk to revenue for performing non-covered/non-reimbursed services; negotiating contracts with Medicaid MCOs is needed since many services are not reimbursed/under-reimbursed.
Mitigation: Allow uniform, universal coverage; to negotiate contracts with MCOs, need to combine efforts across project teams within the PPS and across PPSs to strengthen/consolidate the message & sustain patient care in DSRIP projects

Risk: Lack of transportation will be a challenge for LCHP patients.
Mitigation: To meet this challenge, LCHP will pilot a program using care coordinators in one county to prepare and maintain smoker registries, coordinate transportation and provide follow-up using strategies developed by the project team. Once evaluated, the program will be initiated in all other counties.

Risk: Union objections to smoking consequences (enforcement at certain sites).
Mitigation: Be aware of site requirements and enforcement options.

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

IPQR Module 4.b.i.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 1-Adopt tobacco-free outdoor policies that support and enforce tobacco-free grounds throughout the PPS	In Progress	65% of identified targets have adopted tobacco-free outdoor policies	09/01/2015	12/31/2017	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 1. Develop and adopt policies that support and enforce tobacco-free grounds throughout the PPS, including community-based sites and review and update a summary of current intitutional policies regarding tobacco-free environment (one-time)	In Progress	1. Develop and adopt policies that support and enforce tobacco-free grounds throughout the PPS, including community-based sites and review and update a summary of current intitutional policies regarding tobacco-free environment (one-time)	09/01/2015	12/31/2017	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 2. Review and update a summary of current institutional policies regarding tobacco-free environment (one-time)	In Progress	2. Review and update a summary of current institutional policies regarding tobacco-free environment (one-time)	09/01/2015	12/31/2017	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 3. Identify no-smoking signage and encourage education and collaboration (especially with facilities violating policy)	In Progress	3. Identify no-smoking signage and encourage education and collaboration (especially with facilities violating policy)	09/01/2015	12/31/2017	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 4. Establish connections with other organizations having related policies, support their success and strengthing those with less success	In Progress	4. Establish connections with other organizations having related policies, support their success and strengthing those with less success	09/01/2015	12/31/2017	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 5. Recognize organizations going smoke-free outdoors to incent others (ongoing)	In Progress	5. Recognize organizations going smoke-free outdoors to incent others (ongoing)	09/01/2015	12/31/2017	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
Milestone 2-Develop and implement a policy to ensure screening and treatment of tobacco	Not Started	Follow-up schedule showing a minimum number of health service partners have been trained on guidelines	04/01/2016	12/31/2017	04/01/2016	12/31/2017	12/31/2017	DY3 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
dependency following the US Public Health Service Guidelines.								
Task 1. Implement or adapt an existing EHR that captures and promotes screening and treatment at every encounter (outpatient and inpatient) and links to resources such as reference documents for drug interactions	Not Started	1. Implement or adapt an existing EHR that captures and promotes screening and treatment at every encounter (outpatient and inpatient) and links to resources such as reference documents for drug interactions	10/01/2016	09/30/2017	10/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task 2. Develop and use routine schedule performance measures for monitoring tobacco use screening and treatment	Not Started	2. Develop and use routine schedule performance measures for monitoring tobacco use screening and treatment	10/01/2016	12/31/2017	10/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task 3. Implement or adapt workflow to optimize delivery of tobacco use screening and treatment	Not Started	3. Implement or adapt workflow to optimize delivery of tobacco use screening and treatment	10/01/2016	12/31/2017	10/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task 4. Follow up in 6 months to observe provision of counseling and optimal pharmacotherapy (as appropriate) at every visit, suggest adjustments as needed (e.g., further training)	Not Started	4. Follow up in 6 months to observe provision of counseling and optimal pharmacotherapy (as appropriate) at every visit, suggest adjustments as needed (e.g., further training)	04/01/2016	09/01/2016	04/01/2016	09/01/2016	09/30/2016	DY2 Q2
Task 5. Establish an annual check-in program to ensure continued guideline adherence and address related issues	Not Started	5. Establish an annual check-in program to ensure continued guideline adherence and address related issues	10/01/2016	12/31/2017	10/01/2016	12/31/2017	12/31/2017	DY3 Q3
Milestone 3-Use electronic medical records to prompt providers to complete 5 A's (Ask, Assess, Advise, Assist, and Arrange).	In Progress	% of patients asked the 5 A's (where EMR) or chart audit (where no EMR)	10/01/2015	06/30/2017	10/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 1. Identify partners having an electronic medical record; identify technology enhancements/upgrades needed to count/track patient engagement	Not Started	1. Identify partners having an electronic medical record; identify technology enhancements/upgrades needed to count/track patient engagement	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 2. Create an EHR template for documenting the 5 A's	In Progress	2. Create an EHR template for documenting the 5 A's	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 3. For partners with an EMR, identify current capability to prompt providers to complete 5 A's	Not Started	3. For partners with an EMR, identify current capability to prompt providers to complete 5 A's	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 4. Identify where EMRs need to add in provider prompts to complete 5 A's, or to accomplish the goal another way if there is no EMR or if EMR cannot be enhanced (e.g., manually with forms)	Not Started	4. Identify where EMRs need to add in provider prompts to complete 5 A's, or to accomplish the goal another way if there is no EMR or if EMR cannot be enhanced (e.g., manually with forms)	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 5. Institute for all health care team members routine tobacco use screening and treatment training that covers the 5 A's and recommendation to NYS Quit Line	Not Started	5. Institute for all health care team members routine tobacco use screening and treatment training that covers the 5 A's and recommendation to NYS Quit Line	07/01/2016	06/30/2017	07/01/2016	06/30/2017	06/30/2017	DY3 Q1
Milestone 4-Facilitate referrals to the NYS Smokers' Quit line.	Not Started	Contact NYS Smokers' Quitline to enroll in secure site access.	03/31/2016	12/31/2017	03/31/2016	12/31/2017	12/31/2017	DY3 Q3
Task 1. Identify a variety of communication forums in which to promote the quit line	Not Started	1. Identify a variety of communication forums in which to promote the quit line	03/31/2016	12/31/2017	03/31/2016	12/31/2017	12/31/2017	DY3 Q3
Task 2. Identify a variety of social groups to target in promoting the Quit Line	Not Started	Identify a variety of social groups to target in promoting the Quit Line	03/31/2016	12/31/2017	03/31/2016	12/31/2017	12/31/2017	DY3 Q3
Task 3. Refer patients to NYS Smokers' Quit line as follow up to on-site counseling and pharmacotheraphy evaluation with bi-directional communication so providers receive feedback from referrals	Not Started	Refer patients to NYS Smokers' Quit line as follow up to on-site counseling and pharmacotheraphy evaluation with bi-directional communication so providers receive feedback from referrals	01/01/2017	12/31/2017	01/01/2017	12/31/2017	12/31/2017	DY3 Q3
Milestone 5-Increase Medicaid and other health plan coverage of tobacco dependence treatment counseling and medications.	Not Started	Contact with MCOs and top 10 insurers in NYS (re top #s of enrolees)	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task 1. Collaborate with other DSRIP projects within the PPS and with other PPS's to identify	Not Started	1. Collaborate with other DSRIP projects within the PPS and with other PPS's to identify MCO/payers to target for advocacy efforts	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
MCO/payers to target for advocacy efforts								
Task 2. Advocate for tobacco use to be covered under mental health in addition to medical coverage	Not Started	2. Advocate for tobacco use to be covered under mental health in addition to medical coverage	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task 3. Identify ACA opportunities for coverage, collaborate with professional organizations working on tobacco cessation (statewide, national). Collaborate with participating health plans to identify value based methods for reimbursement for tobacco dependence treatment	Not Started	3. Identify ACA opportunities for coverage, collaborate with professional organizations working on tobacco cessation (statewide, national). Collaborate with participating health plans to identify value based methods for reimbursement for tobacco dependence treatment	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3
Milestone 6-Promote smoking cessation benefits among Medicaid providers.	Not Started	# of people trained in benefits available; measure billing/reimbursement outcomes (to monitor for increases in funding/reimbursement)	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task 1. Identify Medicaid provider targets for orientation and promotion of smoking cessation benefits/reimbursements (e.g., billing offices)	Not Started	1. Identify Medicaid provider targets for orientation and promotion of smoking cessation benefits/reimbursements (e.g., billing offices)	01/01/2016	01/31/2017	01/01/2016	01/31/2017	03/31/2017	DY2 Q4
Task 2. Incorporate provider training in tobacco dependence treatment into hospital priviledge requirements and conduct biennial review of progress	Not Started	2. Incorporate provider training in tobacco dependence treatment into hospital priviledge requirements and conduct biennial review of progress	06/30/2016	06/30/2017	06/30/2016	06/30/2017	06/30/2017	DY3 Q1
Task 3. Educate billing departments on billing/coding methods for reimbursement on smoking cessation practices	Not Started	3. Educate billing departments on billing/coding methods for reimbursement on smoking cessation practices	03/01/2016	12/31/2017	03/01/2016	12/31/2017	12/31/2017	DY3 Q3
Milestone 7-Create universal, consistent health insurance benefits for prescription and over-the-counter cessation medications.	Not Started	"1. # payers covering medications 2. develop position statement re universal health benefits (e.g., coverage for nicotine gum for 6 months)"	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task 1. Identify MCO/payers to target for advocacy efforts; collaborate with other PPS's for	Not Started	1. Identify MCO/payers to target for advocacy efforts; collaborate with other PPS's for advocacy efforts	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
advocacy efforts								
Task 2. Identify inconsistent management of various Medicaid products in the Managed Medicaid environment (including mental health), to identify opportunities for consistency in billing and reimbursement	Not Started	2. Identify inconsistent management of various Medicaid products in the Managed Medicaid environment (including mental health), to identify opportunities for consistency in billing and reimbursement	07/01/2016	06/30/2017	07/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task 3. Identify opportunities for thought leadership (e.g., articles in newsletters and publications)	Not Started	3. Identify opportunities for thought leadership (e.g., articles in newsletters and publications)	06/01/2016	12/31/2017	06/01/2016	12/31/2017	12/31/2017	DY3 Q3
Milestone 8-Promote cessation counseling among all smokers, including people with disabilities.	Not Started	Count the number of tobacco cessation promotion events within the PPS geography	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task 1. Ensure US Public Health Services Guidelines for Treating Tobacco Use are followed throughout the community, by providers serving people with disabilities (and their employees)	Not Started	1. Ensure US Public Health Services Guidelines for Treating Tobacco Use are followed throughout the community, by providers serving people with disabilities (and their employees)	06/01/2016	07/31/2017	06/01/2016	07/31/2017	09/30/2017	DY3 Q2
Task 2. Develop feedback reports using quality measures for screening and treatment (including CPT to II codes) to providers/clinics using the EHR	Not Started	2. Develop feedback reports using quality measures for screening and treatment (including CPT to II codes) to providers/clinics using the EHR	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task 3. Identify referral resources that advocates can use when referring their peers; identify/update tobacco cessation materials for distribution to patients	Not Started	3. Identify referral resources that advocates can use when referring their peers; identify/update tobacco cessation materials for distribution to patients	01/31/2016	12/31/2017	01/31/2016	12/31/2017	12/31/2017	DY3 Q3
Task 4. Promote national stop-smoking events, nationally, regionally, and across the PPS footprint	Not Started	4. Promote national stop-smoking events, nationally, regionally, and across the PPS footprint	03/31/2016	12/31/2017	03/31/2016	12/31/2017	12/31/2017	DY3 Q3
Task 5. Leverage social media components to events and cessation program awareness	Not Started	5. Leverage social media components to events and cessation program awareness	03/31/2016	12/31/2017	03/31/2016	12/31/2017	12/31/2017	DY3 Q3
Task	Not Started	6. Adopt a buddy program to support smoking cessation efforts	09/30/2016	12/31/2017	09/30/2016	12/31/2017	12/31/2017	DY3 Q3

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
6. Adopt a buddy program to support smoking cessation efforts								
Task 7. Identify opportunities to embed smoking cessation into other programs (e.g, healthy bodies). Institute a PPS-wide policy that ensures tobacco status is queried and documented and that decision-support for treatment is embedded in each encounter.	Not Started	7. Identify opportunities to embed smoking cessation into other programs (e.g, healthy bodies). Institute a PPS-wide policy that ensures tobacco status is queried and documented and that decision-support for treatment is embedded in each encounter.	06/30/2016	12/31/2017	06/30/2016	12/31/2017	12/31/2017	DY3 Q3

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
1-Adopt tobacco-free outdoor policies that support and enforce tobacco-free grounds throughout the PPS	
2-Develop and implement a policy to ensure screening and treatment of tobacco dependency following the US Public Health Service Guidelines.	
3-Use electronic medical records to prompt providers to complete 5 A's (Ask, Assess, Advise, Assist, and Arrange).	
4-Facilitate referrals to the NYS Smokers' Quit line.	
5-Increase Medicaid and other health plan coverage of tobacco dependence treatment counseling and medications.	
6-Promote smoking cessation benefits among Medicaid providers.	
7-Create universal, consistent health insurance benefits for prescription and over-the-counter cessation medications.	
8-Promote cessation counseling among all smokers, including people with disabilities.	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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

Instructions :

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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 'Bassett Medical Center ', 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:	MARY IMOGENE BASSETT HSP
Secondary Lead PPS Provider:	
Lead Representative:	Michael Tengeres
Submission Date:	03/15/2016 02:53 PM

Comments:	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Status Log				
Quarterly Report (DY,Q)	**Status**	**Lead Representative Name**	**User ID**	**Date Timestamp**
DY1, Q3	Adjudicated	Michael Tengeres	sacolema	03/31/2016 05:13 PM
DY1, Q3	Submitted	Michael Tengeres	tengerm	03/15/2016 02:53 PM
DY1, Q3	Returned	Michael Tengeres	sacolema	03/01/2016 05:14 PM
DY1, Q3	Submitted	Michael Tengeres	tengerm	01/28/2016 02:10 PM
DY1, Q3	In Process		ETL	01/03/2016 08:01 PM

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Comments Log			
Status	**Comments**	**User ID**	**Date Timestamp**
Adjudicated	The IA has adjudicated the DY1, Q3 Quarterly Report.	sacolema	03/31/2016 05:13 PM
Returned	The IA is returning the DY1, Q3 Quarterly Report to the PPS for Remediation.	sacolema	03/01/2016 05:14 PM

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Section	Module Name	Status
Section 01	IPQR Module 1.1 - PPS Budget Report (Baseline)	Completed
	IPQR Module 1.2 - PPS Budget Report (Quarterly)	Completed
	IPQR Module 1.3 - PPS Flow of Funds (Baseline)	Completed
	IPQR Module 1.4 - PPS Flow of Funds (Quarterly)	Completed
	IPQR Module 1.5 - Prescribed Milestones	Completed
	IPQR Module 1.6 - PPS Defined Milestones	Completed
	IPQR Module 1.7 - IA Monitoring	
Section 02	IPQR Module 2.1 - Prescribed Milestones	Completed
	IPQR Module 2.2 - PPS Defined Milestones	Completed
	IPQR Module 2.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 2.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 2.5 - Roles and Responsibilities	Completed
	IPQR Module 2.6 - Key Stakeholders	Completed
	IPQR Module 2.7 - IT Expectations	Completed
	IPQR Module 2.8 - Progress Reporting	Completed
	IPQR Module 2.9 - IA Monitoring	
Section 03	IPQR Module 3.1 - Prescribed Milestones	Completed
	IPQR Module 3.2 - PPS Defined Milestones	Completed
	IPQR Module 3.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 3.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 3.5 - Roles and Responsibilities	Completed
	IPQR Module 3.6 - Key Stakeholders	Completed
	IPQR Module 3.7 - IT Expectations	Completed
	IPQR Module 3.8 - Progress Reporting	Completed
	IPQR Module 3.9 - IA Monitoring	
Section 04	IPQR Module 4.1 - Prescribed Milestones	Completed
	IPQR Module 4.2 - PPS Defined Milestones	Completed

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

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

Bassett Medical Center (PPS ID:22)

Section	Module Name	Status
	IPQR Module 10.8 - IA Monitoring	
Section 11	IPQR Module 11.1 - Workforce Strategy Spending	Completed
	IPQR Module 11.2 - Prescribed Milestones	Completed
	IPQR Module 11.3 - PPS Defined Milestones	Completed
	IPQR Module 11.4 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 11.5 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 11.6 - Roles and Responsibilities	Completed
	IPQR Module 11.7 - Key Stakeholders	Completed
	IPQR Module 11.8 - IT Expectations	Completed
	IPQR Module 11.9 - Progress Reporting	Completed
	IPQR Module 11.10 - Staff Impact	Completed
	IPQR Module 11.11 - IA Monitoring	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

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

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Section	Module Name / Milestone #	Review Status	
Section 01	Module 1.1 - PPS Budget Report (Baseline)	Pass & Complete	
	Module 1.2 - PPS Budget Report (Quarterly)	Pass & Ongoing	
	Module 1.3 - PPS Flow of Funds (Baseline)	Pass & Complete	
	Module 1.4 - PPS Flow of Funds (Quarterly)	Pass (with Exception) & Ongoing	IA
	Module 1.5 - Prescribed Milestones		
	Milestone #1 Complete funds flow budget and distribution plan and communicate with network	Pass & Ongoing	
Section 02	Module 2.1 - Prescribed Milestones		
	Milestone #1 Finalize governance structure and sub-committee structure	Pass & Complete	
	Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Pass & Complete	
	Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	Pass & Complete	
	Milestone #4 Establish governance structure reporting and monitoring processes	Pass & Complete	
	Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	Pass & Complete	
	Milestone #6 Finalize partnership agreements or contracts with CBOs	Pass & Ongoing	
	Milestone #7 Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	Pass & Ongoing	
	Milestone #8 Finalize workforce communication and engagement plan	Pass & Ongoing	
	Milestone #9 Inclusion of CBOs in PPS Implementation.	Pass & Complete	
Section 03	Module 3.1 - Prescribed Milestones		
	Milestone #1 Finalize PPS finance structure, including reporting structure	Pass & Complete	
	Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	Pass & Ongoing	
	Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Fail	IA
	Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	Pass & Ongoing	
	Milestone #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the	Pass & Ongoing	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Section	Module Name / Milestone #	Review Status	
	latest		
	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 & Ongoing	
	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 & Ongoing	
	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 & Ongoing	
	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 & Ongoing	
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

Bassett Medical Center (PPS ID:22)

Section	Module Name / Milestone #	Review Status	
	Milestone #1 Perform a clinical integration 'needs assessment'.	Pass & Ongoing	
	Milestone #2 Develop a Clinical Integration strategy.	Pass & Ongoing	
Section 11	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	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project ID	Module Name / Milestone #	Review Status	
2.a.ii	Module 2.a.ii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.a.ii.3 - Prescribed Milestones		
	Milestone #1 Ensure that all participating PCPs in the PPS meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.	Pass & Ongoing	
	Milestone #2 Identify a physician champion with knowledge of PCMH/APCM implementation for each primary care practice included in the project.	Pass & Ongoing	
	Milestone #3 Identify care coordinators at each primary care site who are responsible for care connectivity, internally, as well as connectivity to care managers at other primary care practices.	Pass & Ongoing	
	Milestone #4 Ensure 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 direct 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 Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management.	Pass & Ongoing	
	Milestone #8 Implement preventive care screening protocols including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) for all patients to identify unmet needs. A process is developed for assuring referral to appropriate care in a timely manner.	Pass & Ongoing	
	Milestone #9 Implement open access scheduling in all primary care practices.	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	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project ID	Module Name / Milestone #	Review Status	
	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.b.viii	Module 2.b.viii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.b.viii.3 - Prescribed Milestones		
	Milestone #1 Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.	Pass & Ongoing	
	Milestone #2 Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.	Pass & Ongoing	
	Milestone #3 Develop 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-like principles.	Pass & Ongoing	
	Milestone #5 Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	Pass & Complete	
	Milestone #6 Create coaching program to facilitate and support implementation.	Pass & Ongoing	
	Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	Pass & Ongoing	
	Milestone #8 Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.	Pass & Ongoing	
	Milestone #9 Utilize telehealth/telemedicine to enhance hospital-home care collaborations.	Pass & Ongoing	
	Milestone #10 Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.	Pass & Ongoing	
	Milestone #11 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Pass & Ongoing	
	Milestone #12 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	Pass & Ongoing	
	Module 2.c.i.3 - Prescribed Milestones		
	Milestone #1 Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.	Pass & Ongoing	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project ID	Module Name / Milestone #	Review Status	
	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	
	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 & Ongoing	
	Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	Pass & Ongoing	
	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 & Ongoing	
	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 & Ongoing	
	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	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project ID	Module Name / Milestone #	Review Status	
	Milestone #8 Include beneficiaries in development team to promote preventive care.	Pass & Ongoing	
	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.	Pass & Ongoing	
	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 & Ongoing	
	Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	Pass & Ongoing	
	Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	Pass & Ongoing	
	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	Pass & Ongoing	
	Module 3.a.i.3 - Prescribed Milestones		
	Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices	Pass & Ongoing	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project ID	Module Name / Milestone #	Review Status	
	must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.		
	Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Pass & Ongoing	
	Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Pass & Ongoing	
	Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #5 Co-locate primary care services at behavioral health sites.	Pass & Ongoing	
	Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Pass & Ongoing	
	Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Pass & Ongoing	
	Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #9 Implement IMPACT Model at Primary Care Sites.	Pass & Ongoing	
	Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Pass & Ongoing	
	Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Pass & Ongoing	
	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.iv	Module 3.a.iv.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.a.iv.3 - Prescribed Milestones		
	Milestone #1 Develop community-based addiction treatment programs that include outpatient SUD sites with PCP integrated teams, and stabilization services including social services.	Pass & Ongoing	
	Milestone #2 Establish referral relationships between community treatment programs and inpatient detoxification services with development of referral protocols.	Pass & Ongoing	
	Milestone #3 Include a project medical director, board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/naltrexone as well as familiarity with other withdrawal management agents.	Pass & Ongoing	
	Milestone #4 Identify and link to providers approved for outpatient medication management of opioid addiction who agree to provide continued maintenance therapy and collaborate with the treatment program and care manager. These may include practices with collocated behavioral health services, opioid treatment programs or outpatient SUD clinics.	Pass & Ongoing	
	Milestone #5 Develop community-based withdrawal management (ambulatory detoxification) protocols based upon	Pass & Ongoing	

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

DSRIP Implementation Plan Project

Bassett Medical Center (PPS ID:22)

Project ID	Module Name / Milestone #	Review Status	
	evidence based best practices and staff training.		
	Milestone #6 Develop care management services within the SUD treatment program.	Pass & Ongoing	
	Milestone #7 Form agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.	Pass & Ongoing	
	Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
3.d.iii	Module 3.d.iii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.d.iii.3 - Prescribed Milestones		
	Milestone #1 Implement evidence-based asthma management guidelines between primary care practitioners, specialists, and community-based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population based approach to asthma management.	Pass & Ongoing	
	Milestone #2 Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.	Pass & Ongoing	
	Milestone #3 Deliver educational activities addressing asthma management to participating primary care providers.	Pass & Ongoing	
	Milestone #4 Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.	Pass & Ongoing	
	Milestone #5 Use EHRs or other technical platforms to track all patients engaged 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.i	Module 4.b.i.2 - PPS Defined Milestones	Pass & Ongoing	