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

DSRIP Implementation Plan Project

Maimonides Medical Center (PPS ID:33)

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

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Section 01 – Budget

IPQR Module 1.1 - PPS Budget 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	34,713,348	36,993,019	59,822,355	52,972,467	34,713,348	219,214,536
Cost of Project Implementation & Administration	**29,506,346**	**27,744,764**	**32,902,295**	**21,188,987**	**17,356,674**	**128,699,066**
Administration	5,986,949	5,097,769	6,879,034	6,982,186	5,958,846	30,904,784
Implementation	23,519,397	22,646,995	26,023,261	14,206,801	11,397,828	97,794,282
Revenue Loss	**0**	**1,849,651**	**8,973,353**	**10,594,493**	**1,735,667**	**23,153,164**
Internal PPS Provider Bonus Payments	**0**	**1,849,651**	**11,964,471**	**15,891,740**	**15,621,007**	**45,326,869**
Cost of non-covered services	**0**	**0**	**0**	**0**	**0**	**0**
Other	**5,207,002**	**5,548,953**	**5,982,236**	**5,297,247**	**0**	**22,035,438**
Reinvestment Fund	5,207,002	5,548,953	5,982,236	5,297,247	0	22,035,438
Total Expenditures	**34,713,348**	**36,993,019**	**59,822,355**	**52,972,467**	**34,713,348**	**219,214,537**
Undistributed Revenue	**0**	**0**	**0**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
0294	Other	33_MDL0105_1_2_20160315234142_2016-3-15_Maimonides_PPS_-_Updated_Baseline_Budget_Table_-_Total_DSRIP_Award.pdf	3/15/2016 Maimonides PPS Updated Baseline Budget Table - Total DSRIP Award	03/15/2016 11:43 PM

Narrative Text :

Description of uploaded file:
The MAPP baseline budget table includes the total Net Project Valuation (NPV) amount, before adjustments. The baseline budget table has been revised to separate projected spending in the Implementation line into two subcomponents: 'Administration' and 'Implementation.' Amounts now shown in the 'Administration' include: staff and OTPS expenses associated with the Maimonides Central Services Organization (supporting the DSRIP program) and DSRIP planning and fiduciary fees. Please see also the uploaded file 'Maimonides PPS – Updated Baseline Budget Table – Total DSRIP Award' which illustrates the budgeted use of total expected DSRIP revenue of $412,344,429.

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Narrative text:
The DSRIP award letter issued on May 11, 2015 documented maximum possible funding of $489,039,450 for the Maimonides PPS, including:

a. Net Project Valuation (NPV) – $219,214,536
b. Safety Net Equity Performance (SNE-P) – $88,542,755
c. Safety Net Equity Guarantee (SNE-G) – $132,814,132
d. Net High Performance Fund – $26,970,632
e. Additional High Performance Fund, State Only – $21,497,395

The CCB's baseline budget table uses the subtotal of items a-c above ($440,571,423), excluding possible High Performance fund payments (totaling $48.5M), as the basis for estimating maximum funding. The percentage of NPV and SNE-P waiver revenue is higher in the early years when proportionally more of the total payment is based on reporting (P4R) and achieving Domain 1 process milestones, and lower in the later years, with the transition to pay-for-performance (P4P). The total SNE-G amount was spread evenly over each DSRIP year. CCB's approved baseline budget includes $412,344,429 in expected DSRIP funding distributed across budget categories as noted in the uploaded table. This baseline budget table has been updated to separate the costs of DSRIP program 'Administration' from other 'Implementation' expenses. Updated cells are highlighted in yellow.

Module Review Status

Review Status	IA Formal Comments
Pass & Complete	

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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
34,713,348	219,214,536	25,554,035	210,055,223

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	**3,104,334**	**9,159,313**	**20,347,033**	**68.96%**	**119,539,753**	**92.88%**
Administration	2,141,720					
Implementation	962,614					
Revenue Loss	**0**	**0**	**0**		**23,153,164**	**100.00%**
Internal PPS Provider Bonus Payments	**0**	**0**	**0**		**45,326,869**	**100.00%**
Cost of non-covered services	**0**	**0**	**0**		**0**	
Other	**0**	**0**	**5,207,002**	**100.00%**	**22,035,438**	**100.00%**
Reinvestment Fund	0					
Total Expenditures	**3,104,334**	**9,159,313**				

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 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	34,713,348	36,993,019	59,822,355	52,972,467	34,713,348	219,214,536
Practitioner - Primary Care Provider (PCP)	2,427,059	3,020,381	5,498,769	4,455,859	3,512,430	18,914,498
Practitioner - Non-Primary Care Provider (PCP)	809,019	1,079,039	2,306,312	2,122,076	1,857,400	8,173,846
Hospital	15,396,696	16,606,204	25,128,379	23,734,006	15,398,174	96,263,459
Clinic	809,020	1,183,794	2,957,222	2,957,861	2,715,638	10,623,535
Case Management / Health Home	2,427,058	2,919,238	4,729,512	3,301,679	2,139,249	15,516,736
Mental Health	809,020	1,017,630	1,832,923	1,405,688	999,162	6,064,423
Substance Abuse	224,768	354,157	919,858	984,259	905,495	3,388,537
Nursing Home	858,439	1,324,751	3,325,432	3,243,034	2,052,676	10,804,332
Pharmacy	0	3,612	59,174	119,397	171,647	353,830
Hospice	49,420	54,262	131,515	139,242	176,204	550,643
Community Based Organizations	1,294,431	1,641,213	3,074,694	2,503,816	1,941,955	10,456,109
All Other	1,618,039	1,825,750	2,364,027	1,139,804	281,849	7,229,469
PPS PMO	5,985,684	5,092,566	6,845,797	6,959,044	5,992,029	30,875,120
Total Funds Distributed	**32,708,653**	**36,122,597**	**59,173,614**	**53,065,765**	**38,143,908**	**219,214,537**
Undistributed Revenue	**2,004,695**	**870,422**	**648,741**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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The MAPP baseline funds flow table includes the total NPV amount per year that CCB expects will flow to providers/organizations in each of the NYSDOH specified categories (i.e. excluding Safety Net Equity Funds). The updated baseline funds flow table now includes a line for 'PMO' expenses. Costs associated with the Maimonides Central Services Organization (the 'PMO' for our PPS), DSRIP planning costs and the PPS fiduciary fee have been moved from the Hospitals line (where they were reported in the prior iteration) to the PMO line. Projected funds flow to Hospitals over 5 years is now estimated at 43.9% of total expected DSRIP funds, while funds flowing to PMO activities are estimated at 14.1% of expected DSRIP funds.

Module Review Status

Review Status	IA Formal Comments
Pass & Complete	

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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
34,713,348	219,214,536	25,554,035	210,055,223

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.i	2.a.iii	2.b.iii	2.b.iv	3.a.i	3.b.i	3.d.ii	3.g.i	4.a.iii	4.c.ii		
Practitioner - Primary Care Provider (PCP)	0	0	0	0	0	0	0	0	0	0	0	0	2,427,059	18,914,498
Practitioner - Non-Primary Care Provider (PCP)	0	0	0	0	0	0	0	0	0	0	0	0	809,019	8,173,846
Hospital	124,128	6,179,107	95.751	0	0	4.249	0	0	0	0	0	0	9,217,589	90,084,352
Clinic	19,000	19,000	0	30	0	27	25	18	0	0	0	0	790,020	10,604,535
Case Management / Health Home	0	0	0	0	0	0	0	0	0	0	0	0	2,427,058	15,516,736
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	809,020	6,064,423
Substance Abuse	0	0	0	0	0	0	0	0	0	0	0	0	224,768	3,388,537
Nursing Home	0	0	0	0	0	0	0	0	0	0	0	0	858,439	10,804,332
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	353,830
Hospice	0	0	0	0	0	0	0	0	0	0	0	0	49,420	550,643
Community Based Organizations	163,650	163,650	92.441	0	0	0	0	0	0	0	7.559	0	1,130,781	10,292,459
All Other	0	0	0	0	0	0	0	0	0	0	0	0	1,618,039	7,229,469
PPS PMO	2,797,556	2,797,556	100	0	0	0	0	0	0	0	0	0	3,188,128	28,077,564
Total Funds Distributed	**3,104,334**	**9,159,313**												

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

Module Review Status

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

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IPQR Module 1.5 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Complete funds flow budget and distribution plan and communicate with network	In Progress	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	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task Refine and update CCB baseline funding schedule (based on input from the provider network), detailing distribution of funding across budget categories, and review with Finance and Executive Committees.	Completed	Refine and update CCB baseline funding schedule (based on input from the provider network), detailing distribution of funding across budget categories, and review with Finance and Executive Committees.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop CCB program-specific budgets and funding plans and review with Finance and Executive Committees.	In Progress	Develop CCB program-specific budgets and funding plans and review with Finance and Executive Committees.	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Finalize Funds Flow Budget and Distribution Plan.	Not Started	Finalize Funds Flow Budget and Distribution Plan.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Initiate ongoing communication and education of Participants regarding funding and project schedules.	Not Started	Initiate ongoing communication and education of Participants regarding funding and project schedules.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Assess final CCB attribution and PMPM to calculate final valuation and maximum possible funding over the 5 year DSRIP period.	Completed	Assess final CCB attribution and PMPM to calculate final valuation and maximum possible funding over the 5 year DSRIP period.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	

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IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

Milestone Review Status

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

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IPQR Module 1.6 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 1.7 - IA Monitoring

Instructions :

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Section 02 – Governance

IPQR Module 2.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize governance structure and sub-committee structure	Completed	This milestone must be completed by 9/30/2015. Governance and committee structure, signed off by PPS Board.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task Identify size and number of governance committees.	Completed	Identify size and number of governance committees.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Identify and appoint members of the Executive Committee.	Completed	Identify and appoint members of the Executive Committee.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Develop the governance structure and receive approval from the Executive Committee.	Completed	Develop the governance structure and receive approval from the Executive Committee.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Solicit suggestions for and appoint initial members of the Finance Committee, IT Committee, Workforce Committee, and Care Delivery and Quality Committee; identify individuals to serve as members of the Nominating Committee and Hub Steering Committees, as appropriate.	Completed	Solicit suggestions for and appoint initial members of the Finance Committee, IT Committee, Workforce Committee, and Care Delivery and Quality Committee; identify individuals to serve as members of the Nominating Committee and Hub Steering Committees, as appropriate.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Appoint compliance officer.	Completed	Appoint compliance officer.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Appoint Compliance Subcommittee.	Completed	Appoint Compliance Subcommittee.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #2 Establish a clinical governance structure,	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

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
including clinical quality committees for each DSRIP project									
Task Draft charter for Care Delivery and Quality Committee. The charter will describe the responsibilities of the Care Delivery and Quality Committee, the process for appointing members to the Care Delivery and Quality Committee, and the consensus-based decision making process of the Care Delivery and Quality Committee.	Completed	Draft charter for Care Delivery and Quality Committee. The charter will describe the responsibilities of the Care Delivery and Quality Committee, the process for appointing members to the Care Delivery and Quality Committee, and the consensus-based decision making process of the Care Delivery and Quality Committee.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Identify and appoint members of the Care Delivery and Quality Committee.	Completed	Identify and appoint members of the Care Delivery and Quality Committee.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Establish work groups to support Care Delivery and Quality Committee regarding detailed clinical operational planning, including identification of performance metrics.	Completed	Establish work groups to support Care Delivery and Quality Committee regarding detailed clinical operational planning, including identification of performance metrics.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Draft, and obtain approval from Care Delivery and Quality Committee on scope, charge and meeting frequency of work groups.	Completed	Draft, and obtain approval from Care Delivery and Quality Committee on scope, charge and meeting frequency of work groups.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop standard form reports that will be used to track performance as against targets, including metrics of relevance to each DSRIP project, for presentation at workgroup and CDQ Committee meetings.	Completed	Develop standard form reports that will be used to track performance as against targets, including metrics of relevance to each DSRIP project, for presentation at workgroup and CDQ Committee meetings.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	Completed	This milestone must be completed by 9/30/2015. Upload of bylaws and policies document or committee guidelines.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task Under the leadership of the Maimonides Central Services Organization (CSO), draft and obtain approval from the Executive Committee for charters for the Finance Committee, IT Committee, Workforce Committee, Care Delivery	Completed	Under the leadership of the Maimonides Central Services Organization (CSO), draft and obtain approval from the Executive Committee for charters for the Finance Committee, IT Committee, Workforce Committee, Care Delivery and Quality Committee, Nominating Committee and Hub Steering Committees.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
and Quality Committee, Nominating Committee and Hub Steering Committees.									
Task Under the leadership of the CSO, draft CCB guidelines for consensus-based decision making at governance and other committees.	Completed	Under the leadership of the CSO, draft CCB guidelines for consensus-based decision making at governance and other committees.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop CCB governance policies, including policies and/or procedures regarding Participant assessments and related communications, disclosure of conflicts of interest and financial relationships, process for ensuring that DSRIP payments are not released to excluded persons, plans to support identification and reporting of DSRIP overpayments, etc., and the process for revising and adding policies as necessary in the future.	Completed	Develop CCB governance policies, including policies and/or procedures regarding Participant assessments and related communications, disclosure of conflicts of interest and financial relationships, process for ensuring that DSRIP payments are not released to excluded persons, plans to support identification and reporting of DSRIP overpayments, etc., and the process for revising and adding policies as necessary in the future.	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 Draft procedures by which the Executive Committee and Committees will (a) keep minutes, (b) send minutes to the Executive Committee, other Committees and Maimonides, as applicable, (c) make minutes available for CCB Participant review, and (d) monitor Participants' performance.	Completed	Draft procedures by which the Executive Committee and Committees will (a) keep minutes, (b) send minutes to the Executive Committee, other Committees and Maimonides, as applicable, (c) make minutes available for CCB Participant review, and (d) monitor Participants' performance.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Finalize governance and committee structure/procedures.	Completed	Finalize governance and committee structure/procedures.	07/01/2015	12/31/2015	07/01/2015	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)	In Progress	Community engagement plan, including plans for two-way communication with stakeholders.	04/01/2015	03/31/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO

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DSRIP Implementation Plan Project

Maimonides Medical Center (PPS ID:33)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Identify community resources and organizations and recruit participation in CCB governance, prioritizing Participants that deliver services to the diverse Brooklyn community, such as CAMBA, Caribbean Women's Health Association, GLWD, and Village Care.	Completed	Identify community resources and organizations and recruit participation in CCB governance, prioritizing Participants that deliver services to the diverse Brooklyn community, such as CAMBA, Caribbean Women's Health Association, GLWD, and Village Care.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Under the leadership of the Care Delivery and Quality Committee, draft community engagement plan, which includes draft schedule for public communications and community events, as applicable.	In Progress	Under the leadership of the Care Delivery and Quality Committee, draft community engagement plan, which includes draft schedule for public communications and community events, as applicable.	07/01/2015	12/31/2015	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Finalize community engagement plan.	Not Started	Finalize community engagement plan.	01/01/2016	03/31/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Milestone #6 Finalize partnership agreements or contracts with CBOs	In Progress	Signed CBO partnership agreements or contracts.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Draft and obtain review/feedback from Committees on Master Services Agreement and exhibits describing legal terms and conditions of CCB-CCB Participant relationship and CCB governance structure.	Completed	Draft and obtain review/feedback from Committees on Master Services Agreement and exhibits describing legal terms and conditions of CCB-CCB Participant relationship and CCB governance structure.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Send the Master Services Agreement to CCB Participants (including CBOs).	Completed	Send the Master Services Agreement to CCB Participants (including CBOs).	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Finalize Master Services Agreement and execute with CCB Participants (including CBOs).	In Progress	Finalize Master Services Agreement and execute with CCB Participants (including CBOs).	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 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	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task	Completed	Identify public sector agencies and contacts in CCB service	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Identify public sector agencies and contacts in CCB service area including but not limited to NYSDOH, NYCDOHMH, OASAS and OMH.		area including but not limited to NYSDOH, NYCDOHMH, OASAS and OMH.							
Task Under the leadership of the Care Delivery and Quality Committee, develop agency coordination plan for communicating and coordinating with public sector agencies/programs.	In Progress	Under the leadership of the Care Delivery and Quality Committee, develop agency coordination plan for communicating and coordinating with public sector agencies/programs.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Identify key contacts at each public sector agency Participant in the CCB network and establish agency- and/or project-specific outreach plans.	In Progress	Identify key contacts at each public sector agency Participant in the CCB network and establish agency- and/or project-specific outreach plans.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Finalize agency coordination plan.	Not Started	Finalize agency coordination plan.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
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).	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Working with key workforce organizations and unions (e.g., SEIU 1199, New York State Nurses Association (NYSNA), Committee of Interns and Residents (CIR), Civil Service Employees Association (CSEA) Greater NY Hospital Association (GNYHA) The Healthcare Association of New York State (HANYS) and others), define communication needs/messages and available communication channels for engaging key stakeholders.	Completed	Working with key workforce organizations and unions (e.g., SEIU 1199, New York State Nurses Association (NYSNA), Committee of Interns and Residents (CIR), Civil Service Employees Association (CSEA) Greater NY Hospital Association (GNYHA) The Healthcare Association of New York State (HANYS) and others), define communication needs/messages and available communication channels for engaging key stakeholders.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop workforce communication and engagement plan under the leadership of the Maimonides CSO's Director of PPS Workforce Development and subject to review and approval by the CCB Workforce Committee and appropriate stakeholders, including Participant	In Progress	Develop workforce communication and engagement plan under the leadership of the Maimonides CSO's Director of PPS Workforce Development and subject to review and approval by the CCB Workforce Committee and appropriate stakeholders, including Participant HR leads.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
HR leads.									
Task Present draft of workforce communication and engagement plan to Participant stakeholders for review and discussion; revise draft to reflect stakeholder input and feedback, including feedback from Participant human resources executives, unions, educators and others with workforce expertise.	Not Started	Present draft of workforce communication and engagement plan to Participant stakeholders for review and discussion; revise draft to reflect stakeholder input and feedback, including feedback from Participant human resources executives, unions, educators and others with workforce expertise.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Present draft of workforce communication and engagement plan to the CCB Workforce Committee for review and approval.	Not Started	Present draft of workforce communication and engagement plan to the CCB Workforce Committee for review and approval.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Present revised/final draft of workforce communication and engagement plan to the CCB Executive Committee for review and approval.	Not Started	Present revised/final draft of workforce communication and engagement plan to the CCB Executive Committee for review and approval.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Milestone #9 Inclusion of CBOs in PPS Implementation.	In Progress	Explain your plans for contracting with CBOs and their continuing role as your PPS develops over time; detail how many CBOs you will be contracting with and by when; explain how they will be included in project delivery and in the development of your PPS network.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Identify CBOs for participation in CCB governance, prioritizing Participants that deliver services to the diverse Brooklyn community.	Completed	Identify CBOs for participation in CCB governance, prioritizing Participants that deliver services to the diverse Brooklyn community.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Invite CCB Participants, including CBOs, to participate in the Project Advisory Committee (PAC) and hold initial PAC meeting.	Completed	Invite CCB Participants, including CBOs, to participate in the Project Advisory Committee (PAC) and hold initial PAC meeting.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task As discussed in the "Finalize partnership agreements or contracts with CBOs" milestone, finalize Master Services Agreement and execute with CCB Participants (including CBOs).	In Progress	As discussed in the "Finalize partnership agreements or contracts with CBOs" milestone, finalize Master Services Agreement and execute with CCB Participants (including CBOs).	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Assess CBO services, service areas, and	In Progress	Assess CBO services, service areas, and capabilities.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
capabilities.									
Task As discussed in the "Finalize cultural competency / health literacy strategy" milestone, CBOs will provide input into and feedback on the cultural competency/health literacy strategy.	Completed	As discussed in the "Finalize cultural competency / health literacy strategy" milestone, CBOs will provide input into and feedback on the cultural competency/health literacy strategy.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description
Finalize governance structure and sub-committee structure	If there have been changes, please describe those changes and upload any supporting documentation as necessary.	Please state if there have been any changes during this reporting quarter. Please state yes or no in the corresponding narrative box.
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	0294	Other	33_MDL0203_1_3_20160126114413_CCB_Governance_Committee_Membership_DY1_Q3.xlsx	CCB governance committee membership contact information	01/26/2016 11:44 AM
	0294	Meeting Materials	33_MDL0203_1_3_20160126114037_CCB_Meeting_Schedule_DY1_Q3.xlsx	CCB meeting schedule DY1 Q3	01/26/2016 11:40 AM
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	0294	Other	33_MDL0203_1_3_20160201113727_CCB_Charter_CDQ_Committee.pdf	CCB charter - CDQ committee	02/01/2016 11:37 AM
	0294	Other	33_MDL0203_1_3_20160126113645_CCB_Clinical_Governance_Committee_Members_DY1_Q3.xlsx	CCB clinical committee membership contact information	01/26/2016 11:36 AM
	0294	Meeting Materials	33_MDL0203_1_3_20160126113543_CCB_Clinical_Committee_Meeting_Schedule_DY1_Q3.xlsx	CCB clinical committee meeting schedule DY1 Q3	01/26/2016 11:35 AM
Establish governance structure reporting and monitoring processes	0294	Other	33_MDL0203_1_3_20160201130441_CCB_Committee_Reporting_and_Monitoring_Plan.pdf	Governance & committee structure reporting & monitoring document	02/01/2016 01:04 PM

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize governance structure and sub-committee structure	Yes, there have been changes during this reporting quarter. Please see attached supporting documentation that contain updates.
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	The Care Delivery and Quality (CDQ) Committee continued to meet regularly, with meetings in Q3 on November 5, 2015, and December 11, 2015. The CDQ workgroups, PCMH (including our Domain 3 projects), care management (including Health Home at Risk), ED Triage and 30 Day Readmissions, continued to meet to develop detailed operational plans to support CCB's eight Domain 2 and 3 projects. Recommendations from the CDQ workgroups were presented to the CDQ for their review and discussion. Following CDQ's approval, the recommendations were reported to the CCB Executive Committee for their review and approval. Standard forms to track and monitor performance on key metrics for each DSRIP project have been created and presented along with the detailed operational plans to the CDQ Committee. CCB also convenes working groups for specific DSRIP project initiatives as needed.
Finalize bylaws and policies or Committee Guidelines where applicable	No, there have been no changes during this reporting quarter.
Establish governance structure reporting and monitoring processes	The CCB governance structure has been finalized and is documented in the Master Services Agreement, committee charters approved by the Executive Committee, as well approved minutes of the Executive Committee and other meetings. CCB's governance committees include an Executive Committee, Care Delivery and Quality Committee, Finance Committee, Information Technology Committee, Workforce Committee, Compliance Committee, Community Engagement Committee and Nominating Committee. Additional committees may be formed as appropriate to support ongoing and future work, with similar approval and ongoing oversight by the Executive Committee and other committees, as appropriate. CCB's governance committee members represent a diverse and engaged cross-section of our Participant network and bring to bear their substantial expertise and experience, focusing on the betterment of the PPS, the achievement of PPS goals, and PPS responsibilities and commitments, rather than the particular interests of their own organizations. This approach and mandate has been central to the evolution of CCB and its governance structure. Through CCB's established practices and as documented in CCB's Committee Reporting and Monitoring Plan, the Executive Committee receives regular, appropriate updates on the activities of all governance committees and there is substantial cross-committee reporting to ensure and support dialogue, collaboration and oversight. CCB has established a standard form for governance committee meeting minutes, as well as a process by which they are distributed for review in advance of the meeting at which they will be presented for approval. Using the Salesforce CRM platform, CCB is piloting a Participant-facing "Resource Portal" and has established our participant survey and database. CCB will utilize these channels to further engage and support governance, including providing access to event and meeting calendars, announcements, approved meeting minutes and other relevant documents.
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	CCB has made significant progress in focusing on community engagement, including the development of the Community Engagement Advisory Committee. This Committee was instrumental in developing the Cultural Competency and Health Literacy Strategy, which incorporates some of the initial thinking on our community engagement plan. We are pushing back this milestone from March 2016 (DY1 Q4) to June 2016 (DY2 Q1) to allow for: additional input from the Committee, experience during the implementation of the Cultural Competency and Health Literacy Strategy, and aligned deadlines with the health disparities training plan.
Finalize partnership agreements or contracts with CBOs	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	
Finalize workforce communication and engagement plan	
Inclusion of CBOs in PPS Implementation.	

Milestone Review Status

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

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IPQR Module 2.2 - PPS Defined Milestones

Instructions :

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

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

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.

One challenge will be developing and negotiating the Master Services Agreement, the schedules containing additional Participant-specific obligations, and funding schedules with the CCB Participants due to the size of the PPS and the diversity of Participant types, size and the services offered. CCB Participants represent the full spectrum of health care providers, social services organizations and other community-based entities, with a range of capabilities and limitations. Additionally, there are a number of Participants that are participating in other PPSs. Notwithstanding the diversity of the CCB Participants, the plan for review of the Master Services Agreement and schedules with CCB Participants' legal counsel will be transparent and will aim to reach mutually agreeable terms among all Participants. Another challenge will be engaging members of the committees in a meaningful and productive way to achieve the CCB's goals over a relatively short timeline. A strong working governance structure will depend upon: the clear definition of roles and responsibilities; the identification of key staff to support the governance process; the availability of information and technology to support decision-making; and the time that members of the various committees can devote to preparing for meetings (e.g., reading materials distributed in advance of meetings), attending meetings, and otherwise being actively involved in the committees. CCB recognizes that Committee members have significant obligations to their organizations outside of CCB and will schedule meetings well in advance and limit them to a reasonable time period. CCB will also seek to create a strong performance reporting infrastructure to support data sharing and decision-making across CCB, which should help improve coordination and effectiveness of the CCB governance structure.

IPQR Module 2.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

The ability to develop the schedules that are part of the partnership agreements with CBOs will depend on the development of clinical operational plans which will detail work plans and Participant obligations by DSRIP project. Creation of the funding schedules is dependent upon outputs of the finance workstream, which, in turn, will depend upon the availability of information concerning the funds available to Maimonides (PPS lead) to support implementation of the DSRIP projects. Additionally, and as specified in more detail in later sections, the ability of the CCB governance to be effective in oversight of CCB's performance requires establishing appropriate IT systems for collection and reporting of performance information.

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IPQR Module 2.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Lead Applicant and Equity Contributor	Maimonides Medical Center	Leadership Participant; fiduciary oversight; governance oversight; membership/leadership of key CCB committees, including Executive, Care Delivery and Quality and Finance
Maimonides Central Services Organization (CSO) Staff	CSO Staff members	PPS management, including ongoing policy development, development of DSRIP plans and budgets, oversight of DSRIP program operations, oversight of accounting, financial management, analytics and reporting, IT and other support functions, and management of consultant resources
Hospital Partners	New York Methodist Hospital, Wyckoff Heights Medical Center, Interfaith Medical Center, Kingsbrook Jewish Medical Center, New York Community Hospital	Participants in key CCB committees and workgroups; participation in key CCB projects; collaboration with other CCB Participants
Key Health Care Provider Organizations	Brownsville Multi-Service Family Health Center, Bedford-Stuyvesant Family Health Center, Brooklyn Plaza Medical Center, Health Care Choices, Housing Works, Brightpoint Health, Metropolitan Jewish Health System, Village Care, Kingsboro Psychiatric Center, others	Participants in key CCB committees and workgroups; participation in key CCB projects; collaboration with other CCB Participants
Physician Organizations and Health Homes	Higher Ground IPA, Advantage Care, Brooklyn Health Home, Coordinated Behavioral Care Health Home, others	Participants in key CCB committees and workgroups; participation in key CCB projects; collaboration with other CCB Participants
Key Advisors and Consultants	Manatt, Phelps and Phillips; Community Care of North Carolina (CCNC); others	Providing assistance to CSO management team with drafts of Master Services Agreement (MSA) and other governance documents (Manatt); assisting with development of plans and budgets for DSRIP projects (Manatt); providing technical assistance with refinement of provider engagement and care management strategies (CCNC)
Major CBOs and/or social service agencies	CAMBA, Caribbean Women's Health Association, God's Love We Deliver, and others	Participants in key CCB committees and workgroups; participation in key CCB projects; collaboration with other CCB Participants; assisting with identification and evaluation of community needs and resources to meet those needs

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Module 2.6 - IPQR Module 2.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
All PPS Participants	Representatives from Participant organizations	Project Advisory Committee (PAC) members; participation in selected CCB projects; liaison to various communities served by CCB network
Medicaid Managed Care Organizations (MCOs)	HealthFirst, AmidaCare, others	Participants in key CCB committees and workgroups
External Stakeholders		
Government agencies, such as NYS DOH, NYC DOHMH, OMH, OASAS, DSS	Oversight and collaboration	Overseeing DSRIP contract and processing release of DSRIP funds (NYS DOH); providing ongoing guidance with respect to DSRIP deliverables and requirements (NYS DOH); participating in workgroup and committees (NYC DOHMH); providing oversight, regulations, and collaboration (all)
Non-partner MCOs	Potential participants in value-based payment contract proposals	Feedback on proposed value-based payment and other managed care contracting plans
Non-partner CBOs	Potential Participants in community and patient engagement activities	Providing forum to facilitate communications with Medicaid beneficiaries, community leaders, others; feedback on proposed outreach strategies

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.

CCB will deploy IT solutions that allow for collaboration and effective management of CCB's committees and workgroups. In order for CCB governance to be effective, CCB will employ tools to collect reliable performance data and analyze this information for rapid cycle evaluation and other performance monitoring responsibilities.

One major solution that CCB will use across DSRIP workstreams is the GSI Health Coordinator platform, called the "Dashboard". This existing web-based care planning tool has been used successfully over the last few years within the Brooklyn Health Home network. The Dashboard facilitates coordinated care planning and communication among collaborating providers and patients about the physical, behavioral and social factors impacting patients' lives. Subject to patient consent, all providers involved in the care of a patient have access to this platform, which includes key clinical data including hospitalization alerts from the Healthix (RHIO). CCB also intends to use the Dashboard infrastructure to provide data and analytic support for population health management, reporting, and data exchange for all Participants, which will be especially critical for providers who do not have EHRs. CCB will leverage the Dashboard and other solutions to help ensure that leadership has access to the information it needs on a timely basis as well as increase the effectiveness and efficiency of decision-making.

Given the breadth of CCB's Participants, in both scale and diversity, CCB will leverage technology solutions to ensure that CCB's communications reach and engage Participants, community organizations, agencies, and other stakeholders involved in Brooklyn's transformation. CCB will also use the CCB website and other communication vehicles to allow patients and other stakeholders to raise issues, concerns, or suggestions and help inform CCB governance.

IPQR Module 2.8 - Progress Reporting

Instructions :

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

Success will be measured by (1) the occurrence of meetings of the Executive Committee, Finance Committee, Care Delivery and Quality Committee, Workforce Committee, IT Committee and Hub Steering Committees at a frequency in accordance with the applicable charter, (2) implementation of CCB policies and procedures, (3) execution of the Master Services Agreement and performance by Maimonides and Participants (including CBOs) of obligations against the Agreement. The CCB PPS is large and diverse, posing potential challenges to realizing these aspects of progress reporting. To address this challenge, CCB will seek to meaningfully engage and activate all of its Participants at the outset of DSRIP implementation, identify their unique roles in achieving project and overall success, and motivate their participation and collaboration with other Participants and, as needed, with other PPSs.

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IPQR Module 2.9 - IA Monitoring

Instructions :

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Section 03 – Financial Stability

IPQR Module 3.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize PPS finance structure, including reporting structure	Completed	This milestone must be completed by 12/31/2015. PPS finance structure chart / document, signed off by PPS Board.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Develop Finance Committee charter and establish roles and responsibilities of PPS lead with respect to oversight of financial management functions.	Completed	Develop Finance Committee charter and establish roles and responsibilities of PPS lead with respect to oversight of financial management functions.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Present Finance Committee charter to Executive Committee for review and approval.	Completed	Present Finance Committee charter to Executive Committee for review and approval.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Identify and appoint members to Finance Committee and convene first meeting.	Completed	Identify and appoint members to Finance Committee and convene first meeting.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Establish preliminary schedule of Finance Committee meetings, rules for participation (e.g., quorum, consensus decision-making, in-person and phone meetings).	Completed	Establish preliminary schedule of Finance Committee meetings, rules for participation (e.g., quorum, consensus decision-making, in-person and phone meetings).	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Establish standard format for documentation of Finance Committee actions in meeting minutes and for regular reports to Executive Committee.	Completed	Establish standard format for documentation of Finance Committee actions in meeting minutes and for regular reports to Executive Committee.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop CCB-specific financial reporting structure and processes, including a proposed	Completed	Develop CCB-specific financial reporting structure and processes, including a proposed approach to development of DSRIP budget and funds flow tables, and present to	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
approach to development of DSRIP budget and funds flow tables, and present to Executive Committee for approval.		Executive Committee for approval.							
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	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task Identify and appoint members to the Sustainability Workgroup of the Finance Committee and convene first meeting.	In Progress	Identify and appoint members to the Sustainability Workgroup of the Finance Committee and convene first meeting.	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Assess financial impact of DSRIP projects, by project and provider type and present findings to Finance Committee.	In Progress	Assess financial impact of DSRIP projects, by project and provider type and present findings to Finance Committee.	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Review and revise financial health current state assessment tool as needed to capture key financial health and sustainability indicators.	In Progress	Review and revise financial health current state assessment tool as needed to capture key financial health and sustainability indicators.	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Develop plan to address challenges of Financially Fragile Participants, including metrics, monitoring process, and strategies.	In Progress	Develop plan to address challenges of Financially Fragile Participants, including metrics, monitoring process, and strategies.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Develop CCB Financial Sustainability Plan and present to Finance Committee and Executive Committee for approval.	In Progress	Develop CCB Financial Sustainability Plan and present to Finance Committee and Executive Committee for approval.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Release communication to PPS Participants	Not Started	Release communication to PPS Participants explaining the purpose/importance of the annual financial health	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
explaining the purpose/importance of the annual financial health assessment tool as an element of CCB's sustainability strategy and administer updated financial health current state assessment tool to all Participants.		assessment tool as an element of CCB's sustainability strategy and administer updated financial health current state assessment tool to all Participants.							
Task Analyze results of annual Participant financial health current state assessment and, if applicable, identify financially fragile Participants.	Not Started	Analyze results of annual Participant financial health current state assessment and, if applicable, identify financially fragile Participants.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Sustainability Workgroup will report findings from assessment to Finance Committee and Executive Committee.	Not Started	Sustainability Workgroup will report findings from assessment to Finance Committee and Executive Committee.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Completed	This milestone must be completed by 12/31/2015. Finalized Compliance Plan (for PPS Lead).	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Incorporate DSRIP related risk assessment as part of ongoing Maimonides' Compliance Program reviews and establish appropriate channels of communication between the Maimonides Compliance Officer and the CSO management team.	Completed	Incorporate DSRIP related risk assessment as part of ongoing Maimonides' Compliance Program reviews and establish appropriate channels of communication between the Maimonides Compliance Officer and the CSO management team.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Incorporate required adherence to key policies, including compliance policies, in CCB Master Services Agreement as appropriate.	Completed	Incorporate required adherence to key policies, including compliance policies, in CCB Master Services Agreement as appropriate.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop CCB policies, including compliance policies, and present to the Executive Committee for approval.	Completed	Develop CCB policies, including compliance policies, and present to the Executive Committee for approval.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Publish CCB policies, including compliance policies and provisions for anonymous reporting of DSRIP related compliance concerns.	Completed	Publish CCB policies, including compliance policies and provisions for anonymous reporting of DSRIP related compliance concerns.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop communications/outreach plan to	Completed	Develop communications/outreach plan to ensure that Medicaid beneficiaries, Participants and other stakeholders,	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
ensure that Medicaid beneficiaries, Participants and other stakeholders, both internal and external, are aware of mechanisms to report compliance concerns.		both internal and external, are aware of mechanisms to report compliance concerns.							
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	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task Review final State value-based payment roadmap upon release.	Completed	Review final State value-based payment roadmap upon release.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop value-based payment assessment and Participant value-based payment reporting framework.	In Progress	Develop value-based payment assessment and Participant value-based payment reporting framework.	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Assess the current state of value-based payment and associated revenue across CCB Participants.	In Progress	Assess the current state of value-based payment and associated revenue across CCB Participants.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Develop preferred compensation and MCO strategy framework through Sustainability workgroup/ Finance Committee.	Not Started	Develop preferred compensation and MCO strategy framework through Sustainability workgroup/ Finance Committee.	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Review and achieve sign off with CCB Executive Committee.	Not Started	Review and achieve sign off with CCB Executive Committee.	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	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3	YES
Task Conduct gap assessment between CCB's current volume of value-based revenue (from baseline assessment) and target of 90% across the PPS network.	In Progress	Conduct gap assessment between CCB's current volume of value-based revenue (from baseline assessment) and target of 90% across the PPS network.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task	In Progress	Develop provider and MCO education and engagement	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Develop provider and MCO education and engagement strategy to facilitate CCB Participants' and MCOs' understanding of value-based payment concepts and contracting arrangements.		strategy to facilitate CCB Participants' and MCOs' understanding of value-based payment concepts and contracting arrangements.							
Task Initiate provider and MCO education and engagement campaign with CCB Participants.	Not Started	Initiate provider and MCO education and engagement campaign with CCB Participants.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Establish Participant value-based payment reporting requirements and procedures to enable ongoing monitoring of CCB value-based payment revenue.	Not Started	Establish Participant value-based payment reporting requirements and procedures to enable ongoing monitoring of CCB value-based payment revenue.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Define CCB organizational requirements necessary to support for transition to value-based payment.	Not Started	Define CCB organizational requirements necessary to support for transition to value-based payment.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Review baseline and gap assessment results with PPS Participants and MCOs to inform development of value-based payment transition plan.	Not Started	Review baseline and gap assessment results with PPS Participants and MCOs to inform development of value-based payment transition plan.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Develop value-based payment transition plan with input from PPS Participants and MCOs.	Not Started	Develop value-based payment transition plan with input from PPS Participants and MCOs.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Finalize CCB value-based payment transition plan and present to Executive Committee for approval.	Not Started	Finalize CCB value-based payment transition plan and present to Executive Committee for approval.	10/01/2016	12/31/2016	10/01/2016	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	In Progress		04/01/2015	03/31/2020	10/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Milestone #7 Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	In Progress		04/01/2015	03/31/2020	10/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
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	In Progress		04/01/2015	03/31/2020	10/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES

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 PPS finance structure, including reporting structure	0294	Other	33_MDL0303_1_3_20160201114258_CCB_Charter_Finance_Committee.pdf	This document, with the CCB finance committee membership, is meant to satisfy the first minimum standard on the finance structure identifying the role of the PPS and other entities	02/01/2016 11:42 AM
	0294	Other	33_MDL0303_1_3_20160201104807_CCB_Finance_Committee_Membership_DY1_Q3.xlsx	This document, with the CCB finance committee charter, is meant to satisfy the first minimum standard on the finance structure, identifying the role of the PPS and other entities.	02/01/2016 10:48 AM
	0294	Meeting Materials	33_MDL0303_1_3_20160126120010_CCB_Finance_Committee_Meeting_Schedule_DY1_Q3.xlsx	CCB finance committee meeting schedule DY1 Q3	01/26/2016 12:00 PM
	0294	Other	33_MDL0303_1_3_20160126115936_CCB_Organizational_Chart.pdf	CCB organizational chart	01/26/2016 11:59 AM
	0294	Other	33_MDL0303_1_3_20160126115731_CCB_Executive_Committee_Meeting_Minutes_03.03.2015.pdf	Evidence of CCB Board (Executive Committee) approval of the various committee charters.	01/26/2016 11:57 AM
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	0294	Documentation/Certification	33_MDL0303_1_3_20160126152610_CCB_OMIG_Compliance_Program_Certification.pdf	CCB OMIG Compliance Program Certification	01/26/2016 03:26 PM

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize PPS finance structure, including reporting structure	The Chief Administrative and Financial Officer of the Maimonides Central Services Organization (CSO) is responsible for overseeing DSRIP-related administrative and financial management functions for the PPS, including the development of budgets and funds flow plans, the establishment of internal controls to support the processing of DSRIP-related payments, and development and distribution of reports on budgeted vs. actual DSRIP income and expense. The CCB Finance Committee charter sets forth the roles of the Finance Committee, Executive Committee and Maimonides Medical Center, as PPS lead, in connection with the review and approval of plans and budgets, reporting, and the development and ongoing monitoring of financial sustainability plans for CCB. The charter also confirms that a quorum for meetings will be 60% of the members, and that the CCB Finance Committee shall meet not less frequently than 4 times per year. The CCB Finance Committee includes individuals with a wide range of experience in the financial and/or general management of health and social services organizations, as well as individuals with experience in managed care and contract management. Chaired by the CSO's Chief Administrative and Financial Officer, the CCB Finance Committee met for the first time before DY1 began, and met seven times during the first 3 quarters of DY1. Minutes of CCB Finance Committee meetings are prepared in a standard format, and distributed for review in advance of the meeting at which they are presented for approval. A report from the Finance Committee is a standing item on the agenda for each meeting of the CCB Executive Committee. A proposed approach to the development of DSRIP budget and funds flow tables was presented to and discussed with members of the Finance Committee at meetings on March 25 and May 27, 2015. At its meeting in late May, the CCB Finance Committee reviewed the funding categories in the May 11, 2015 DSRIP Award Letter, discussed the relationship between the sources of funds (including Safety Net Equity and High Performance funds) and conditions for attaining them, and approved the budget and funds flow tables that were to be submitted as part of the Implementation Plan due on June 1, 2015. The CCB Finance Committee at a subsequent meeting reviewed and approved the required revision of budget and funds flow tables to include only the NPV component of the overall DSRIP Award, but insisted that detailed reports on CCB's planned use of the total funds awarded were also included and addressed in a narrative explaining the required change. The CCB Finance Committee's recommendations were presented to and approved by the CCB Executive Committee. Following up on the discussion at meetings during DY1 Q2 of DSRIP program planning and budgeting, the CCB Finance Committee also reviewed, provided feedback on and approved the proposed approach to the development of Participant- and Project-specific Schedules (to attach to the Master Services Agreement) detailing project implementation plans, reporting requirements and payment amounts/schedules. The proposed approach was also presented to and approved by the CCB Executive Committee. Quarterly reports illustrating the source of DSRIP funds by funding category (through DY1 Q3, including only the initial NPV payment) and use of DSRIP funds (for management of the PPS, centralized program costs, or payments to Participants pursuant to Schedule B agreements) are presented to and discussed by the CCB Finance Committee, and shared with the CCB Executive Committee as well.
Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	CCB Participants are connected via a Master Services Agreement (MSA) to MMC. CCB is governed by an Executive Committee and managed by the Maimonides CSO. Members of the CSO management team staff CCB's governance committees and work groups, and are responsible for development of DSRIP project plans and budgets. CCB project plans and budgets are the framework within which project-specific agreements are developed. Referred to as "Schedules" attached to a Participant's MSA, these agreements document a Participant's engagement in specific DSRIP projects/activities, and outline the requirements that must be met to receive DSRIP payments. The NYS Office of the Medicaid Inspector General (OMIG) has confirmed that it is the PPS lead (in this case MMC) that is required to have a compliance program consistent with New York State Social Services Law 363-d. MMC's Compliance Program is overseen by the SVP / Corporate Compliance Officer, and certification of the program was submitted as required in December of 2015.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	The OMIG issued DSRIP compliance guidance in April and September of 2015 stressing the importance of dedicating resources and developing systems to ensure Medicaid funds distributed as part of the DSRIP program are not connected with fraud, waste, and abuse. PPS leads are not responsible for tracking Participant use of DSRIP payments, but must have processes in place to link Participant payments to approved project plans and Participant-specific budgets. CCB has established a Compliance Committee (chaired by the MMC Corporate Compliance Officer), to serve as the forum for the review of DSRIP-specific compliance guidelines and issues; the CCB Compliance Committee charter sets forth the frequency of meetings, manner of acting, and role of members. The Corporate Compliance Officer and the Maimonides CSO's Chief Administrative and Financial Officer have worked together to identify DSRIP-related risks, and the CSO has implemented processes to address those risks, including identification of Participants and others need of compliance training, and monthly screening of contracted entities to ensure that excluded entities do not receive DSRIP payments. The PPS will identify and report any overpayments that may be issued based upon data that is later found to be incorrect, regardless of reason. Both the MSA and Schedule B templates reference Participant obligations to adhere to CCB compliance guidelines, including required Participant attestation of compliance adherence upon execution and in ongoing reporting. The CSO has established a CCB Participant database, including fields to track status of MSA execution, Participant-specific plans and budgets, and compliance status. Certain CSO staff (individuals not involved in the negotiation of Participant-specific schedules) have been conduct monthly exclusion screenings using the SanctionCheck system. Prerequisites to the release of payment to a CCB Participant include: signed MSA, signed Schedule, completed survey and satisfactory compliance check. The Chief Administrative and Financial Officer has primary responsibility for overseeing DSRIP program compliance. Others involved include the VP for Analytics & Business Operations, who oversees the Participant database, the Manager for Healthcare Analytics, who is responsible for conducting the monthly exclusion screenings, and the Director of Contracting and Compliance Support, who joined the team in December of 2015. CSO staff have worked in consultation with GNHYA and compliance contacts at other PPSs to develop DSRIP-specific educational materials to complement existing CCB network-wide communications (newsletters, MSA release, etc.) concerning compliance. Upon finalization (in early DY1 Q4) of the materials developed in the GNYHA working group, CCB will add them to or replace existing CCB-specific educational materials.
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	

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Milestone Review Status

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

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IPQR Module 3.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

One challenge to implementing these cross-cutting organizational strategies is Participant engagement and capacity. Community Care of Brooklyn (CCB) must meaningfully engage a large, diverse group of Participants in the finalization of DSRIP implementation plans, including the establishment of metrics that will be used to measure progress towards the achievement of the milestones that will drive payments. Participants will have a wide range of needs and concerns, and vary in their capacity to dedicate resources to the DSRIP effort. Additionally, Participants will vary in their capacity to understand and track performance to support the activities for which the Participant is responsible. CCB will address this challenge through the development and distribution of Participant-facing educational materials to support the Master Services Agreement and communicate individual Participant funding schedules at the outset of DSRIP implementation to ensure that Participants understand the process and the links between achieving project milestones and receiving payments.

CCB's inability to access Participant data or analytics for reporting is another risk. CCB will educate Participants on the obligations and requirements with respect to performance reporting and will work collaboratively with Participants to develop a performance reporting strategy that includes necessary metrics and other data that will drive payments to the PPS and to Participants. CCB will engage Participants in the strategy and design of reporting mechanisms and processes to facilitate information gathering and to ensure that analyses and reports are reflective of performance. CCB will also establish systems for monitoring information that may be accessed by the NYSDOH directly (e.g., Medicaid claims data, other performance data) to ensure that CCB and Participants understand and have an opportunity to validate that information.

Another risk is the availability of DSRIP waiver funds and CCB's ability to achieve and draw down incentive payments on time and in amounts sufficient to support the work that CCB and its Participants have committed to undertake. CCB must successfully achieve and report on State-established milestones and metrics to draw down incentive payments and subsequently distribute funds to its Participants. The PPS has and will continue to engage in a thoughtful planning process to ensure it is able to achieve DSRIP milestones and metrics in a timely manner and to the best of its ability.

Lastly, engagement with Medicaid Managed Care Organizations (MCOs) poses a challenge to implementing CCB's financial strategies. The transition to value-based payment across CCB will require the engagement and willingness of Medicaid MCOs to transform their existing fee-for-service contracts into value-based payment contracts. To address this challenge, CCB will continue engaging Medicaid MCOs through DSRIP implementation planning, participation in the Finance Committee and Sustainability Workgroup, and ongoing meetings to ensure Medicaid MCOs are meaningfully engaged in the development of transition plans and have sufficient lead time to prepare for the transition to value-based payment.

IPQR Module 3.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

CCB's financial strategy is dependent on several work streams, including performance reporting, governance, workforce, IT, and provider engagement.

The performance reporting infrastructure will support provider, practice, and organization-level reporting and evaluation to drive DSRIP incentive payments. CCB will identify a point-of-contact in each Participant organization for finance-related matters (e.g., reporting and policies/procedures) and will base Participant reporting requirements on DSRIP reporting milestones/metrics. Performance reporting and incentive payments will be detailed in each Participant's Master Services Agreement.

The financial sustainability and governance work streams are interdependent as the CCB governance structure must be capable of executing financial responsibilities and the CCB governance structure must evolve to incorporate Medicaid MCOs to support transition to value-based payment. Similarly, financial sustainability is also dependent on workforce, which will be a major component to the PPS's overall success. Developing and implementing a sound workforce strategy to support its Participants and enable the implementation of DSRIP projects and their respective care models is a key factor in the PPS's ability to ultimately achieve outcomes and draw down incentive payments.

The CCB IT systems must also support central finance and performance reporting to inform and track PPS and project-level budgets and funds flow. The CCB IT systems must support population health management to enable Participants to improve patient outcomes that will drive the transition to value-based payment with Medicaid MCOs and other payers.

CCB must effectively engage and educate Participants – including physicians with a wide range of skills and abilities – to ensure successful implementation of the value-based payment strategy. Without Participants' active engagement and participation in DSRIP projects and overall performance reporting structure, CCB will not be able to obtain and implement value-based payment models. CCB will work with Participants through the Project Advisory Committee and in other forums as it develops funds flow methodologies and the value-based payment roadmap. This will help to ensure Participants understand the requirements to transition to value-based payment and are prepared to function as an integrated network to elevate CCB's ability to realize value-based payment models with MCOs and other payers.

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
CCB Executive Committee	Chairperson: David Cohen, MD, MSc, Executive Vice President for Clinical Affairs and Affiliations, MMC, and CEO, Maimonides Central Services Organization (CSO)	Overall PPS oversight; leadership of integrated delivery system development efforts, review and approval of recommendations from the CCB Care Delivery and Quality, Finance, and other committees; identification of issues for consideration by MMC.
CCB Finance Committee	Chairperson: Caroline D. Greene, Chief Administrative & Financial Officer, Maimonides Central Services Organization (CSO)	Oversight of PPS finances; review and approval of budgets and funds flow models; oversight of managed care contracting and CCB sustainability efforts
CCB Sustainability Workgroup	CCB Finance Committee Chairperson: Caroline D. Greene, Chief Administrative & Financial Officer, Maimonides Central Services Organization (CSO); Workgroup chair to be determined	Oversee development and implementation of plan to conduct assessment to determine the financial health of the CCB network; develop financial sustainability plan, including value-based managed care contracting strategy.
Chief Administrative & Financial Officer, Maimonides Central Services Organization (CSO)	Caroline D. Greene	Primary PPS lead for administrative and financial matters; lead development and implementation of financial management strategies; oversee key administrative functions, including IT, analytics and reporting, contracting and administrative support functions; collaborate with CCB Participants and key MCOs to identify and pursue VBP and other managed care contracting opportunities; oversee development and implementation of overall VBP strategy; recruit staff, including an executive to lead managed care contracting, to support achievement of CCB sustainability goals.
Compliance Officer, Maimonides Medical Center (MMC)	Martin Cammer, Senior Vice President and Chief Compliance Officer, Maimonides Medical Center	Collaborate with senior CSO leadership on refinement of the MMC Compliance Plan to incorporate DSRIP-related risks and mitigation strategies and development of a Compliance Program for the CSO and CCB.
Controller / Deputy Finance Officer, Maimonides CSO	Currently open position reporting to: Caroline D. Greene, Chief Administrative & Financial Officer, Maimonides Central Services Organization (CSO)	Preparing interim and annual financial reports on PPS budgeted vs. actual revenue and expense, and developing cash flow budgets and funds flow reports; establishing and overseeing internal control plans; serving as liaison with outside auditor(s) with respect to the annual audit of MMC (for DSRIP-specific activities) and CSO books and records.

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IPQR Module 3.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Michael Carbery	Chief Information Officer for Population Health, Maimonides Central Services Organization (CSO)	Provide needed IT support for CCB's analytics & reporting and managed care contracting functions.
Chief Executives of CCB Participant entities	Leadership of CCB Participant entities	Overseeing Participants' fulfillment of DSRIP responsibilities as outlined in MSA and Participant-specific Schedules.
External Auditors	Audit	Participate in annual audit of the books and records of Maimonides Medical Center, to include the review/audit of PPS funds flow; perform annual audit of the Maimonides CSO.
Robert Cimino	Vice President, Analytics & Business Operations, Maimonides Central Services Organization (CSO)	Establish performance reporting and analytics capacity within the CSO; ensure the accuracy, timeliness and accessibility of performance reporting.
Medicaid Managed Care Organizations (MCOs)	HealthFirst, AmidaCare, others	Participants in key CCB committees and workgroups.
External Stakeholders		
Non-partner MCOs and other payers	Review/negotiation of CCB value-based payment contract proposals.	Collaborate with CCB to implement the PPS's value based strategy, including establishment of an effective contracting process.
NYSDOH	DSRIP requirements, guidance, and reporting	Confirm requirements and guidance for DSRIP reporting and development of budgets and funds flow.
Community groups	Representation of communities served	Provide input and feedback to inform development, implementation and ongoing refinement of DSRIP program plans and initiatives.
Government agencies, such as NYS DOH, NYC DOHMH, OMH, OASAS, DSS	Oversight and collaboration	Overseeing DSRIP contract and processing release of DSRIP funds (NYS DOH); providing ongoing guidance with respect to DSRIP deliverables and requirements (NYS DOH); participating in workgroup and committees (NYC DOHMH); providing oversight, regulations, and collaboration (all)

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IPQR Module 3.7 - IT Expectations

Instructions :

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

The Central Services Organization (CSO) and Finance Committee will depend on automated systems to support financial sustainability and overall success of CCB. Systems must be capable of capturing and reporting performance information at both a PPS and project level in order to support achievement of DSRIP goals and subsequent payments. As described in the Performance Reporting section below, this information will be used for CCB governance as well as rapid cycle evaluation. Data will need to be collected in a reliable and coordinated manner from CCB's wide network of Participants for various purposes, including information on Participants' financial health and transition to value based payments. These systems will need to be secure, reliable, and accurate, in order to be used to calculate DSRIP payments to Participants based on performance and update project/PPS budget and funds flow projections.

IPQR Module 3.8 - Progress Reporting

Instructions :

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

CCB will measure the success of the financial sustainability work stream by the establishment of a financial management team within the CSO, the creation of a Finance Committee and Sustainability Workgroup, and implementation of the financial management and reporting structure. In addition, CCB will evaluate and revise/modify the CCB financial reporting structure to reflect the changing needs of the PPS as a whole and its Participants, develop a plan to address challenges of financially fragile Participants, receive approval on the CCB value-based payment plan, and collaborate with managed care organizations and other stakeholders to support the transition to value-based payment.

During the DSRIP planning phase, CCB completed initial financial health assessments of the PPS lead (Maimonides) and CCB Participants. The assessment will be modified/updated as necessary and re-administered to all Participants on an annual basis and the results summarized by the Chief Administrative and Financial Officer for review with the CCB Finance Committee. The Finance Committee will also provide feedback to ensure the assessment is comprehensive and tracking financial metrics reflective of Participants' financial health.

The CSO will work closely with Maimonides (the fiduciary), Executive Committee, and Finance Committee to monitor and ensure CCB's progress against State requirements and process measures. The CSO will support the CCB finance and reporting structure through the preparation of regular reports and updates on budget, funds flow, and Participant trends.

IPQR Module 3.9 - IA Monitoring

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Instructions :

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Section 04 – Cultural Competency & Health Literacy

IPQR Module 4.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize cultural competency / health literacy strategy.	Completed	This milestone must be completed by 12/31/2015. Cultural competency / health literacy strategy signed off by PPS Board. The strategy should: -- Identify priority groups experiencing health disparities (based on your CNA and other analyses); -- Identify key factors to improve access to quality primary, behavioral health, and preventive health care -- Define plans for two-way communication with the population and community groups through specific community forums -- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors); and -- Identify community-based interventions to reduce health disparities and improve outcomes.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Establish and convene Care Delivery and Quality Committee to oversee development of cultural competency/health literacy strategy.	Completed	Establish and convene Care Delivery and Quality Committee to oversee development of cultural competency/health literacy strategy.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Review Community Needs Assessment (CNA) to identify priority populations experiencing health disparities and relevant community-based organizations (CBOs).	Completed	Review Community Needs Assessment (CNA) to identify priority populations experiencing health disparities and relevant community-based organizations (CBOs).	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Identify and inventory CBOs and other	Completed	Identify and inventory CBOs and other organizations with cultural and health literacy competencies/programs currently	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
organizations with cultural and health literacy competencies/programs currently serving CCB beneficiaries.		serving CCB beneficiaries.							
Task Solicit input from CBOs, Participants, and other PPS partners, including CAMBA, Caribbean Women's Health Association, GLWD, NAMI, and Village Care, to identify priority populations experiencing health disparities through such methods as surveys, community forums and the Care Delivery and Quality Committee meetings.	Completed	Solicit input from CBOs, Participants, and other PPS partners, including CAMBA, Caribbean Women's Health Association, GLWD, NAMI, and Village Care, to identify priority populations experiencing health disparities through such methods as surveys, community forums and the Care Delivery and Quality Committee meetings.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Identify gaps in existing cultural competency and health literacy programs, particularly for priority populations, based on inventory and Community Needs Assessment (CNA).	Completed	Identify gaps in existing cultural competency and health literacy programs, particularly for priority populations, based on inventory and Community Needs Assessment (CNA).	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop draft strategy to address gaps and leverage/augment existing resources and programs, including planning for the development and deployment of required tools for patients to use in managing their health.	Completed	Develop draft strategy to address gaps and leverage/augment existing resources and programs, including planning for the development and deployment of required tools for patients to use in managing their health.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Present draft strategy to key community leaders and/or Project Advisory Committee (PAC) and obtain feedback.	Completed	Present draft strategy to key community leaders and/or Project Advisory Committee (PAC) and obtain feedback.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Revise strategy to reflect input from key community leaders and/or PAC and present to the Executive Committee for review/approval.	Completed	Revise strategy to reflect input from key community leaders and/or PAC and present to the Executive Committee for review/approval.	10/01/2015	12/31/2015	10/01/2015	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 groups identified in your cultural competency strategy -- Training plans for other segments of your workforce (and	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		others as appropriate) regarding specific population needs and effective patient engagement approaches							
Task Identify and inventory existing training programs for clinicians and other members of the workforce that serve CCB beneficiaries and address health disparities among racial ethnic groups.	In Progress	Identify and inventory existing training programs for clinicians and other members of the workforce that serve CCB beneficiaries and address health disparities among racial ethnic groups.	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Review CNA and other available data to identify critical areas of health and social disparities for training support.	Completed	Review CNA and other available data to identify critical areas of health and social disparities for training support.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Identify gaps in training programs based on inventory of existing programs and review of CNA and other available data, and begin to develop training strategies that address identified gaps by augmenting current training programs, and identifying the need for development of new training programs.	In Progress	Identify gaps in training programs based on inventory of existing programs and review of CNA and other available data, and begin to develop training strategies that address identified gaps by augmenting current training programs, and identifying the need for development of new training programs.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Working with the Workforce and Care Delivery and Quality Committees, develop draft training plan to address gaps and leverage/augment existing training programs, identifying distinct needs by sub-population, type of provider or other workforce members and present to the Executive Committee for review and approval.	Not Started	Working with the Workforce and Care Delivery and Quality Committees, develop draft training plan to address gaps and leverage/augment existing training programs, identifying distinct needs by sub-population, type of provider or other workforce members and present to the Executive Committee for review and approval.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Identify, in collaboration with the Workforce and Care Delivery and Quality Committees, provider champions to deploy the training plan and ongoing evaluation and enhancement.	Not Started	Identify, in collaboration with the Workforce and Care Delivery and Quality Committees, provider champions to deploy the training plan and ongoing evaluation and enhancement.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Implement training plan using a system/methodology to monitor and report on adoption and delivery.	Not Started	Implement training plan using a system/methodology to monitor and report on adoption and delivery.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task	Not Started	Initiate ongoing evaluation of training effectiveness through	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Initiate ongoing evaluation of training effectiveness through such methods as surveys and focus groups.		such methods as surveys and focus groups.							

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.	0294	Templates	33_MDL0403_1_3_20160315161946_CCB_CCHL_Meeting_Schedule_DY1_Q3.xlsx	CCB Cultural Competency and Health Literacy Meeting Schedule Template	03/15/2016 04:19 PM
	0294	Other	33_MDL0403_1_3_20160315161728_Appendix_-_CCB_Initial_Compendium_of_Cultural_Competency_Tools.pdf	CCB Cultural Competency and Health Literacy Strategy Appendix - CCB Initial Compendium of Cultural Competency Tools	03/15/2016 04:17 PM
	0294	Other	33_MDL0403_1_3_20160315161642_CCB_Cultural_Competency_and_Health_Literacy_Strategy.pdf	CCB Cultural Competency and Health Literacy Strategy, revised per IA feedback	03/15/2016 04:16 PM
	0294	Other	33_MDL0403_1_3_20160315161208_2016-03-11_CCB_Executive_Committee_Minutes.pdf	3/11/2016 Draft CCB Executive Committee minutes / PPS Board approval of the revised Cultural Competency and Health Literacy Strategy	03/15/2016 04:12 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize cultural competency / health literacy strategy.	In Q2, we established the Community Engagement Committee to advise the Executive Committee on efforts related to community engagement, health disparities, cultural competency, and health literacy. CCB has identified CBOs to participate as members of the Committee, bringing each organization's experience meeting the unique needs of diverse segments of Brooklyn's population. As part of the CCB Participant Survey, launched in September 2015, we are collecting information about each Participant's services, service areas, and capabilities, including that of CBOs. Review of the Community Needs Assessment identified several priority populations experiencing health disparities. Clinical

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	populations with behavioral health conditions, asthma, and palliative care conditions experience significant health disparities, and these disparities are experienced disproportionately by historically disenfranchised communities with large ethnic and racial diversity, and include significant immigrant communities. Additional details on the disparities are presented in the Cultural Competency and Health Literacy Strategy. CCB contracted with a partner CBO, the Arthur Ashe Institute for Urban Health, to coordinate, collect feedback, and develop the CCB Cultural Competency and Health Literacy Strategy. Arthur Ashe engaged other community partners including the Brooklyn Perinatal Network, the Caribbean Women's Health Association, and CAMBA, to craft our approach. In addition, key informant interviews were conducted with other stakeholder organizations who work with a diverse array of sub-populations experiencing health disparities. The Community Engagement Committee reviewed the Strategy and provided feedback. On December 18, 2015, the Executive Committee approved the CCB Cultural Competency and Health Literacy Strategy. Upon feedback from the Independent Assessor, the CCB Cultural Competency and Health Literacy Strategy was revised and reviewed by the Community Engagement Committee. On March 11, 2015, the Executive Committee approved the revised CCB Cultural Competency and Health Literacy Strategy.
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	

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IPQR Module 4.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

The CNA confirmed that CCB will serve large and diverse communities in Brooklyn characterized by concentrated populations of minority groups and poverty. Many Brooklyn providers have challenges addressing the needs and preferences of the varied cultures of their patients and are not well connected to community resources that can help address and improve their patients' health needs. This is compounded by the social and cultural factors that impact patients' abilities to access care, including language, education, and adverse socioeconomic factors. As CCB develops its cultural competency/health literacy and training strategies, it will develop programs that equip providers and other members of the workforce with the skills and tools they need to effectively communicate with and engage patients from all walks of life and to build a workforce with whom patients will identify and respect. CCB will work closely with its workforce partners to design curricula that address the health disparities among its ethnically and culturally diverse patient population. CCB will regularly update such curricula to address new immigrant groups, reflect learnings from partners' work in their communities, and ensure that CCB providers and staff have access to the best resources available. CCB will also work to develop educational resources that meet the language and cultural needs of the communities served.

CCB may face risks with respect to patient participation and engagement in CCB initiatives. To mitigate this risk and promote participation and engagement, CCB will make the initiatives and resources available to patients in their communities – rather than exclusively in health care settings. CCB will also actively monitor patient participation to assess whether individual initiatives are effectively reaching the target population and make adjustments or develop alternative initiatives as needed. Lastly, and perhaps most importantly, CCB will engage patients and community leaders in the development of the cultural competency and health literacy strategy and design of initiatives, actively seeking their feedback to understand which initiatives are likely to be well received or rejected by the target population.

Finally, CCB recognizes that many Participants are currently under-resourced and may require flexibility with respect to when and where they participate in cultural competency and health literacy training programs. To mitigate the risk of low provider participation in trainings, CCB will offer trainings through various media – online, telephonic and in-person—to facilitate ongoing access to information of relevance.

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.)

The successful implementation of CCB's health literacy/cultural competency and training strategies is dependent on the practitioner engagement and workforce work streams. If CCB is unable to meaningfully engage practitioners or cultivate an adequate workforce to serve its beneficiaries, efforts to develop programs and curricula will have a less than optimal effect. Additionally, CCB will need to deploy a broad worker training program which will encompass health literacy/cultural competency. Deployment of cultural competency training programs is dependent on the

broader training strategy.

The development of IT systems and organizational processes to support provider relations and patient demographics will also be critical to ensuring that (1) CCB is aware of and can track all CCB providers and other members of the workforce, their access to programs, and completion of curricula and (2) CCB can capture important data about beneficiaries' cultural and linguistic backgrounds and preferences to inform providers and connect beneficiaries with appropriate resources.

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IPQR Module 4.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
CCB Care Delivery and Quality Committee	Chairperson: Karen Nelson, MD, MPH, Senior Vice President, Integrated Delivery Systems, MMC, and Chief Medical Officer, Maimonides Central Services Organization (CSO)	Oversee the development of CCB Cultural Competency / Health Literacy standards and the strategy to achieve them
CCB Workforce Committee	Committee Chairperson TBD DY1 Q2 Interim Lead: David Cohen, MD, MSc, Executive Vice President for Clinical Affairs and Affiliations, MMC, and CEO, Maimonides Central Services Organization (CSO)	Oversee development and implementation of CCB's training strategy, to include training for CCB Participant staff in cultural competency and health literacy

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IPQR Module 4.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
CCB Participant network providers, including PCPs and other providers such as CAMBA, a.i.r. NYC, JASA, NAMI, and Village Care	Recipients of educational and training programs	Commitment to the achievement of CCB's cultural competency standards
Training Vendor (Contractor TBD)	Development and implementation of cultural competency training program	Develop and implement CCB's cultural competency training & education program
CBOs, such as Caribbean Women's Health Association, God's Love We Deliver, National Alliance on Mental Illness, others	Provide feedback on proposed approach to increasing / enhancing cultural competency of the CCB network	Providing subject matter expertise; assisting with development/strengthening of channels of communication with Medicaid beneficiaries
External Stakeholders		
Religious/Cultural Institutions	Provide feedback on training and communication strategies	Providing subject matter expertise; assisting with development/strengthening of communications strategies
Patients & Families	Recipients of improved services; consultation on design of cultural competency / health literacy initiatives	Feedback on proposed cultural competency / health literacy initiatives

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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.

CCB will use IT systems to support the identification of cultural competency gaps, development of culturally competent resources/trainings, and implementation of the cultural competency/health literacy strategy. In the identification of cultural competency gaps, CCB will use data to identify demographic characteristics, health disparities, and health care usage information, within the very diverse populations across Brooklyn. This data will underpin the formation of the cultural competency/health literacy strategy, which will lay out the target populations, interventions, and trainings that will be conducted. Additionally, IT systems will support CCB in regularly assessing progress against the strategy and DSRIP milestones related to cultural competency and health literacy.

IPQR Module 4.8 - Progress Reporting

Instructions :

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

Addressing cultural competency and health literacy across CCB will determine CCB's ability to achieve and perform against project requirements. CCB will measure the success of the cultural competency and health literacy strategy by the extent to which health outcomes improve across our entire attributed beneficiary population, taking into account improvements across different segments of the population (e.g., different race/ethnicities/primary language, etc.). Achievement will also be measured by attainment of overall DSRIP goals of reducing unnecessary emergency room and hospital utilization by 25%.

At a more granular level, we will measure success by working closely and cultivating meaningful working relationships with community-based organizations (CBOs) and other key leaders from communities characterized by health disparities to develop an actionable cultural competency and health literacy strategy and corresponding training plan that are adopted by the Executive Committee. Another measure of success will be the number of providers and other professionals trained in cultural competency and health literacy. The CSO will support the development of the strategy and training plan and, subsequently, track our progress against the strategy. We will also work closely with CBOs and key Participants to assess target population to measure patient engagement and satisfaction and analyze available data to inform changes to our strategy and initiatives.

IPQR Module 4.9 - IA Monitoring

Instructions :

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Section 05 – IT Systems and Processes

IPQR Module 5.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	In Progress	Detailed IT current state assessment. Relevant QEs (RHIOs/HIEs) should be involved in performing this assessment.	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Establish CCB IT Committee and populate membership from key CCB Participants and stakeholders.	Completed	Establish CCB IT Committee and populate membership from key CCB Participants and stakeholders.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Engage RHIO and other NYS resources to determine RHIO/SHIN-NY technical capacity to meet connectivity and other technological gaps identified in the Participant Survey.	In Progress	Engage RHIO and other NYS resources to determine RHIO/SHIN-NY technical capacity to meet connectivity and other technological gaps identified in the Participant Survey.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Assess CCB Participants' current IT capabilities through the Participant Survey, which asks questions regarding RHIO connectivity, EHR use, Meaningful Use Attestation status, etc.	In Progress	Assess CCB Participants' current IT capabilities through the Participant Survey, which asks questions regarding RHIO connectivity, EHR use, Meaningful Use Attestation status, etc.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Complete CCB Current State Assessment, identifying Participant readiness and need for: local EHR system implementation/upgrade and/or RHIO Connectivity; the PPS provided Care Coordination system, GSI Health Coordinator ("the Dashboard"); and other	Not Started	Complete CCB Current State Assessment, identifying Participant readiness and need for: local EHR system implementation/upgrade and/or RHIO Connectivity; the PPS provided Care Coordination system, GSI Health Coordinator ("the Dashboard"); and other centrally provided and NYS systems (e.g. MAPP).	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
centrally provided and NYS systems (e.g. MAPP).									
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	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Under the leadership of the PPS CIO, work with the IT Committee and other PPS committees and workgroups, as well as with key Stakeholders, to establish a process for developing and updating the IT Change Management Plan, including the Communication Plan, the Provider-facing Education and Training plan, the Technical Change Management Plan, and an overall Impact and Risk Assessment.	Completed	Under the leadership of the PPS CIO, work with the IT Committee and other PPS committees and workgroups, as well as with key Stakeholders, to establish a process for developing and updating the IT Change Management Plan, including the Communication Plan, the Provider-facing Education and Training plan, the Technical Change Management Plan, and an overall Impact and Risk Assessment.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Under the leadership of the PPS CIO and assigned workgroup, develop the proposed IT Change Management Communication Plan in accordance with the agreed upon process.	In Progress	Under the leadership of the PPS CIO and assigned workgroup, develop the proposed IT Change Management Communication Plan in accordance with the agreed upon process.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Under the leadership of the PPS CIO and assigned workgroup, develop the proposed IT Change Management Education and Training Plan in accordance with the agreed upon process.	In Progress	Under the leadership of the PPS CIO and assigned workgroup, develop the proposed IT Change Management Education and Training Plan in accordance with the agreed upon process.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Under the leadership of the PPS CIO and assigned workgroup, develop the proposed IT Technical Change Management Plan in accordance with the agreed upon process. This	In Progress	Under the leadership of the PPS CIO and assigned workgroup, develop the proposed IT Technical Change Management Plan in accordance with the agreed upon process. This includes the process for defining, authorizing and implementing changes and enhancements to PPS	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
includes the process for defining, authorizing and implementing changes and enhancements to PPS provided IT systems, and for addressing challenges to local Participant adoption and use of common IT platforms and applications.		provided IT systems, and for addressing challenges to local Participant adoption and use of common IT platforms and applications.							
Task Under the leadership of the PPS CIO and workgroups, submit the merged, comprehensive IT Change Management Plan to the IT Committee for Review, Comment, and Approval. Revisit and revise change items and revise with relevant as appropriate.	In Progress	Under the leadership of the PPS CIO and workgroups, submit the merged, comprehensive IT Change Management Plan to the IT Committee for Review, Comment, and Approval. Revisit and revise change items and revise with relevant as appropriate.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Under the leadership of the PPS CIO and key stakeholders, submit the comprehensive IT Change Management Plan to the Executive Committee for Approval.	In Progress	Under the leadership of the PPS CIO and key stakeholders, submit the comprehensive IT Change Management Plan to the Executive Committee for Approval.	10/01/2015	09/30/2016	10/01/2015	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	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Under the leadership of the PPS CIO and IT Committee, in collaboration with PPS Clinical/Operational and key Stakeholders, develop a cross-functional governance	In Progress	Under the leadership of the PPS CIO and IT Committee, in collaboration with PPS Clinical/Operational and key Stakeholders, develop a cross-functional governance framework for establishing the PPS Roadmap for Clinical Data Sharing via Interoperable Systems. The Roadmap will	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
framework for establishing the PPS Roadmap for Clinical Data Sharing via Interoperable Systems. The Roadmap will be tailored to maximize the adoption and effectiveness of all three interoperable tiers of the PPS technical architecture, including NYS, PPS, and local Participant EHR data and services, particularly the rapid adoption of the PPS provided centralized Care Coordination system.		be tailored to maximize the adoption and effectiveness of all three interoperable tiers of the PPS technical architecture, including NYS, PPS, and local Participant EHR data and services, particularly the rapid adoption of the PPS provided centralized Care Coordination system.							
Task As part of the Roadmap, under the leadership of the PPS CIO and IT Committee, develop a plan for maximizing the speed of adoption and use of the HIPAA compliant centralized PPS Care Coordination system (GSI Health Coordinator), which is already interoperable with the RHIO/SHIN-NY via an HL7/IHE standards based interface; thereby immediately enabling HIPAA compliant data sharing among PPS Participants and Programs.	In Progress	As part of the Roadmap, under the leadership of the PPS CIO and IT Committee, develop a plan for maximizing the speed of adoption and use of the HIPAA compliant centralized PPS Care Coordination system (GSI Health Coordinator), which is already interoperable with the RHIO/SHIN-NY via an HL7/IHE standards based interface; thereby immediately enabling HIPAA compliant data sharing among PPS Participants and Programs.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Under the leadership of the PPS CIO, the CCB IT Committee and other PPS Stakeholders, define and prioritize technical enhancements to the PPS provided centralized Care Coordination system (GSI Health Coordinator). Enhancements will be focused on the key care management, standards based (ONC, HL7, IHE) Communication, Reporting, and ease of access (e.g., Single Sign-On) capabilities promoting widespread adoption and support for implementation of DSRIP projects.	Not Started	Under the leadership of the PPS CIO, the CCB IT Committee and other PPS Stakeholders, define and prioritize technical enhancements to the PPS provided centralized Care Coordination system (GSI Health Coordinator). Enhancements will be focused on the key care management, standards based (ONC, HL7, IHE) Communication, Reporting, and ease of access (e.g., Single Sign-On) capabilities promoting widespread adoption and support for implementation of DSRIP projects.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Analyze the results of the PPS Participant survey to identify gaps in local Participant EHR and RHIO/SHIN-NY connectivity.	Not Started	Analyze the results of the PPS Participant survey to identify gaps in local Participant EHR and RHIO/SHIN-NY connectivity.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Based on the results of the PPS Participant	Not Started	Based on the results of the PPS Participant survey, prioritize efforts and resources to maximize the speed and	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
survey, prioritize efforts and resources to maximize the speed and effectiveness of Safety Net Provider certified EHR adoption/upgrade and HL7/IHE standards based RHIO/SHIN-NY connectivity.		effectiveness of Safety Net Provider certified EHR adoption/upgrade and HL7/IHE standards based RHIO/SHIN-NY connectivity.							
Task Merge the multiple work streams into a comprehensive PPS Data Sharing and Interoperability Roadmap. Submit to the IT Committee and other relevant workgroups and stakeholders for review, comment, and revision. Include a schedule for review/revision to adapt to changes in regulations, technology standards, and statewide services (e.g. MAPP,SHIN-NY), etc.	Not Started	Merge the multiple work streams into a comprehensive PPS Data Sharing and Interoperability Roadmap. Submit to the IT Committee and other relevant workgroups and stakeholders for review, comment, and revision. Include a schedule for review/revision to adapt to changes in regulations, technology standards, and statewide services (e.g. MAPP,SHIN-NY), etc.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Submit the PPS Data Sharing and Interoperability Roadmap to the Executive Committee for approval.	Not Started	Submit the PPS Data Sharing and Interoperability Roadmap to the Executive Committee for approval.	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	In Progress	PPS plan for engaging attributed members in Qualifying Entities, signed off by PPS Board. The plan should include your approach to outreach into culturally and linguistically isolated communities.	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Review list of attributed members from NYS.	Not Started	Review list of attributed members from NYS.	04/01/2015	03/31/2020	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Working with the Care Delivery and Quality Committee, the CSO's Chief Medical Officer, Associate Medical Director and other members of the CSO management team will draft a patient engagement plan, taking into account findings from the Community Needs Assessment (CNA) and cultural competency/health literacy considerations.	In Progress	Working with the Care Delivery and Quality Committee, the CSO's Chief Medical Officer, Associate Medical Director and other members of the CSO management team will draft a patient engagement plan, taking into account findings from the Community Needs Assessment (CNA) and cultural competency/health literacy considerations.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Convene patient focus groups to identify and assess appropriate patient engagement channels (e.g., phone, texts, email, in-person, etc.) for	Not Started	Convene patient focus groups to identify and assess appropriate patient engagement channels (e.g., phone, texts, email, in-person, etc.) for specific patient populations (e.g. based on primary diagnosis, age, ethnicity, etc.).	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
specific patient populations (e.g. based on primary diagnosis, age, ethnicity, etc.).									
Task Develop patient engagement plan detailing plans for various population-appropriate patient engagement channels based on feedback of focus groups on modalities to be used, channels for outreach, and level of effort required. The plan will also identify and mechanisms for tracking and measuring patient engagement (e.g., email open rate, number of completed care plans, number of attributed members providing RHIO consent, etc.) and plans for refining engagement strategy over time, based on outcomes.	Not Started	Develop patient engagement plan detailing plans for various population-appropriate patient engagement channels based on feedback of focus groups on modalities to be used, channels for outreach, and level of effort required. The plan will also identify and mechanisms for tracking and measuring patient engagement (e.g., email open rate, number of completed care plans, number of attributed members providing RHIO consent, etc.) and plans for refining engagement strategy over time, based on outcomes.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Present plan to Executive Committee for review and approval.	Not Started	Present plan to Executive Committee for review and approval.	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Milestone #5 Develop a data security and confidentiality plan.	In Progress	Data security and confidentiality plan, signed off by PPS Board, including: -- Analysis of information security risks and design of controls to mitigate risks -- Plans for ongoing security testing and controls to be rolled out throughout network.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Under the leadership of the PPS CIO/CISO and IT Committee, and working with key NYS Stakeholders, define the scope and approach for conducting a comprehensive PPS Data Security and Confidentiality gap assessment to analyze security risks and design appropriate mitigation controls.	Completed	Under the leadership of the PPS CIO/CISO and IT Committee, and working with key NYS Stakeholders, define the scope and approach for conducting a comprehensive PPS Data Security and Confidentiality gap assessment to analyze security risks and design appropriate mitigation controls.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Under the leadership of the PPS CIO/CISO and IT Committee, and working with key NYS stakeholders, identify major sources, types, access channels, user roles, and special technical and administrative requirements.	Completed	Under the leadership of the PPS CIO/CISO and IT Committee, and working with key NYS stakeholders, identify major sources, types, access channels, user roles, and special technical and administrative requirements.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Under the leadership of the PPS CIO/CISO and IT Committee, work with NYS, RHIO, and PPS legal counsel to explore and evaluate consent instruments (existing and desired/future) for sharing of patient data among PPS Participants, including data sourced from payers and the RHIO/SHIN-NY.	Completed	Under the leadership of the PPS CIO/CISO and IT Committee, work with NYS, RHIO, and PPS legal counsel to explore and evaluate consent instruments (existing and desired/future) for sharing of patient data among PPS Participants, including data sourced from payers and the RHIO/SHIN-NY.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Under the leadership of the PPS CIO/CISO and IT Committee, define high level technical and administrative requirements (e.g., BAAs, NYS IAL, etc.).	Completed	Under the leadership of the PPS CIO/CISO and IT Committee, define high level technical and administrative requirements (e.g., BAAs, NYS IAL, etc.).	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Identify gaps between current NYS, PPS and PPS Participant technical, administrative, and process capabilities versus requirements, evaluate risks presented by identified gaps and potential mitigation strategies.	In Progress	Identify gaps between current NYS, PPS and PPS Participant technical, administrative, and process capabilities versus requirements, evaluate risks presented by identified gaps and potential mitigation strategies.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Develop plan for implementation of controls and testing in alignment with PPS priorities for Clinical and other data sharing across channels and provider (PPS Participant) types, including provisions for periodic review and revision to address the changes in program needs, data sources, standards, NYS guidance and regulations.	In Progress	Develop plan for implementation of controls and testing in alignment with PPS priorities for Clinical and other data sharing across channels and provider (PPS Participant) types, including provisions for periodic review and revision to address the changes in program needs, data sources, standards, NYS guidance and regulations.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Finalize and obtain Executive Committee approval of data security and confidentiality plan.	In Progress	Finalize and obtain Executive Committee approval of data security and confidentiality plan.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

NYS Confidentiality – High

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop a data security and confidentiality plan.	0294	Other	33_MDL0503_1_3_20160314171551_CCB_DY1_Q3_PPS_template_in_lieu_of_SSPs_Remediation_Period_Revised.pdf	CCB DY1 Q3 PPS Template in Lieu of SSPs, revised per remediation period comments	03/14/2016 05:15 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	
Develop an IT Change Management Strategy.	
Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	
Develop a specific plan for engaging attributed members in Qualifying Entities	
Develop a data security and confidentiality plan.	

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	

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IPQR Module 5.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

The primary challenges to implementing the IT strategy center on the vast number of CCB Participants and the wide variation in their existing IT capabilities, systems, and capacity. Notably, CCB includes a large number of voluntary providers with neither the IT infrastructure nor the resources to support the procurement or implementation of new systems. These providers may also be hesitant to participate in an IT strategy unless there is a clear tie to benefits for the provider, including financial incentives. To address these risks, CCB will undertake a deliberate and thoughtful approach to engaging providers in the development and roll out of the PPS's IT strategy, and identify provider champions to both serve on the IT Committee and communicate changes to their peers. CCB will also, through its IT assessment, identify and subsequently develop resources and offer funding, as available, to assist providers with implementation.

The IT strategy will rely heavily on the Central Services Organization's (CSO) ability to support its development and execution. The CSO has been established, but it is a new organization with new personnel. To mitigate the risk that CSO development may delay work on the IT strategy, the CSO will rely on experienced IT leadership and personnel to lead its IT strategy and planning activities.

The success of the IT strategy and PPS will, to some extent, be dependent on CCB's ability to effectively work with Healthix (RHIO) and CCB Participants' vendors to enable connectivity, data exchange, and reporting. To mitigate this risk, CCB will engage Healthix and key Participant vendors early in the process to ensure processes and communication mechanisms are in place to facilitate timely implementation, along with the required data sharing policies. CCB will leverage its role as a large PPS encompassing many providers to negotiate effectively with Healthix. CCB will also offer an existing web-based care management platform, the GSI Health Coordinator (often referred to as the Dashboard), to Participants without existing systems to promote access to a shared IT platform.

IPQR Module 5.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

IT will be critical to the success of nearly every workstream described in the Implementation Plan and its interdependencies are far reaching. Notably, the clinical integration work stream will rely on information gathered through the IT assessment and development of system requirements to inform the PPS's strategy and use cases. The population health management strategy will inform the development of platforms or shared systems to support the PPS, as will the cultural competency and health literacy strategy with respect to both provider and patient-facing tools. The workforce and practitioner engagement work streams are linked to IT as there will be a major training component for practitioners, their staff, and members of their care teams to ensure systems are utilized effectively and promote care coordination. Finally, CCB's governance work stream and committees will serve to ensure the coordination of IT with all of the necessary work streams in an effort to achieve economies of scale and

prioritize activities and development to meet the needs of CCB Participants and support the achievement of DSRIP goals.

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IPQR Module 5.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Chief Information Officer for Population Health, Maimonides Central Services Organization (CSO)	Michael Carbery	Leadership of IT Governance, IT Change Management, IT Strategy and IT roadmap development processes
Data and Security Lead, Maimonides Central Services Organization (CSO)	Unfilled Position, reporting to the CIO for Population Health	Data security and confidentiality plan
CCB IT Committee	Committee Chairperson TBD DY1 Q2 Interim Lead: Michael Carbery, Chief Information Officer for Population Health, Maimonides Central Services Organization (CSO)	IT strategy and roadmap, IT Change Management
CCB Care Delivery and Quality Committee, including key Participant leadership	Chairperson: Karen Nelson, MD, MPH, Senior Vice President, Integrated Delivery Systems, MMC, and Chief Medical Officer, Maimonides Central Services Organization (CSO)	Qualified Entity engagement plan

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IPQR Module 5.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
CCB Participants	Responsible for managing EHR interfaces and interoperability	Clinical data sharing and use of systems
CCB Executive Committee	Approval and oversight	Patient engagement plan and IT Strategy and roadmap
Key Hospitals and Medical Practices	Key CCB Participants	Clinical data sharing and use of systems
IT Vendors such as GSI Health	Provider of IT platforms	IT vendor for GSI Health Coordinator ("Dashboard"), others
External Stakeholders		
Healthix (RHIO)	RHIO Platform Lead	Roadmap for identifying need for and delivering new data sharing and other capabilities
Government agencies, such as NYS DOH, NYC DOHMH, OMH, OASAS, DSS	Oversight and collaboration	Overseeing DSRIP contract and processing release of DSRIP funds (NYS DOH); providing ongoing guidance with respect to DSRIP deliverables and requirements (NYS DOH); participating in workgroup and committees (NYC DOHMH); providing oversight, regulations, and collaboration (all)
Consumers/Families/Caregivers	Beneficiaries and focus group members	Input and feedback on Qualified Entity engagement plan

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IPQR Module 5.7 - Progress Reporting

Instructions :

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

Securely and effectively connecting all Participants to allow for data sharing and collaborative patient care will play a large role in CCB's ability to successfully implement projects, improve care, and achieve broader DSRIP goals. To measure CCB's progress in achieving the IT strategy, we will track multiple measures of IT implementation and capabilities among Participants, including, but not limited to: EHR completeness reports, implementation and utilization of Meaningful Use and PCMH level-3 certified EHRs, and documentation and use of the GSI Health Coordinator Dashboard. The IT Committee will develop additional metrics as it develops the IT Strategy and roadmap to measure the PPS's progress against the strategy and budget.

IPQR Module 5.8 - IA Monitoring

Instructions :

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Section 06 – Performance Reporting

IPQR Module 6.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Establish reporting structure for PPS-wide performance reporting and communication.	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	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Review documents pertaining to DSRIP metrics and reporting requirements, including the Metrics Specification Manual, the Domain 1 Project Requirements Milestones and Metrics document, and the Baseline data.	Completed	Review documents pertaining to DSRIP metrics and reporting requirements, including the Metrics Specification Manual, the Domain 1 Project Requirements Milestones and Metrics document, and the Baseline data.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Assess, across all projects, needs for PPS-specific performance metrics (to supplement the existing State metrics) through discussions with Participants, committees, subject matter experts.	In Progress	Assess, across all projects, needs for PPS-specific performance metrics (to supplement the existing State metrics) through discussions with Participants, committees, subject matter experts.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Identify sources of data and propose collection methods for those metrics that will not be provided by the State.	In Progress	Identify sources of data and propose collection methods for those metrics that will not be provided by the State.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Identify point person(s) for reporting at each Participant.	In Progress	Identify point person(s) for reporting at each Participant.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Assess collection and reporting capabilities of	In Progress	Assess collection and reporting capabilities of CSO/Participants relative to identified needs.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
CSO/Participants relative to identified needs.									
Task Identify and develop a plan to address identified gaps between collection and reporting requirements and capabilities of the PPS and Participants.	In Progress	Identify and develop a plan to address identified gaps between collection and reporting requirements and capabilities of the PPS and Participants.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Assess Managed Care Organization (MCO) capabilities for data exchange relative to requirements for performance metric submission.	Not Started	Assess Managed Care Organization (MCO) capabilities for data exchange relative to requirements for performance metric submission.	10/01/2015	06/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Collaborating across project teams and relevant committees, develop a performance reporting strategy encompassing infrastructure, required IT support, support for Rapid Cycle Evaluation initiatives, alignment with MCOs, communication strategies, roles and responsibilities at Participants and PPS, available implementation support and provisions for ongoing review and revision of the strategy.	In Progress	Collaborating across project teams and relevant committees, develop a performance reporting strategy encompassing infrastructure, required IT support, support for Rapid Cycle Evaluation initiatives, alignment with MCOs, communication strategies, roles and responsibilities at Participants and PPS, available implementation support and provisions for ongoing review and revision of the strategy.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Present performance reporting and communications strategy to the Finance and Executive Committees for approval.	Not Started	Present performance reporting and communications strategy to the Finance and Executive Committees for approval.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Communicate relevant components, responsibilities and schedules from the performance reporting and communications strategy to Participants and implement across the PPS network.	Not Started	Communicate relevant components, responsibilities and schedules from the performance reporting and communications strategy to Participants and implement across the PPS network.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
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.	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task Identify Participant-level performance reporting training needs (based on the performance reporting structure detailed in Milestone #1)	In Progress	Identify Participant-level performance reporting training needs (based on the performance reporting structure detailed in Milestone #1) addressing expectations for project-specific data collection and reporting as well as broader performance	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
addressing expectations for project-specific data collection and reporting as well as broader performance and quality initiatives, such as Rapid Cycle Evaluation.		and quality initiatives, such as Rapid Cycle Evaluation.							
Task Develop performance reporting training program, including appropriate, effective method(s) (e.g. instructor-led workshops, webinars, e-learning via an online platform such as Salesforce) tailored to the subject matter as well as the capacity and needs of Participants.	Not Started	Develop performance reporting training program, including appropriate, effective method(s) (e.g. instructor-led workshops, webinars, e-learning via an online platform such as Salesforce) tailored to the subject matter as well as the capacity and needs of Participants.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Develop rollout schedule for Participants; identify specific individuals to participate in specific modules/programs.	Not Started	Develop rollout schedule for Participants; identify specific individuals to participate in specific modules/programs.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Finalize the performance reporting training program and receive approval from the Finance and Executive Committee.	Not Started	Finalize the performance reporting training program and receive approval from the Finance and Executive Committee.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Pilot training to representative sample of target Participants for feedback.	Not Started	Pilot training to representative sample of target Participants for feedback.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Finalize and initiate training to broader target audience of Participants, including solicitation of feedback for ongoing refinement.	Not Started	Finalize and initiate training to broader target audience of Participants, including solicitation of feedback for ongoing refinement.	07/01/2016	12/31/2016	07/01/2016	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

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish reporting structure for PPS-wide performance reporting and communication.	
Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	

Milestone Review Status

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

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IPQR Module 6.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

Participants in the CCB network have varying levels of reporting and analytical capabilities, yet all will need to understand how to interpret reports and use them to improve clinical care management and financial outcomes. To mitigate this risk, CCB's training programs will educate key personnel within each Participant entity on the PPS reporting structure and processes, and resource materials will be made available with respect to performance reporting. CCB will also work with individual Participants to ensure they have the necessary infrastructure to capture and report data per State or CCB reporting requirements. If a Participant lacks sufficient infrastructure, the Central Services Organization (CSO) will identify alternative means for the Participant to collect and report required data through the RHIO, Dashboard, or other means. To the extent Participants belong to more than one PPS, CCB will work with those Participants to ensure Participants can appropriately segment and report data by PPS.

It will be important to define and communicate CCB's performance reporting priorities and expectations to ensure Participants understand the relationship between targeted performance levels and DSRIP funding, as well as the impact of performance on financial sustainability. CCB will address this at a high level through the Master Services Agreement (MSA) contracting process, with Participant-specific exhibits detailing roles and responsibilities relative to each project, reporting requirements, and funding terms. The CSO's responsibilities with respect to analytics and reporting will also be documented and communicated to Participants. Since CCB will evolve with experience and be a "learning entity," it will be essential that the CSO have the capacity to support ongoing assessment and the re-setting of performance expectations over time as necessary to ensure the achievement of both project-specific and overall DSRIP goals. To mitigate the risk that Participants do not actively engage in performance reporting, CCB is developing a practitioner communications plan that will, among other things, address performance reporting expectations and processes, including various options that can be used to reach Participants (e.g., in-person meetings, webinars, newsletters, website updates, etc.)

Over the course of the DSRIP program, it will be increasingly important that Participants be provided with or are able to access reports and analyses that identify specific issues in need of attention to ensure that key milestones and targets are met. The CSO's Analytics & Reporting team will develop performance reports and assist with the interpretation of data to support timely, evidence-based decision making across the CCB network.

As the performance reporting structure is developed, CCB will identify key individuals within each Participant to support performance reporting needs and activities at the organization level. Based on Maimonides' experience implementing the Brooklyn Health Home, CCB anticipates that many small Participants, such as solo or small practice providers, will not have resources readily available to support reporting. Recognizing the importance of accurate and regular reporting to CCB's overall performance, the PPS workforce strategy will address reporting competencies and positions to ensure Participants have adequate support.

IPQR Module 6.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

For a clinical quality and performance reporting program to be effective, it must be developed in coordination with the Participant engagement strategy and CCB's approach to population health management. This is critical to ensure that all Participants understand the reporting and performance measurement process and both understand and buy in to the metrics being used to measure performance.

The performance reporting program must also be developed and rolled out with the support of CCB leadership and in the context of the PPS's overall governance structure. CCB will work closely with the appropriate governance committees, specifically the Executive, Finance, and Care Delivery and Quality Committees, to obtain input into the performance reporting structure and metrics and vet the communication plan before it is rolled out to Participants. The Finance Committee will play a particularly important role in assisting CCB as it identifies ties between the performance reporting structure and funds flow.

Finally, the PPS's needs for performance reporting related to the data that Participants will need to submit to CCB and the feedback reports to Participants will require coordination with CCB's IT systems. The CSO leadership will work in tandem to make sure that IT needs for performance reporting are communicated and incorporated into the larger CCB IT Strategy.

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IPQR Module 6.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Vice President, Analytics & Business Operations, Maimonides Central Services Organization (CSO)	Robert Cimino	Establish performance reporting and analytics capacity within the CSO, ensure the accuracy, timeliness and accessibility of performance reporting
Project Planning Workgroups, including Care Management, PCMH, 30-Day Readmissions and ED Triage	Kishor Malavade, MD, Associate Medical Director, Maimonides Central Services Organization (CSO)	Define reporting requirements and methodologies for DSRIP projects
CCB Executive Committee	Chairperson: David Cohen, MD, MSc, Executive Vice President for Clinical Affairs and Affiliations, MMC, and CEO, Maimonides Central Services Organization (CSO)	Review and approval of performance reporting plans and structure
CCB Care Delivery & Quality Committee	Chairperson: Karen Nelson, MD, MPH, Senior Vice President, Integrated Delivery Systems, MMC, and Chief Medical Officer, Maimonides Central Services Organization (CSO)	Review and approval of performance reporting plans and structure, focusing on care management and quality metrics and reporting
CCB Finance Committee	Chairperson: Caroline D. Greene, Chief Administrative & Financial Officer, Maimonides Central Services Organization (CSO)	Review and approval of performance reporting plans and structure, focusing on the links between performance reporting, the achievement of performance targets, and DSRIP payments

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IPQR Module 6.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Participants' IT Staff	Reporting and IT System maintenance	Monitor use and support of reporting systems
CCB Workforce Committee	Advise on performance reporting training	Reviewing link between performance reporting training and workforce training curricula and materials
Participants (e.g., hospitals, clinics, PCPs, specialists, post-acute and long-term care providers, CBOs, and others)	Implement performance reporting processes	Provide performance data; employ standardized care practices to improve patient care outcomes
Michael Carbery	Chief Information Officer for Population Health, Maimonides Central Services Organization (CSO)	Ensure implementation of all IT requirements related to performance reporting, data security and confidentiality
External Stakeholders		
Managed Care Organizations	Provide key information to the CCB PPS to support value based purchasing	Provide data to PPS; value based payments
New York State Department of Health	Provide required metrics and key data to the PPS to evaluate performance and impact on patient outcomes	Provide key data to the PPS to evaluate performance and impact
Patients and Advocates	Provide qualitative feedback to CCB and Participants on provider/CBO performance	Data sources and feedback
Healthix and other NYS RHIOs/QEs	Provide key data to the PPS to evaluate performance and impact	Data source

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IPQR Module 6.7 - IT Expectations

Instructions :

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

Timely and accurate performance reporting across CCB will require the establishment of systems of communication among and between the Maimonides CSO and Participants, as well as the establishment of a shared database into which Participant-generated performance reports can be added and from which standard (and possibly customized) performance reports can be pulled. Performance data will need to be collected and maintained in a secure manner consistent with applicable standards, taking into consideration the types of and sources of information that will be involved in assessing Participant and CCB performance over time. The CSO's IT team will play a key role in supporting the performance reporting function, through the establishment and maintenance of secure approaches to the exchange of information, and through participation in the management and support of CCB-specific performance reporting databases. The CIO for the Maimonides CSO will be responsible for ensuring compliance with NYS DOH, Office of Health Insurance Programs requirements applicable to entities receiving Medicaid data in connection with the DSRIP program, such as the requirement that there be two-factor authentication (a.k.a. dual authentication) installed and tested within their IT systems before access to protected health information (PHI) is provided to CSO employees and contractors and/or to CCB Participant entities. The CIO will also be responsible for maintaining (and updating, as necessary) the list of users authorized to access certain NYS DOH systems and files, including but not limited to MAPP and Salient.

IT capabilities will be employed to maximize the impact and effectiveness of the performance reporting structure. CCB will employ tools (e.g., the GSI Health Coordinator/Dashboard, linkages with Healthix (RHIO) for quality metrics, etc.) to collect reliable performance data and analyze this information for rapid cycle evaluation and other performance monitoring responsibilities. However, CCB Participants are at varying levels of readiness and capacity for utilizing the Dashboard and sharing data with Healthix and will require technical assistance to ensure they can actively participate in the PPS's performance reporting structure. Once implemented broadly, these solutions will help ensure that CCB and Participant leadership has access to the information it needs on a timely basis as well as increase the effectiveness and efficiency of decision-making.

IPQR Module 6.8 - Progress Reporting

Instructions :

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

The success of the CCB performance reporting work stream will be determined upon the acceptance by the Executive Committee of the proposed PPS-wide performance reporting and communication structure, including the adoption of plans to support rapid cycle evaluation of performance relative to agreed-upon DSRIP project goals and targets. CCB's progress in this work stream will be documented through the generation of regular performance reports at various levels (e.g., the PPS; regional , if/as appropriate; project-specific; Participant; and population-levels), and will be distributed to the Care Delivery and Quality, Finance, and Executive Committees for review and feedback. CCB will coordinate the development of the performance reporting training program and work with its Participants to identify and train local staff focused on clinical quality and

performance reporting. To measure the success of these trainings, the CSO will identify key performance personnel associated with each Participant as well as track the number of trainings completed.

IPQR Module 6.9 - IA Monitoring

Instructions :

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Section 07 – Practitioner Engagement

IPQR Module 7.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop Practitioners communication and engagement plan.	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	03/31/2020	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Develop, launch and maintain CCB eNewsletter and website to keep CCB Participants up to date on DSRIP progress and initiatives	In Progress	Develop, launch and maintain CCB eNewsletter and website to keep CCB Participants up to date on DSRIP progress and initiatives	04/01/2015	03/31/2020	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Working with CCB Participants and CBOs, organize CCB practitioners into provider-specific types, such as medical, behavioral health and substance abuse to identify key thought leaders (including leaders in behavioral health and substance abuse treatment programs, among other areas)	Completed	Working with CCB Participants and CBOs, organize CCB practitioners into provider-specific types, such as medical, behavioral health and substance abuse to identify key thought leaders (including leaders in behavioral health and substance abuse treatment programs, among other areas)	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Outreach to CCB's major practitioner groups/communities telephonically and through scheduled in-person visits across organizational types to encourage participation in the Care Delivery and Quality and Finance Committees	In Progress	Outreach to CCB's major practitioner groups/communities telephonically and through scheduled in-person visits across organizational types to encourage participation in the Care Delivery and Quality and Finance Committees	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Through the Care Delivery and Quality Committee, develop practitioner communication and engagement plan, including approach to DSRIP projects, CCB's quality improvement agenda and practitioner performance reporting	In Progress	Through the Care Delivery and Quality Committee, develop practitioner communication and engagement plan, including approach to DSRIP projects, CCB's quality improvement agenda and practitioner performance reporting	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Present practitioner communication and engagement plan to CCB Care Delivery and Quality and Executive Committees for review/approval	Not Started	Present practitioner communication and engagement plan to CCB Care Delivery and Quality and Executive Committees for review/approval	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
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	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Review CCB practitioner listing and organize into provider-specific types (such as medical, behavioral health and substance abuse, etc.) for DSRIP project training and education purposes	Completed	Review CCB practitioner listing and organize into provider-specific types (such as medical, behavioral health and substance abuse, etc.) for DSRIP project training and education purposes	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Working with the Workforce Committee and key training partners, research vendors or Participants with curriculum development and/or training capabilities, including higher educational entities	In Progress	Working with the Workforce Committee and key training partners, research vendors or Participants with curriculum development and/or training capabilities, including higher educational entities	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Leverage early PAC meetings to present CCB-specific DSRIP projects and the CCB quality improvement agenda to give practitioners context of the CCB DSRIP program goals	In Progress	Leverage early PAC meetings to present CCB-specific DSRIP projects and the CCB quality improvement agenda to give practitioners context of the CCB DSRIP program goals	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Draft the practitioner training/education plan, to include 1) modalities and metrics to measure the success of trainings, such as focus groups, surveys, completion of CCB deliverables, and 2)	In Progress	Draft the practitioner training/education plan, to include 1) modalities and metrics to measure the success of trainings, such as focus groups, surveys, completion of CCB deliverables, and 2) supports necessary to provide to practitioners on a continual basis to ensure compliance with	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
supports necessary to provide to practitioners on a continual basis to ensure compliance with CCB requirements		CCB requirements							
Task Identify longer term professional education and training needs to be discussed with area colleges, medical schools and other degree-granting entities as appropriate for consideration in the review of strategies to address the future supply of qualified providers of medical and other professional services	Not Started	Identify longer term professional education and training needs to be discussed with area colleges, medical schools and other degree-granting entities as appropriate for consideration in the review of strategies to address the future supply of qualified providers of medical and other professional services	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Present practitioner training/education plan to Care Delivery and Quality Committee for review/approval	Not Started	Present practitioner training/education plan to Care Delivery and Quality Committee for review/approval	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop Practitioners communication and engagement plan.	The completion date of this milestone has been moved up to align with the development and approval of a practitioner communication and engagement plan, including approach to DSRIP projects, CCB's quality improvement agenda and practitioner performance reporting. Communicating with and engaging our practitioners is critical to the success of all of our DSRIP initiatives, and subsequently needs to be in place early in DY2.
Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
agenda.	

Milestone Review Status

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

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IPQR Module 7.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

Community Care of Brooklyn (CCB) has seen a high level of engagement in the practitioner community to date. CCB has included both primary care and subspecialist clinicians from key PPS Participants throughout the application planning process based on the DSRIP projects we selected. Among the physicians participating are: Dr. Steven Silber, Vice President, New York Methodist Hospital; Dr. Russell Portenoy from MJHS; and Dr. Kishor Malavade from Maimonides Medical Center who chairs the City-wide PPS Domain 4 Mental Health and Substance Abuse (MHSA) Infrastructure Workgroup. The MHSA workgroup includes physicians from four PPSs participating in cross-PPS planning for the project. Other practitioner types who are active in CCB DSRIP project planning include nursing, social workers, health educators, mental health professionals, substance abuse professionals.

CCB has held numerous all member webinars to educate practitioners about the transformative nature and resources that DSRIP will bring to Brooklyn's health care delivery system. We have expanded the number and types of practitioners included in the implementation planning process to include a broader group that has more physicians, nurses, social workers, care managers and behavioral health professionals. Additionally, CCB has already begun conversations with key practitioners to initiate engagement and discuss their participation in CCB. The long term success of clinical improvement projects in Domain 3 depends on practitioner willingness to adopt standardized clinical guidelines, processes and protocols across the CCB network proven to result in lower costs and better outcomes.
The biggest risk to achieving these milestones is engaging thousands of practitioners who may be hesitant to take time away from their practice to participate in the Project Advisory Committee and/or to attend the educational and training sessions provided by CCB. CCB hopes to mitigate this problem by providing resources and support to practices in various methods and timeframes to help practitioners work at the top of their licenses and participate in DSRIP activities.

IPQR Module 7.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

It is difficult to point to a DSRIP workstream in which practitioner engagement is not interdependent. For example, the use of IT by providers is fundamental to practitioners adopting population health management, tracking quality metrics for performance reporting, monitoring patient activity between visits and receiving alerts that enable quick follow up and communication when patients are in the hospital or ED. Additionally, the linkage to financial sustainability is notable since practitioner success with DSRIP will improve CCB abilities to produce cost savings, improve quality of care and patient outcomes that ultimately lead to financial sustainability via cost reductions and incentive payments to practitioners.

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IPQR Module 7.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Chief Medical Officer, Maimonides Central Services Organization (CSO)	Karen Nelson, MD, MPH	Oversee CCB practitioner engagement and clinical programs
Associate Medical Director, Maimonides Central Services Organization (CSO)	Kishor Malavade, MD	Oversee CCB practitioner engagement and clinical programs; chair of cross-PPS Mental Health and Substance Abuse (MHSA) Workgroup
Vice President, Clinical Programs & Provider Engagement, Maimonides Central Services Organization (CSO)	Jenny Tsang-Quinn, MD	Oversee physician engagement strategy and PCMH training program
CCB Care Delivery and Quality Committee	Chairperson: Karen Nelson, MD, MPH, Senior Vice President, Integrated Delivery Systems, MMC, and Chief Medical Officer, Maimonides Central Services Organization (CSO)	Develop practitioner engagement plan; monitor and mitigate levels of practitioner engagement
CCB Workforce Committee	Committee Chairperson TBD DY1 Q2 Interim Lead: David Cohen, MD, MSc, Executive Vice President for Clinical Affairs and Affiliations, MMC, and CEO, Maimonides Central Services Organization (CSO)	Oversight of all training strategies, including practitioner education / training

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IPQR Module 7.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Engaged practitioners from across the CCB network	Target of engagement activities	Provide care; attend training sessions
External Stakeholders		
Public sector agencies, medical societies, other professional groups	Liaisons to practitioners	Provide guidance and assistance in engaging practitioners
Patients and caregivers	Recipients of care	Receive care and provide feedback
Other DSRIP PPSs	Strategic collaborators	Identifying opportunities to minimize redundant efforts in addressing the same practitioner community

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IPQR Module 7.7 - IT Expectations

Instructions :

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

CCB will use data and IT systems to collect, analyze, and report on performance across CCB. To the extent there is variation in performance across practitioners, CCB will provide reports and pair up champions with lower performing practices. IT capabilities, such as the GSI Health Coordinator/Dashboard, will allow for the collection and reporting of standardized performance metrics and more advanced analysis to support continuous quality improvement and provide data and analytics to participating practitioners. Other technology will be used to deliver key education and trainings to practitioners, as described in the earlier Workforce section. With Participant leaders, CCB will also explore shared IT platforms/websites for communication and collaboration between practitioners and specific learning networks, including but not limited to the MRT Innovation eXchange (MIX).

IPQR Module 7.8 - Progress Reporting

Instructions :

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

CCB will measure the success of this workstream in three ways. First, at the most basic level, we will monitor attendance at educational and training sessions, all member webinars, and other learning forums provided by the Central Services Organization (CSO). For those who are involved in clinical governance, implementation planning, or advisory groups, we will track attendance at meetings. Second, the CSO will be tracking practitioner performance on each project via rapid cycle evaluation (RCE) and auditing adherence to evidence based guidelines and processes and protocols on a periodic basis. Third, based upon rapid cycle evaluation, we will periodically interview selected practitioners to gain knowledge about their experiences and concerns regarding DSRIP project implementation and impact on them and their patients.

IPQR Module 7.9 - IA Monitoring

Instructions :

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Section 08 – Population Health Management

IPQR Module 8.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop population health management roadmap.	In Progress	Population health roadmap, signed off by PPS Board, including: -- The IT infrastructure required to support a population health management approach -- Your overarching plans for achieving PCMH 2014 Level 3 certification in relevant provider organizations --Defined priority target populations and define plans for addressing their health disparities.	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Develop CCB population health management (PHM) vision that aligns with population needs and priorities identified in Community Needs Assessment (CNA), with focus on addressing health disparities related to socioeconomic factors, including health literacy, language barriers, as well as disparities related to clinical conditions (behavioral health, substance abuse).	In Progress	Develop CCB population health management (PHM) vision that aligns with population needs and priorities identified in Community Needs Assessment (CNA), with focus on addressing health disparities related to socioeconomic factors, including health literacy, language barriers, as well as disparities related to clinical conditions (behavioral health, substance abuse).	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Identify target population of neighborhoods with a high degree of health disparities based on an assessment and input from Participants.	In Progress	Identify target population of neighborhoods with a high degree of health disparities based on an assessment and input from Participants.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Survey target population and conduct gap analysis between current state and future vision with a special focus on primary care practice organizations' current capabilities and readiness for PHM, including NCQA PCMH Level 3 with	In Progress	Survey target population and conduct gap analysis between current state and future vision with a special focus on primary care practice organizations' current capabilities and readiness for PHM, including NCQA PCMH Level 3 with 2014 Standards.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
2014 Standards.									
Task Work with the IT Committee to identify, evaluate, and select IT applications required to automate some PHM functions.	Not Started	Work with the IT Committee to identify, evaluate, and select IT applications required to automate some PHM functions.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Draft the PHM roadmap, which will incorporate the findings of the gap analysis and also the PCMH strategy for providing technical assistance (described further in project 2.a.i).	Not Started	Draft the PHM roadmap, which will incorporate the findings of the gap analysis and also the PCMH strategy for providing technical assistance (described further in project 2.a.i).	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Present the PHM roadmap to the Executive Committee for review and approval.	In Progress	Present the PHM roadmap to the Executive Committee for review and approval.	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
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.	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2	NO
Task Assess trends in inpatient vs. outpatient hospital use by service (e.g., medical, behavioral health) in Brooklyn to identify opportunities and needs to be addressed as part of a PPS-wide bed reduction plan.	In Progress	Assess trends in inpatient vs. outpatient hospital use by service (e.g., medical, behavioral health) in Brooklyn to identify opportunities and needs to be addressed as part of a PPS-wide bed reduction plan.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Analyze data and research on strategies to reduce avoidable inpatient hospitalizations.	In Progress	Analyze data and research on strategies to reduce avoidable inpatient hospitalizations.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Review updated hospital reports on deferred maintenance and efficiency of physical plants to inform assessment of long term viability relative to the clinical and other needs of patient populations currently served, taking into consideration likely impact of DSRIP initiatives on future demand/need for inpatient care.	Not Started	Review updated hospital reports on deferred maintenance and efficiency of physical plants to inform assessment of long term viability relative to the clinical and other needs of patient populations currently served, taking into consideration likely impact of DSRIP initiatives on future demand/need for inpatient care.	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Review existing and/or develop methodologies to project future bed need based on analysis of	Not Started	Review existing and/or develop methodologies to project future bed need based on analysis of trends and impact of DSRIP interventions on inpatient utilization by hospital, taking	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
trends and impact of DSRIP interventions on inpatient utilization by hospital, taking into consideration an analysis of access and availability of needed non-inpatient services.		into consideration an analysis of access and availability of needed non-inpatient services.							
Task Test and apply methodology to CCB hospital Participants to estimate bed reductions.	Not Started	Test and apply methodology to CCB hospital Participants to estimate bed reductions.	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Identify potential workforce impacts and training needs related to the achievement of target bed reductions and shifts to the provision of care in non-inpatient settings.	Not Started	Identify potential workforce impacts and training needs related to the achievement of target bed reductions and shifts to the provision of care in non-inpatient settings.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task Work with NYS DOH, OMH, OASAS and other regulatory bodies to obtain needed approvals to proceed with bed reductions and other changes required to support overall plans.	Not Started	Work with NYS DOH, OMH, OASAS and other regulatory bodies to obtain needed approvals to proceed with bed reductions and other changes required to support overall plans.	01/01/2017	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1	
Task Present bed reduction plan to CCB Finance Committee and Executive Committee for review and approval.	Not Started	Present bed reduction plan to CCB Finance Committee and Executive Committee for review and approval.	07/01/2017	09/30/2017	07/01/2017	09/30/2017	09/30/2017	DY3 Q2	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop population health management roadmap.	
Finalize PPS-wide bed reduction plan.	

Milestone Review Status

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

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IPQR Module 8.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

One challenge to accomplishing this work stream is that this is a very new concept to many providers. This may impede provider acceptance of the need to adopt new technologies and work flows to support PHM. To address this risk, the Maimonides Central Services Organization (CSO) will implement a communications and education strategy to enhance providers' understanding and acceptance of PHM. The CSO will also develop and centralize resources and technologies to support providers' transitions to PHM.

CCB anticipates that providers may be slow to adopt new technology which could impact its ability to meet its speed and scale targets. To mitigate this risk, CCB is prepared to devote significant resources to provider training and oversight. CCB will use a variety of training methods to reach providers (in-person, web-based, and telephonic) and will provide training and technical assistance during off hours to meet provider needs.

A third, and potentially the largest challenge is that not all primary care provider (PCP) sites may achieve NCQA PCMH Level 3 Recognition by DY 3. CCB estimates that over half of CCB's PCPs have not yet achieved any level of NCQA PCMH recognition and the process for achieving PCMH recognition is time consuming and requires strong support and time commitment from leadership. There are many barriers that PCPs face, particularly community-based practitioners in small practices, when pursuing and maintaining PCMH recognition. There is a risk that some of these barriers (e.g., level of staff support, technology infrastructure, level of investment, etc.) might be difficult to overcome. To mitigate this risk, CSO staff has been actively reaching out to community physicians and plans to provide in person and online technical assistance to meet NCQA PCMH requirements.

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.)

Population health management (PHM) is interdependent with the IT, clinical integration, and practitioner engagement work streams.

While IT alone will not yield a highly functioning PHM-based primary care practice, it is a necessary component to successfully embed PHM into the daily work flows of a primary care practice. Close alignment of IT architecture and its components with PHM goals must be central to planning, including the selection of applications and phasing in of new technologies along with training capabilities.

Clinical integration intersects with the PHM roadmap in multiple areas, specifically regarding the readiness assessment phase and the identification of data needs including how to integrate data from social services, supported housing providers, and other CBOs into the care planning and registry tools.

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Finally, CCB's ability to achieve population health management will depend on its success at engaging and educating providers toward common protocols to achieve DSRIP goals, including recognition of the importance of health literacy and cultural competence when engaging patients in behavioral change.

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IPQR Module 8.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Vice President, Care Delivery and Regional Oversight, Maimonides Central Services Organization (CSO)	Shari Suchoff	Participate in ongoing refinement of Population Health Management strategy for PPS; participate in leadership of CCB hospital and other organizational engagement efforts
Vice President, Clinical Programs & Provider Engagement, Maimonides Central Services Organization (CSO)	Jenny Tsang-Quinn, MD	Develop work plan for all relevant providers to achieve PCMH 2014 Level 3 Certification; implement PHM IT solutions; participate in leadership of CCB practitioner engagement efforts
Vice President, Care Management, Maimonides Central Services Organization (CSO)	Madeline Rivera, RN	Oversee expansion and strengthening of Care Management capacity across the CCB network; serve as liaison to Brooklyn Health Home and other Health Homes
CCB Executive Committee	Chairperson: David Cohen, MD, MSc, Executive Vice President for Clinical Affairs and Affiliations, MMC, and CEO, Maimonides Central Services Organization (CSO)	Inform and approve the PHM Roadmap, PCMH work plan, and bed reduction plan.
CCB Care Delivery and Quality Committee	Chairperson: Karen Nelson, MD, MPH, Senior Vice President, Integrated Delivery Systems, MMC, and Chief Medical Officer, Maimonides Central Services Organization (CSO)	Overseeing development and review of population health management strategies and programs.

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IPQR Module 8.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Michael Carbery	Chief Information Officer for Population Health, Maimonides Central Services Organization (CSO)	Information Technology related requirements for PHM
CCB Participants, including PCPs	Implementers of PHM	Perform PHM functions and transition to PCMH Level 3
CBOs, including organizations focused on crime reduction, housing, and transportation (e.g. CAMBA, Caribbean Women's Health Association, GLWD, Village Care, JASA, etc.)	Support care management	Work with care management teams to improve PHM of target populations
Workforce	Bed reduction plan	Affected by bed reduction plan and recipient of CCB training
Robert Cimino	Vice President, Analytics & Business Operations, Maimonides Central Services Organization (CSO)	Establish performance reporting and analytics capacity within the CSO; ensure the accuracy, timeliness and accessibility of performance reporting.
Key Hospital Leadership	Participant Leadership	Inform the development of the Bed Reduction Plan
External Stakeholders		
Government agencies, such as NYS DOH, NYC DOHMH, OMH, OASAS, DSS	Oversight and collaboration	Overseeing DSRIP contract and processing release of DSRIP funds (NYS DOH); providing ongoing guidance with respect to DSRIP deliverables and requirements (NYS DOH); participating in workgroup and committees (NYC DOHMH); providing oversight, regulations, and collaboration (all)
Labor Unions, including 1199SEIU, New York State Nurses Association (NYSNA), Committee of Interns and Residents (CIR), Civil Service Employees Association (CSEA), others	Representatives of subsets of affected staff	Provide input into bed reduction plan
Patients/Consumers	Patients/Consumers	Provide input into bed reduction plan
Managed Care Organizations (MCOs)	Key partner in payment reform	Feedback on CCB value-based payment reforms
NCQA	Standards for PCMH	Provide standards and requirements for PCMH Level 3 recognition
Other DSRIP PPSs	Strategic collaborators	Coordinate efforts in addressing the same patient population

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IPQR Module 8.7 - IT Expectations

Instructions :

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

IT infrastructure will be foundational to properly managing the health of the CCB population. Overall, the CCB network will be required to improve the health of their patients on a community level, and CCB will rely on IT infrastructure and tools to aid Participants in this endeavor. As noted in the milestones above, working closely with the IT Committee, the CSO will explore IT solutions to automate population health management functions (e.g., EMRs, registries) and other applications to support Participants in multi-level reporting, predictive modeling, and continuous quality improvement.

As mentioned elsewhere in this plan, CCB intends to use the GSI Health Coordinator platform, called the "Dashboard," to support multiple workstreams. This existing web-based care planning tool has been used successfully over the last few years within the Brooklyn Health Home network and its functionality could be expanded to address PHM requirements. Additionally, CCB will work hand in hand with the RHIO (Healthix) to support data sharing and needs for population health management, being thoughtful as to not duplicate functionality that certain Participants may have already through their EMRs or other data/IT platforms.

IPQR Module 8.8 - Progress Reporting

Instructions :

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

A series of measurements related to engagement with PHM applications and training will indicate successful implementation of this work stream. Specific measurements include: number of team members who have begun or completed training on PHM applications; number of providers (primary care team, behavioral health teams, and others) who actively use EMRs, care panning tools, and patient registries; number of primary care practices that have begun PCMH recognition; and number of PCP practices that achieved NCQA level 1, 2 or 3 PCMH recognition; and Executive Committee's approval of the bed reduction plan. In addition, and as specified in more detail under the Performance Reporting section, CCB will survey practitioners regarding adherence to evidence-based practices and analyze CCB Participant data on required performance metrics, such as reduction in preventable admissions and ED visits and HEDIS metrics.

IPQR Module 8.9 - IA Monitoring

Instructions :

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Section 09 – Clinical Integration

IPQR Module 9.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform a clinical integration 'needs assessment'.	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	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Identify data sources and process for data collection to support clinical integration needs assessment.	Completed	Identify data sources and process for data collection to support clinical integration needs assessment.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Assess/collect data on clinical integration needs of clinical Participants (including individual providers and community-based organizations) using a standardized tool.	In Progress	Assess/collect data on clinical integration needs of clinical Participants (including individual providers and community-based organizations) using a standardized tool.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Analyze data collected to identify major gaps in clinical integration and priority groups for technical assistance or other supports. This analysis will be used to develop the clinical integration needs assessment and recommendations.	Not Started	Analyze data collected to identify major gaps in clinical integration and priority groups for technical assistance or other supports. This analysis will be used to develop the clinical integration needs assessment and recommendations.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task	Not Started	Present clinical integration needs assessment to Care	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Present clinical integration needs assessment to Care Delivery and Quality Committee for approval.		Delivery and Quality Committee for approval.							
Milestone #2 Develop a Clinical Integration strategy.	In Progress	Clinical Integration Strategy, signed off by Clinical Quality Committee, including: -- Clinical and other info for sharing -- Data sharing systems and interoperability -- A specific Care Transitions Strategy, including: hospital admission and discharge coordination; and care transitions and coordination and communication among primary care, mental health and substance use providers -- Training for providers across settings (inc. ED, inpatient, outpatient) regarding clinical integration, tools and communication for coordination -- Training for operations staff on care coordination and communication tools	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Define the vision for clinical integration, including the target population, technology, and data sharing capabilities that will support shared decision-making and risk taking in connection with specific subsets of the population to be served by the CCB network.	Completed	Define the vision for clinical integration, including the target population, technology, and data sharing capabilities that will support shared decision-making and risk taking in connection with specific subsets of the population to be served by the CCB network.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Work with Care Delivery and Quality Committee to define care transitions and care coordination strategies.	Completed	Work with Care Delivery and Quality Committee to define care transitions and care coordination strategies.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Define workflows, clinical data sets and other information needed to support clinical integration.	In Progress	Define workflows, clinical data sets and other information needed to support clinical integration.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Identify implications for workforce development and training.	In Progress	Identify implications for workforce development and training.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Identify potential opportunities for clinical integration of certain segments of the CCB network to address the needs of certain segments of the Medicaid population served by	Not Started	Identify potential opportunities for clinical integration of certain segments of the CCB network to address the needs of certain segments of the Medicaid population served by CCB, through full- or partial-risk contracts as defined in the VBP roadmap, including criteria that will be used to determine Participant	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
CCB, through full- or partial-risk contracts as defined in the VBP roadmap, including criteria that will be used to determine Participant eligibility for inclusion.		eligibility for inclusion.							
Task Work with IT Committee to develop IT systems strategy to support clinical integration.	Not Started	Work with IT Committee to develop IT systems strategy to support clinical integration.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Draft document outlining preliminary Clinical Integration Strategy, including key assumptions about the projected achievement of DSRIP goals and future state of the CCB network.	Not Started	Draft document outlining preliminary Clinical Integration Strategy, including key assumptions about the projected achievement of DSRIP goals and future state of the CCB network.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Obtain Care Delivery and Quality Committee, Finance Committee and Executive Committee approval of the Clinical Integration Strategy.	Not Started	Obtain Care Delivery and Quality Committee, Finance Committee and Executive Committee approval of the Clinical Integration Strategy.	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform a clinical integration 'needs assessment'.	
Develop a Clinical Integration strategy.	

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Milestone Review Status

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

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IPQR Module 9.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

The primary challenge to improving the level of clinical integration is the tight timeline by which we will, by necessity, be conducting assessments of our network in parallel with other assessments and with implementation. For example, ideally, the clinical integration needs assessment would be conducted and completed prior to the IT current state assessment and IT data sharing/interoperability roadmap as the IT work should be tailored to supporting the clinical integration strategy. However, these assessments and strategies will need to be conducted simultaneously to allow us to achieve DSRIP milestones in a timely fashion. The Central Services Organization (CSO) will maintain close communication between the clinical integration and IT teams to avoid risks of these parallel, but related, assessments.

Other risks to effective clinical integration include the large number of voluntary providers in Brooklyn with complex relationships with hospitals or clinics. The diversity in provider number, type, and population served will make obtaining provider buy-in difficult as different providers may require different levels of outreach and support. To address this, the CSO will work closely with provider champions and regional Hubs to customize outreach to providers and encourage engagement. Other risks include the significant immediate requirements for planning, engagement, and start of execution that will rely on the CSO's organizational capacity and timing; the will, skill, and capacity for effective engagement among provider organizations; and sharing patient level data throughout the PPS. These risks will respectively be mitigated by the creation of and reliance on a coordinated governance and planning structure, the development of a practitioner engagement strategy with input from key Participants, and the execution of agreements throughout the PPS to enable data sharing, accompanied by an overarching IT strategy.

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.)

As described in the risks section above, the clinical integration work stream is dependent on nearly every other PPS work stream. It will require the input of the Finance, IT, Workforce, and Care Delivery and Quality Committees as CCB develops strategies to bridge Participants' systems, care models, and ultimately payment models to better serve the target population and transition to value-based purchasing. Of note, the Clinical Integration Strategy will need to be aligned with the IT clinical data sharing/interoperability roadmap as well as the population health management roadmap, as they contain similar aims. Additionally, the clinical integration work stream will rely on information gathered through IT assessments, the clinical operational plans that define the projects care model and the practitioner engagement strategy to achieve Participant buy-in to CCB's clinical integration strategy. Underlying all of these dependencies is the need for a strong governance structure and effective PPS leadership to ensure Committees and the CSO work effectively and collaboratively toward a common goal.

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IPQR Module 9.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
CCB Care Delivery and Quality Committee	Chairperson: Karen Nelson, MD, MPH, Senior Vice President, Integrated Delivery Systems, MMC, and Chief Medical Officer, Maimonides Central Services Organization (CSO)	Made up of members of numerous Participants
Chief Information Officer for Population Health, Maimonides Central Services Organization (CSO)	Michael Carbery	Oversee IT infrastructure to address clinical integration needs
CCB IT Committee	Committee Chairperson TBD DY1Q2 Michael Carbery, Chief Information Officer for Population Health, Maimonides Central Services Organization (CSO)	Oversee IT requirements based on Clinical Integration Strategy
CCB Workforce Committee	Committee Chairperson TBD DY1 Q2 Interim Lead: David Cohen, MD, MSc, Executive Vice President, Clinical Affairs and Affiliations, MMC, and CEO, Maimonides Central Services Organization (CSO)	Develop training plans related to clinical integration strategy

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IPQR Module 9.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Practitioners (including providers across the continuum of care)	Participation in clinical integration efforts	Engage in the process, including the consultation process and training
Clinical staff at Participant organizations across the CCB network	Participation in clinical integration efforts	Engage in the process, including the consultation process and training
Practitioners (including providers across the continuum of care)	Participation in clinical integration efforts	Engage in the process, including the consultation process and training
External Stakeholders		
Patients, Family members, and Caregivers	Recipient of improved care due to clinical integration	Feedback, communication, and participation in clinical integration of providers
Healthix and other NYS RHIOs/QEs	Data source and technology provider	Provision of data and connectivity with Participant systems, as needed

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IPQR Module 9.7 - IT Expectations

Instructions :

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

The Clinical Integration workgroup will work extremely closely with the IT Committee to make sure that the development, modification, and implementation of IT systems are consistent with the Clinical Integration Strategy. The Strategy will lay out CCB's vision for data sharing and improving interoperability across the CCB network. Coordination and participation of the RHIO in this process will be key. While Participants will be at various stages of clinical integration and will likely need to employ different clinical integration approaches, the CSO and Clinical Integration workgroup will help support all Participants in transforming into a clinically integrated network.

IPQR Module 9.8 - Progress Reporting

Instructions :

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

CCB will develop a plan for measuring the success of clinical integration in our network by focusing on several specific metrics, to be identified during the development of the Clinical Integration Strategy. Potential indicators of success in this work stream include the development of a Clinical Integration Needs Assessment, establishment of a Clinical Integration workgroup, and formation and Executive Committee approval of the Clinical Integration Strategy. We will also utilize informal surveys and meetings of Participants to gather feedback on their perspective of the process, gauge need for additional supports, and make adjustments to the strategy as needed to most effectively implement clinical integration and work with our Participants.

IPQR Module 9.9 - IA Monitoring:

Instructions :

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Section 10 – General Project Reporting

IPQR Module 10.1 - Overall approach to implementation

Instructions :

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

Community Care of Brooklyn's (CCB) approach to clinical project implementation is to establish a care model built upon a set of resources and capabilities that are mutually reinforcing and common across PPS Participants. The key components of our care model are described below.

1. Health Information Technology Platform. The GSI Health Coordinator web-based care planning tool (the Dashboard) will serve as the foundation for CCB's implementation plan by facilitating the development of an integrated delivery system. It addresses the lack of effective information exchange across the continuum of care between health care providers and community based organizations (CBOs). Through the Dashboard, providers can communicate in a timely and secure manner to address the determinants of health. DSRIP funds will be used to deploy the Dashboard across the network. The Central Services Organization (CSO) will provide Participants with implementation assistance and training and will provide ongoing support on protocols and workflows. CCB will build upon prior experience in developing and deploying the Dashboard for health homes.

2. Analytics and Reporting Infrastructure. CCB will explore use of the Dashboard to provide a strong analytics infrastructure with embedded population management tools. This will support Participants' timely access to performance reports, enabling providers and other accountable parties to measure and track the impact of their actions. Reporting capabilities will enable CCB to identify changes in care delivery that have a measurable impact on patient satisfaction and outcomes and implement those changes across the PPS.

3. Workforce Strategy. The CCB workforce strategy recognizes the need to re-train health care workers and providers to shift from hospital-based care and volume-based incentives to community-based care and value-based payments, and develop training and educational paths for individuals new to the healthcare workforce. These workforce members will be critical as they assist patients in managing chronic conditions and social issues. CCB plans to work with other PPSs, including OneCity Health, on Brooklyn-based workforce strategies and efforts, with the goal of achieving economies of scale and collectively elevating the available workforce. Areas of collaboration include definition of workforce categories and job descriptions.

4. Clinical Governance. CCB has established the Care Delivery and Quality (CDQ) Committee comprised of key Participant representatives and a diverse group of provider thought-leaders. The Committee will provide direction in defining and implementing change at the Participant and provider-levels. Day-to-day implementation and performance monitoring will be managed through the CSO. Workgroups reporting to the CDQ Committee will, in conjunction with CSO staff, develop clinical operations plans detailing the care model, patient flow, evidence-based protocols, workforce needs, and IT requirements needed to successfully implement the DSRIP projects. These initial plans will be reviewed by the CDQ Committee. The CSO, with input from the CDQ Committee, will work with CCB Participants to monitor performance and provide technical assistance to those needing additional support.

5. Financial Sustainability Plan. CCB will develop a financial sustainability plan grounded in a transparent and coordinated budgeting approach that

takes into account CCB's central services (including the Dashboard), required investments in Participant staffing and IT infrastructure, project personnel (e.g. care managers), and training curricula. CCB will utilize a phased approach based on the State's value-based payment roadmap to transition Participants from primarily fee-for-service payment models to total cost of care or value-based payment models.

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

Instructions :

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

CCB is taking deliberate steps to address interdependencies between projects and cross-cutting PPS initiatives. Maimonides has established a central services organization (CSO) and a governance infrastructure that together will ensure that PPS projects are well organized and coordinated. The CSO and governance structure are grounded in set of organizational policies and procedures that delineate a clear reporting structure and aim to streamline our efforts around cross-cutting initiatives and interdependencies.

During the planning phase, CCB reviewed and documented all project requirements and the steps necessary to achieve each requirement. Through this exercise, CCB identified overlapping and interdependent project requirements and work streams, such as health IT and provider engagement. Specific CSO staff members have been assigned to these cross-cutting work streams and Committees and/or workgroups will be established to oversee and manage these work streams across the PPS and our projects. For example, the IT Committee will work closely with CSO staff to develop a PPS-wide IT strategy and work plan to ensure Participants can meet IT-related project requirements and participate in electronic data sharing and communication that will be critical to many projects' success. In contrast, clinical workgroups will focus on the requirements and risks that are unique to specific projects.

CCB's service area overlaps with other Brooklyn-based and city-wide PPSs. To date, CCB has worked most closely with other PPSs on the Domain 4 population health projects focused on mental health and substance abuse and HIV. Achievement of Domain 4 objectives is dependent on the successful implementation of Domain 4 projects across all PPSs participating in these projects. To avoid duplication of efforts and encourage cross-PPS collaboration, CCB is engaged in multi-PPS planning workgroups focused on the Domain 4 projects. CCB currently chairs the mental health and substance abuse workgroup and believes the foundation for collaboration established during the planning phase will carry over and ultimately contribute to the overall success of our PPS and DSRIP.

Lastly, CCB recognizes that our ability to effectively engage Participants and improve health outcomes is dependent on our ability to develop a sophisticated and responsive performance reporting infrastructure that produces performance reports at the PPS, Participant, practice, and provider levels. Therefore, CCB will invest significant time and resources at the outset of DSRIP implementation to ensure that the PPS will be supported by a reporting infrastructure that is capable of responding to State-required reports as well as reports identified as critical to improving outcomes by CCB's clinical and operational leadership. The IT Committee will oversee the data and analytics infrastructure and CSO staff will regularly generate reports to inform the Executive, Care Delivery and Quality, and Finance Committees. CCB plans to analyze and share data directly with Participants and providers to encourage improvements in their performance and active engagement and in implementing DSRIP projects.

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IPQR Module 10.3 - Project Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
CCB Care Delivery and Quality Committee	Chairperson: Karen Nelson, MD, MPH, Senior Vice President, Integrated Delivery Systems, MMC, and Chief Medical Officer, Maimonides Central Services Organization (CSO)	Inform the implementation and performance of all CCB DSRIP projects
Chief Medical Officer, Maimonides Central Services Organization (CSO)	Karen Nelson, MD, MPH	Oversight of clinical protocols and processes; ultimate oversight of DSRIP project implementation
Associate Medical Director, Maimonides Central Services Organization (CSO)	Kishor Malavade, MD	Oversight of clinical protocols and processes; oversight of DSRIP project implementation; chair of cross-PPS Mental Health and Substance Abuse (MHSA) Workgroup
Project Planning Workgroups, including Care Management, PCMH, 30-Day Readmissions and ED Triage	Kishor Malavade, MD, Associate Medical Director, Maimonides Central Services Organization (CSO)	Responsible for informing and developing clinical operations plans
Vice President, Care Delivery and Regional Oversight, Maimonides Central Services Organization (CSO)	Shari Suchoff	Oversight of system transformation projects and regional implementation
Vice President, Clinical Programs & Provider Engagement, Maimonides Central Services Organization (CSO)	Jenny Tsang-Quinn, MD	Oversight of clinical projects and provider engagement
Care Management Partner Organizations	Housing Works, NADAP, Visiting Nurse Service of New York, CASES, Village Center for Care, others	Provide Committee members, leadership personnel, input into value based purchasing plans
Cross-PPS HIV Workgroup	CCB Participant: Jenny Tsang-Quinn, MD, Vice President, Clinical Programs & Provider Engagement, Maimonides Central Services Organization (CSO)	Responsible for informing cross-PPS strategy to HIV project implementation
Cross-PPS Mental Health and Substance Abuse (MHSA) Workgroup	Lead: Kishor Malavade, MD, Associate Medical Director, Maimonides Central Services Organization (CSO)	Responsible for informing cross-PPS strategy to MHSA project implementation

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

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
CCB Executive Committee	Oversight of DSRIP Projects	Responsible for oversight of project implementation, performance, and outcomes
CCB Workforce Committee	Advise on project training plans	Input into project-specific training plans
CCB Finance Committee	Oversight and input on project budgets	Oversight of PPS finances; review and approval of budgets and funds flow models; oversight of managed care contracting and CCB sustainability efforts
CCB IT Committee	Advise on IT requirements in projects	Responsible for development and oversight of CCB IT strategy to support projects
Government agencies, such as NYS DOH, NYC DOHMH, OMH, OASAS, DSS	Oversight and collaboration	Overseeing DSRIP contract and processing release of DSRIP funds (NYS DOH); providing ongoing guidance with respect to DSRIP deliverables and requirements (NYS DOH); participating in workgroup and committees (NYC DOHMH); providing oversight, regulations, and collaboration (all)
External Stakeholders		
Labor Unions, including 1199SEIU, New York State Nurses Association (NYSNA), Committee of Interns and Residents (CIR), Civil Service Employees Association (CSEA), others	Labor/Union Representation	Expertise and input around job impacts and workforce retraining resulting from DSRIP projects
Healthix (RHIO)	RHIO Platform Lead	Support Participants' connectivity and data needs
Medicaid Managed Care Organizations (MCOs)	Key partner in payment reforms	Collaborate to develop value based payment structure and contracting approach

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.

CCB will use a variety of IT infrastructure to support CCB's ten projects. Given the breadth of requirements and scope of providers, CCB will undertake a significant planning process to identify the IT current state and gaps, and then develop a PPS-wide IT strategy and work plan to implement the strategy. The CSO staff, the membership of the IT and Care Delivery and Quality Committees, and clinical workgroups will be established to oversee and manage these work streams across the PPS and projects. The major IT solutions that will cut across most, if not all, DSRIP projects to create an integrated delivery system are 1) data sharing from provider EHRs with the RHIO and 2) a web-based care planning tool, called the Dashboard.

As a requirement across various projects, CCB will work to transition providers to EHRs and enable data sharing with the RHIO (Healthix). Many of the projects, such as 2.a.i Integrated Delivery Systems, 2.a.iii Health Home at Risk, and 3.b.i Cardiovascular Disease require relevant providers to share data with the RHIO and to obtain EHR systems that meet Meaningful Use standards. This will be a significant undertaking given the breadth of providers and their various states of EHR use across the CCB network.

The GSI Health Coordinator's existing web-based care planning tool, the Dashboard, will serve as the foundation for CCB's population heath management-driven IT architecture, enabling data sharing across Participants and access to patient-level information. The Dashboard is organized in a user-friendly electronic format that facilitates rapid evidence-based treatment and care management decisions among collaborating providers and patients about the physical, behavioral and social factors impacting patients' lives. The Dashboard has been used within the Brooklyn Health Home network for a number of years, and can be used in practices regardless of EHR use. The Dashboard will provide the platform to support care coordination in all of CCB's projects. Additionally, CCB plans to explore use of the Dashboard infrastructure to provide data and analytic support for population health management, reporting, and data exchange for Participants, which will be especially critical for providers who do not have EHRs. CCB plans to provide initial and ongoing training in the use of the Dashboard for members of the care team, with a focus on CCB-specific project requirements and the use of the Dashboard to facilitate timely and effective care management, secure communication among and between members of the care team, and the documentation of care plans and contact information for use by members of the care team going forward. Training will also include information on how information will be pulled from the Dashboard to support DSRIP reporting.

Lastly, the establishment of a centralized analytics and reporting function at the CSO will allow for reporting on performance metrics at the PPS, Participant, practice, and provider levels. This reporting infrastructure will require a standardized, accurate, and timely data collection infrastructure to monitor Participant progress in the various projects, determine where CCB needs to provide additional provider support, and generate performance on State-required quarterly reporting.

IPQR Module 10.6 - Performance Monitoring

Instructions :

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

CCB will monitor and track performance across all DSRIP projects and across the population of Medicaid beneficiaries included in the pool of individuals attributed to the PPS for performance measurement purposes. The CSO analytics and reporting team, CIO and IT staff, the Chief Medical Officer, and the Care Delivery and Quality Committee will work closely to design and implement performance reporting formats for at least three audiences: Participants, CSO project management staff, and the Care Delivery and Quality Committee. Performance reports will integrate Domain 1 process metrics, Domain 2 and 3 quality and outcome metrics, and other internal PPS reporting metrics selected by the Care Delivery and Quality Committee and incorporated into the performance reporting tool. CCB will utilize a rapid cycle evaluation methodology to monitor performance against the established metrics and identify providers at risk of missing performance targets. The rapid cycle evaluation process will also monitor and evaluate CCB performance through data and information provided from the NYS Department of Health through the MAPP and other sources. We will provide our Participants with training and other support to ensure that they have continuous quality improvement processes in place within their organizations, so that they may be active partners to CCB in detecting and addressing operational problems associated with the DSRIP projects in which they participate.

Recruitment of analytics and reporting staff and the development of performance reporting tools and processes are significant priorities for the CSO management team, given the need to commence analysis and reporting early on in the DSRIP process, recognizing that the tools and processes will evolve as the PPS and projects mature. As part of this effort, CCB will define its performance reporting and rapid cycle evaluation strategy, taking into consideration required reports and Participants' current reporting capabilities. CCB plans to present a performance reporting strategy to the Finance and Executive Committees and early in DY2. Once reports are finalized, the CSO will oversee a process to regularly run and share reports with the relevant governance committees and across Participants. While the strategy is under development, CCB will adhere to the State's reporting timeline and generate reports based on data available through the Dashboard, Participant surveys, and manual processes.

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IPQR Module 10.7 - Community Engagement

Instructions :

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

Recognizing that the active involvement and commitment of CBOs will be critical to our success, CCB is undertaking the following approach to ensure that the Brooklyn community engages in our DSRIP projects:

• CCB is developing a survey to gain knowledge of the services and the capacity of CBOs participating in our PPS. The information will enable CCB to match CBOs to Participant resource needs in each DSRIP project, as well as identify areas where CBOs may require support.
• Community-based providers will continue to serve a vital role by serving on clinical implementation workgroups and identifying strategies for patient engagement, health literacy, and cultural competency. CCB will contract with select CBOs to support training, outreach, peer education and project implementation.
• CCB has structured its Project Advisory Committee (PAC) to be fully representative of our membership, with one representative from each Participant including CBOs. The PAC will meet regularly to review project implementation progress, performance reports, and provide feedback based on CBO experiences with patients and in the community.

Successful achievement of DSRIP projects and goals is dependent on community-wide engagement. Brooklyn has many diverse sub-populations and communities that will be challenging to reach without the involvement of local leaders and CBOs. These leaders and CBOs understand the target population and will be a critical resource.

The first risk in engaging the community and CBOs is that demand for services exceeds the resources currently available in Brooklyn. To mitigate this risk, CCB will actively encourage further CBO engagement and the expansion of existing or cultivation of new resources. CCB will seek out opportunities to leverage and support CBOs in the borough. CCB is engaged in cross-PPS planning with respect to HIV and MHSA projects and is beginning conversations around asthma home-based self-management and palliative care..

A second risk is that many CBOs in Brooklyn have limited or no IT infrastructure, limiting their ability to participate in data sharing activities that are critical effective use of care teams. To mitigate this risk, CBO Participants will have access to the Dashboard to ensure they can access and communicate with providers across the PPS and contribute to and update patient care plans. CCB is also developing a PPS-wide health IT strategy and will plan to invest in the infrastructure, staff, and resources required to ensure CBOs may actively participate in DSRIP projects. Lastly, there is risk that CBOs will not fully support CCB's efforts to engage their local communities in health and wellness activities that are new to their culture and values. To mitigate this risk, CCB will develop education and outreach campaigns in conjunction with CBOs to understand specific sensitivities. Materials will be developed and disseminated according to CCB's cultural competency and health literacy standards and will be piloted with a small group of CBOs before they are broadly deployed.

IPQR Module 10.8 - IA Monitoring

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Instructions :

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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.

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IPQR Module 11.2 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Define target workforce state (in line with DSRIP program's goals).	In Progress	Finalized PPS target workforce state, signed off by PPS workforce governance body.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Form dedicated workforce team comprised of the Workforce Committee, CSO staff, and others (e.g., consultants, vendors) with workforce responsibility	In Progress	Form dedicated workforce team comprised of the Workforce Committee, CSO staff, and others (e.g., consultants, vendors) with workforce responsibility	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Initiate work on creation of workforce terminology definitions guide to map specific job titles to the various workforce categories of relevance under DSRIP	In Progress	Initiate work on creation of workforce terminology definitions guide to map specific job titles to the various workforce categories of relevance under DSRIP	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Define target workforce state based on DSRIP projects/goals	In Progress	Define target workforce state based on DSRIP projects/goals	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Identify consultants/experts to help develop target workforce state	Completed	Identify consultants/experts to help develop target workforce state	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Collaborate with selected consultants/experts to ensure baseline workforce survey (see milestone 3) captures information relevant to target workforce state	In Progress	Collaborate with selected consultants/experts to ensure baseline workforce survey (see milestone 3) captures information relevant to target workforce state	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Review and analyze CCB baseline workforce survey data to validate/refine target workforce model	Not Started	Review and analyze CCB baseline workforce survey data to validate/refine target workforce model	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Review and finalize target workforce state with	Not Started	Review and finalize target workforce state with Workforce and Executive Committees and obtain approval	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Workforce and Executive Committees and obtain approval									
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.	10/01/2015	06/30/2017	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Convene stakeholders, participants and workforce development experts to collaborate on workforce transition planning and transition map development	In Progress	Convene stakeholders, participants and workforce development experts to collaborate on workforce transition planning and transition map development	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Identify training and retraining needs as programs develop	In Progress	Identify training and retraining needs as programs develop	10/01/2015	06/30/2017	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Identify existing training curriculum/programs to meet competency gaps	In Progress	Identify existing training curriculum/programs to meet competency gaps	10/01/2015	06/30/2017	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Develop training curricula	In Progress	Develop and deliver training curricula to Participants	10/01/2015	06/30/2017	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Review CCB's workforce survey data and analysis, including gap analysis	Not Started	Review CCB's workforce survey data and analysis, including gap analysis	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Based on workforce survey data, identify and review competency gaps	Not Started	Based on workforce survey data, identify and review competency gaps	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Develop evaluation mechanism for the workforce transition plan and include regular review of this evaluation mechanism in the transition timeline	Not Started	Develop evaluation mechanism for the workforce transition plan and include regular review of this evaluation mechanism in the transition timeline	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Develop a draft workforce transition roadmap leveraging gap assessment (detailed in milestone below), target workforce state, and stakeholder input	Not Started	Develop a draft workforce transition roadmap leveraging gap assessment (detailed in milestone below), target workforce state, and stakeholder input	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Review workforce transition roadmap with Workforce Committee and other stakeholders and edit based on feedback	Not Started	Review workforce transition roadmap with Workforce Committee and other stakeholders and edit based on feedback	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Review final version of workforce transition	Not Started	Review final version of workforce transition roadmap with	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
roadmap with Workforce Committee and Executive Committee for approval		Workforce Committee and Executive Committee for approval							
Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	In Progress	Current state assessment report & gap analysis, signed off by PPS workforce governance body.	10/01/2015	06/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Identify consultants/vendors to help develop a workforce survey, including current and future state targets that align with CCB selected projects	Completed	Identify consultants/vendors to help develop a workforce survey, including current and future state targets that align with CCB selected projects	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop the workforce survey	In Progress	Develop the workforce survey	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Promote and distribute the workforce survey to CCB Participants	In Progress	Promote and distribute the workforce survey to CCB Participants	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Collect information and conduct baseline assessment of current staffing/ workforce within CCB Participants	Not Started	Collect information and conduct baseline assessment of current staffing/ workforce within CCB Participants	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Using baseline assessments, conduct gap analysis between current workforce and target workforce state, including a headcount and competency gap for new and incumbent workers	Not Started	Using baseline assessments, conduct gap analysis between current workforce and target workforce state, including a headcount and competency gap for new and incumbent workers	01/01/2016	06/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Draft report summarizing findings of current state and gap assessments; Review current state and gap assessment report with Workforce Committee and Executive Committee	Not Started	Draft report summarizing findings of current state and gap assessments; Review current state and gap assessment report with Workforce Committee and Executive Committee	01/01/2016	06/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Identify training resources and workforce pipelines to meet identified needs in the gap analysis	On Hold	Identify training resources and workforce pipelines to meet identified needs in the gap analysis	01/01/2016	06/30/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Deliver training/retraining curricula to Participants to close headcount and competency gaps	On Hold	Deliver training/retraining curricula to Participants to close headcount and competency gaps	01/01/2016	06/30/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task	On Hold	Develop mitigation strategies around risks associated with	01/01/2016	06/30/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Develop mitigation strategies around risks associated with transition issues		transition issues							
Task Forecast anticipated number of trained and retrained workers and compare with baseline assessments	On Hold	Forecast anticipated number of trained and retrained workers and compare with baseline assessments	10/01/2015	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Update all workforce tables (e.g. workers redeployed, retrained, new hires, placement impacts, training budget, new hires by category, etc.) according to defined categories	On Hold	Update all workforce tables (e.g. workers redeployed, retrained, new hires, placement impacts, training budget, new hires by category, etc.) according to defined categories	01/01/2016	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Finalize report and receive approval from Workforce Committee	On Hold	Finalize report and receive approval from Workforce Committee	04/01/2016	06/30/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Refine and update the workforce budget analysis based on the gap analysis	On Hold	Refine and update the workforce budget analysis based on the gap analysis	04/01/2016	06/30/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	In Progress	Compensation and benefit analysis report, signed off by PPS workforce governance body.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES
Task As part of a workforce survey, identify the number of employees, vacancies, range of compensation levels, including salaries/benefits, for key positions in current marketplace for State-required workforce categories (e.g., redeploy, retrain, new hire) impacted by DSRIP projects	In Progress	As part of a workforce survey, identify the number of employees, vacancies, range of compensation levels, including salaries/benefits, for key positions in current marketplace for State-required workforce categories (e.g., redeploy, retrain, new hire) impacted by DSRIP projects	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Develop methodology to measure workforce impacts, including number of retrained and redeployed, and new hires along with compensation impacts, including full placement and partial placement	In Progress	Develop methodology to measure workforce impacts, including number of retrained and redeployed, and new hires along with compensation impacts, including full placement and partial placement	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task	Not Started	Using baseline assessment, conduct gap analysis of current	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Using baseline assessment, conduct gap analysis of current compensation/benefits versus anticipated compensation/benefits for workforce categories		compensation/benefits versus anticipated compensation/benefits for workforce categories							
Task Assess difference in benefit levels for workforce categories and develop draft report	Not Started	Assess difference in benefit levels for workforce categories and develop draft report	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Share compensation and benefit analysis report with Workforce Committee and Executive Committee for review/approval	Not Started	Share compensation and benefit analysis report with Workforce Committee and Executive Committee for review/approval	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.	10/01/2015	06/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Convene workforce committee to develop a training strategy, including types of training needed by different types of staff, curriculum, frequency of training, method of training, how training outcomes will be measured, etc.	In Progress	Convene workforce committee to develop a training strategy, including types of training needed by different types of staff, curriculum, frequency of training, method of training, how training outcomes will be measured, etc.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Work with the 1199SEIU Training and Education Fund, the City University of New York, workforce development experts and CCB partners to inventory existing training programs/resources, including their capacity to expand to address CCB workforce training needs, and conduct a training needs assessment	In Progress	Work with the 1199SEIU Training and Education Fund, the City University of New York, workforce development experts and CCB partners to inventory existing training programs/resources, including their capacity to expand to address CCB workforce training needs, and conduct a training needs assessment	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Identify training curriculum/provider gaps	In Progress	Identify training curriculum/provider gaps	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task In collaboration with training providers, update existing training curricula, if needed, and/or develop new curriculum to meet competency gaps	In Progress	In collaboration with training providers, update existing training curricula, if needed, and/or develop new curriculum to meet competency gaps	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Review preliminary training budget and revise/update as necessary	In Progress	Review preliminary training budget and revise/update as necessary	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task	Not Started	Identify training needs using information from CCB's	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Identify training needs using information from CCB's workforce survey results and analysis, which includes competency gaps		workforce survey results and analysis, which includes competency gaps							
Task Identify training providers with capacity to develop and deliver needed training and contract with them	Not Started	Identify training providers with capacity to develop and deliver needed training and contract with them	01/01/2016	06/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Review/finalize training strategy plan and budget with Workforce Committee and Executive Committees	Not Started	Review/finalize training strategy plan and budget with Workforce Committee and Executive Committees	04/01/2016	06/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

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.	The completion date of this milestone has been changed to align with the New York State Department of Health's recommended timeline for completing workforce milestones as communicated in the December 2015 Workforce Reporting Summary.
Perform detailed gap analysis between current state assessment of workforce and projected future state.	The completion date of this milestone has been changed to align with the New York State Department of Health's recommended timeline for completing workforce milestones as communicated in the December 2015 Workforce Reporting Summary.
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.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop training strategy.	The completion date of this milestone has been changed to align with the New York State Department of Health's recommended timeline for completing workforce milestones as communicated in the December 2015 Workforce Reporting Summary.

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	

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IPQR Module 11.3 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

One challenge to implementation is the time required to gather and analyze relevant workforce data, particularly given the tens of thousands of employees at Community Care of Brooklyn (CCB) Participant organizations and the fact that job titles and roles vary significantly across Participants. The development of an effective workforce strategy requires a detailed analysis of program needs and the identification of types of employees affected by DSRIP activities. CCB will gather and analyze information on such factors as the current number of FTEs, type of FTEs, and roles/responsibilities of staff, as compared to the projected future state. While CCB will focus information gathering and analysis on the areas of most relevance to the achievement of DSRIP goals, the scope of this effort and its impact on timing will nonetheless be a concern.

A second challenge is the ability to recruit/hire dedicated staff to support the achievement of DSRIP transformation goals. CCB anticipates that there will be significant numbers of new care manager positions created over the DSRIP period, as well as new care navigators, peer service workers, mental health, and nursing professionals needed. It is also anticipated that the majority of the new positions created will be in outpatient settings, including patient centered medical homes (PCMHs), urgent care centers, Health Homes (HHs), and other ambulatory settings. The numerous Participants and their varied human resources policies could create challenges as we work to hire and recruit for these positions. Additionally, many of the Participant organizations in the CCB network have collective bargaining agreements in place, while many others do not, potentially impacting recruitment efforts. Variation in compensation levels (and the mix of salary and benefits as components of total compensation) across a widely varied group of Participant entities will create challenges as well. CCB will work closely with unions, staff representatives, and other stakeholders through the CCB Workforce Committee and in collaboration with other Brooklyn PPSs. CCB's workforce strategy will be informed by the results of a salary survey and benefit analysis that will help to ensure that compensation levels (including different combinations of salary and benefits) are appropriate and competitive.

Finally, the ability to retrain a significant number of workers and to engage workers to help carry out DSRIP transformations is a challenge. Similar to the issues related to recruitment, CCB will work closely with unions, staff representatives and other stakeholders through our Workforce Committee and in collaboration with other Brooklyn PPSs to develop a comprehensive workforce engagement plan, which is detailed in the Governance 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.)

The workforce work stream is highly dependent on the development of detailed clinical operational plans that set forth the operational requirements and specific staffing models that support the care models being pursued for each project. These plans are further described in the

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General Project Implementation section.

Certain modules in the workforce training curriculum will be dependent on the analysis to be conducted in the cultural competency and health literacy work stream. The workforce must be capable of effectively communicating with the patient population and understand the potential challenges and available resources to address health literacy.

The workforce work stream also overlaps with governance (e.g., CCB decision-making related to affected employees) and finance (e.g., the development of the budget and funds flow to Participants and vendors in order to support the workforce strategy).

IT systems and processes, including the degree to which each Participant is clinically integrated (as detailed in the Clinical Integration section) will impact worker job functions and roles/responsibilities. The development of these two work streams is highly interdependent.

Finally, the ability of CCB to meet its DSRIP targets and transition to value-based purchasing will be critical to sustainability overall and, thus, to the sustainability of the newly-envisioned workforce.

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IPQR Module 11.6 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Maimonides CSO Workforce Lead	TBD (recruitment underway)	Dedicated Project Manager (PM) in the Central Services Organization (CSO) accountable for development of workforce plans and execution of all workforce-related activities.
Workforce Training Vendor	1199 Training and Employment Fund (TEF) and others TBD	One or more training vendors that can support the execution of workforce-related activities and provide training modules and/or certification training to support workforce re-training needs.
Workforce Committee	Made up of individuals nominated from CCB Participant entities	A group of cross-functional resources (e.g. Workforce PM, Human Resources, Maimonides, 1199 TEF, union representatives, etc.) responsible for overall direction, guidance, and decisions.
Labor Representation	1199, NYSNA, CIR, CSEA, and others TBD	Labor groups that can provide insights and expertise into likely workforce impacts, staffing models, and key job categories that will require retraining, redeployment, or hiring.

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IPQR Module 11.7 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Maimonides CSO Workforce Staff	Leaders of workforce activities	Provide oversight and input to development of workforce strategies, training needs assessment, and subsequent training strategy.
HR Leads of CCB Participants	Supportive of HR data collection	Support data collection of compensation and benefit information, current state workforce information and potential hiring needs.
Representatives from Larger CCB Participant Entities	Strategic collaborators	Provide insights and information related to potential destinations of redeployed staff.
External Stakeholders		
Training Vendors	Training providers	Provide technical training curriculum development and recruiting support.
Workforce Consultants	Advisers on workforce activities	Support coordination and execution of workforce activities and analyses; conduct baseline workforce data collection.
Institutions of Higher Learning	Advisers on workforce activities	Involved in training and education of workforce.

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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.

CCB is building a Participant database that will, among other functions, be used to record and maintain information with respect to Participant entities' staffing and workforce needs as related to the DSRIP program. The database may also be used to record and track information about Participant staff involvement in targeted CCB training programs. CCB will also be evaluating options for the use of a computer-based learning management system to support training across the PPS and across levels and types of staff, and the IT team will play a key role in evaluating system options and assisting with the roll out of those programs across entities. The Central Services Organization (CSO) will be responsible for collecting and tracking information on workforce needs and for coordinating the implementation of workforce training programs, and there may be systems developed or purchased to support this work. The CSO workforce lead (recruitment underway) will need access to reliable sources of data and information to fulfill her/his responsibilities with respect to monitoring CCB progress against the target workforce state and preparing progress updates (e.g., quarterly reports on DSRIP milestones), and she/he will partner with IT and analytics and reporting leads to accomplish this.

IPQR Module 11.9 - Progress Reporting

Instructions :

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

Establishment of a well-trained, patient-focused workforce is foundational to achievement of all CCB and DSRIP-related goals. To ensure that the vision for CCB's workforce can be attained, significant time in DY1 will be spent defining the types and numbers of workers CCB will need to successfully implement DSRIP projects, and comparing that "target state" against the types and numbers of workers currently employed by CCB Participants. We will also invest in assessing the workforce's training needs and, leveraging our understanding of training and the current and target workforce states, develop a comprehensive workforce roadmap.

CCB has established a reporting structure through which this important work can be accomplished. Workforce planning and implementation will be performed jointly through the CSO (with dedicated workforce personnel) and with significant involvement of the CCB Workforce Committee. The Workforce Committee will include representation across CCB Participants, including unions and front-line workers. The Workforce Committee will meet frequently, and be heavily involved in contributing to and reviewing all of the Governance deliverables across DY1. All deliverables and recommendations will also be shared with CCB's Executive Committee for review and approval.

During DY2, CCB will finalize the workforce training strategy and track process against the DSRIP Workforce roadmap, training strategy, and target workforce numbers through regular communication with and reporting to and from CCB Participants. We will leverage our IT systems to

ensure timely communication against target workforce numbers, and leverage other tools and metrics (e.g. surveys, training attendance, training satisfaction, etc.) to better understand how workers are impacted through CCB workforce initiatives.

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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**

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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**

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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**

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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**

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Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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IPQR Module 11.11 - IA Monitoring:

Instructions :

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Project 2.a.i – Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management

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

Instructions :

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

1. Access to EMRs/Electronic Data Sharing Systems. Many participating providers do not currently have an electronic medical record (EMR). Those who do have an EMR rely on widely different EMR systems with varying capabilities. Additionally, most Participants do not use an electronic care management tool to effectively manage a patient's services. This limited capacity for data exchange creates a risk to achieving effective communication and coordination. To mitigate this risk, CCB will deploy the GSI Health Coordinator electronic web-based care planning tool, the Dashboard, to designate and connect members of patient care teams and document key elements of a patient's care plan, regardless of EMR used. Subject to patient consent, providers involved in the care of a patient will have access to a shared care plan and population health management platform, which includes clinical data from the RHIO, Healthix.

2. Primary Care Shortage. There is a risk that there may not be enough PCPs to successfully implement DSRIP programs. To mitigate this risk, CCB will work to expand the effective capacity of current provider networks and engage in developing/deploying new training programs and recruitment activities, including the marketing of new jobs/job functions created as a result of DSRIP efforts.

3. Lack of PCMHs. CCB estimates that over half of CCB's PCPs have not yet achieved any level of NCQA Patient Centered Medical Home (PCMH) recognition. To mitigate this risk, CSO staff has been actively engaging physicians and plans to provide technical support to assist with meeting NCQA requirements.

4. Patient Engagement. Social factors are often barriers to building and sustaining strong patient-provider relationships. To mitigate this risk, CCB will recruit and train peers to engage chronically ill populations, communicate health information in a culturally competent manner, and connect patients with services.

5. Recruiting and Retraining Workforce. A risk to development of an integrated delivery system is the ability of Participants to hire, retain, and train the workforce needed. To mitigate these risks, CCB will implement a large scale training initiative carried out by established vendors.

6. Value-Based Payment. There is a risk that the scale and speed of the contracting envisioned by the State (90% of all payments be value based by DY5) may be difficult to achieve. To mitigate this risk, CCB will identify leaders among the smaller practices and work with them to guide them through DSRIP implementation. CCB will also identify and leverage Participants who have already assumed risk in their payment arrangements to pilot and test specific value-based payment programs prior to wider deployment/adoption.

7. Financial Uncertainty. There are financial risks including costs associated with implementation, the ability of Participants to collectively achieve outcomes, and the financial health of Participant entities. CCB plans to use early funds to get DSRIP programs running and to invest in the

centralized infrastructure that will facilitate overall implementation across the network and thus help to ensure that later payments are achieved.

8. Availability of Capital Funds. The availability of capital funds will impact CCB project implementation and performance, as several projects require up-front capital investments. . If capital funding is delayed or not granted this may create a risk to meeting DSRIP goals. To mitigate this risk, CCB will continue to advocate for the favorable review and disposition of Participants' applications. CCB will also work to identify additional sources of capital funding.

9. Regulatory Uncertainty. DOH did not grant all of the waiver requests CCB submitted. Where waivers cannot be granted, CCB will work with its Participants to implement projects in a way that does not require regulatory waivers.

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Identify all Participants in the PPS, including providers and CBOs, and explore options for creation of a Participant database.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task As described in the Governance section, finalize Master Services Agreement and distribute to CCB Participants.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Develop a detailed strategy that defines the role and performance expectations (direct patient care, community support, outreach/education, etc.) for each type of CCB Participant (medical, community-based, social, behavioral, long-term care, etc.) within identified projects that is tailored to the readiness of CCB Participants and commensurate with CCB goals.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Based on strategies created above, develop and execute contracts (or other mechanisms) with providers to provide specified services.	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4

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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 Begin discussions with payers and social service organizations not already identified as CCB Participants and required to support IDS strategy.	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Establish regular meetings or other mechanisms with payers and social service organizations.	Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS produces a list of participating HHs and ACOs.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Identify HHs and ACOs (if applicable) within the CCB network and develop a schedule for recurring meetings.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Assess current state of CCB HH and ACO (if applicable) population health management systems and capabilities	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Working with the IT Committee, identify, evaluate, and select IT applications required to supplement existing Dashboard/IT capabilities and incorporate into population health management roadmap	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Define coordination strategy for HH and ACOs.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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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
providers.									
Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS trains staff on IDS protocols and processes.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Working with project planning workgroups and the Care Delivery and Quality Committee (which are comprised of clinical and social services providers), develop clinical operations plans for the projects, detailing required protocols, interventions, reporting requirements (including any needed registries for population health management), and other processes.	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify the role of each Participant in providing services and incorporate feedback from Participants on roles/responsibilities within the projects.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify PPS IT requirements and systems to support project implementation, data collection and effective care coordination and management	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify staff within each Participating organization that will be responsible for project implementation (e.g. following project protocols, directing patients through care transitions, etc.)	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Establish rapid cycle evaluation programs and other project-appropriate quality improvement mechanisms (such as audits of patient care management plans, assessments of quality and process measures, focus group feedback, and other mechanisms) to ensure that CCB's patients receive appropriate health care and community supports	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Ensure that all PPS safety net providers are actively sharing	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.									
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	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 Practitioner - Non-Primary Care Provider (PCP)	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	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 Mental Health	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 Nursing Home	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.	Project		Not Started	01/01/2017	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Survey providers to gain understanding of existing data-sharing capabilities with Healthix (RHIO)	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish partnership with RHIO and CCB Participants who need to receive and/or contribute patient data to serve patient needs	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Based on the data sharing roadmap and other information, develop and implement support processes to ensure that all PPS safety net providers are actively sharing health information, including alerts and secure messaging.	Project		Not Started	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Project	N/A	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note:	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4

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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.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Assess eligible Participant EHR use and readiness relative to Meaningful Use and PCMH 2014 Level 3 standards	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop a work plan/strategy to encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, which may vary based on provider characteristics such as providers' size, services, current status, readiness levels, etc. ; develop Participant education and engagement strategy to facilitate understanding of IT requirements	Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Recruit or contract for EHR implementation resources as needed	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Implement work plan/strategy by providing technical assistance and other supports for Participant EHR implementation and progress towards Meaningful Use and PCMH standards	Project		Not Started	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Project	N/A	Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Working with the IT and Care Delivery and Quality Committees, review the requirements for population health management (PHM) as defined in the clinical operations plans to identify data collection, reporting, and information exchange needs related to patient registries and other PHM tools.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task In concert with project planning activities, identify systems or enhancements needed to existing systems to meet identified	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1

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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
PHM requirements.									
Task Develop a PHM data collection and reporting roadmap along with mitigation strategies to meet near-term needs for provider participation in PHM	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop and initiate training for Participants on PHM initiatives, including use of interim data collection and reporting solutions, use of EHRs and other available IT solutions.	Project		Not Started	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Initiate PHM data collection, validation/refinement and analysis as required under the clinical operations plans	Project		Not Started	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Acquire or enhance systems in order to achieve PHM requirements, including the development of patient registries.	Project		Not Started	07/01/2016	06/30/2017	07/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task Deploy systems and/or enhancements across CCB Participants, including required training to integrate into ongoing PHM initiatives.	Project		Not Started	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	Project	N/A	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.	Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	10/01/2015	03/31/2018	10/01/2015	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 Identify current status of CCB Primary Care providers achieving PCMH status.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Identify clinical champions and operational leaders in each primary care provider organization to develop and lead each of their providers/sites along the path to NCQA PCMH 2014 Level 3 recognition									
Task Working with IT and Care Delivery and Quality Committees, develop centralized technical assistance programs to assist primary care practices.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Develop timeline and phased approach to providing technical assistance to primary care practices, taking into consideration the practices' PCMH status as identified in Step #1	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Deploy technical assistance program to primary care practices as necessary per the step above and refine program over time.	Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	Project	N/A	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Medicaid Managed Care contract(s) are in place that include value-based payments.	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Working with the Finance and Executive Committees, establish strategy and working relationships with Medicaid MCOs (MCOs) in preparation for discussions relating to establishing value-based payment arrangements	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Engage MCOs and Participants to define requirements necessary to support the development of contracts with Medicaid MCOs	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Evaluate mechanisms to support contracting with Medicaid MCOs and other payers as an integrated system	Project		In Progress	07/01/2016	09/30/2017	07/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Develop value-based payment arrangements for presentation to Medicaid MCOs and other payers	Project		In Progress	07/01/2016	12/31/2017	07/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task Refine and negotiate at least one value-based payment	Project		In Progress	10/01/2017	03/31/2018	10/01/2017	03/31/2018	03/31/2018	DY3 Q4

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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
arrangement with Medicaid MCOs and other payers									
Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Engage the major Medicaid MCOs for participation in CCB activities	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task In collaboration with the Finance Committee and MCOs, develop reporting processes and tools to collect MCO data	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Establish reporting mechanisms to obtain and analyze Medicaid MCO and CCB Participant data relative to utilization, performance, and payment	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop goals/objectives for Medicaid MCO "workgroup" and convene first meeting	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Document Medicaid MCO "workgroup" actions and minutes and provide regular reports to Executive Committee	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	Project	N/A	In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.	Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Develop provider value-based compensation framework/growth plan through CCB Finance Committee	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop provider education and engagement strategy to elevate understanding of value-based payments among Participants	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1

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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 Collect and analyze performance and outcomes data by CCB Participants and providers (see the Performance Reporting section for more details regarding data collection)	Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Working with the Finance Committee and taking into consideration input from the Care Delivery and Quality Committee, develop recommendation for allocation of community good pool funds (provider bonus payments) to reflect CCB Participant and provider performance relative to patient outcomes	Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Present recommendation for allocation of community good pool funds to Executive Committee.	Project		In Progress	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Issue first provider bonus payments for high-performing Participants exceeding outcome and quality; refine process and payments on a continual basis.	Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Convene workgroups to develop clinical operations plans, detailing patient flow and engagement strategies	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify key Participants, including CBOs, for each project and ensure Participant information (including information on specific services and cultural/linguistic and ethnic competencies) is updated/accurate in Participant database (mentioned in a previous milestone)	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop patient engagement and activation protocols for projects, including specific targeted populations or interventions	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Develop recruitment plan for community health workers, care/peer managers and others									
Task Recruit initial group of community health workers, care/peer managers and others and train on engagement strategies	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Solicit feedback from new staff on patient engagement and activation protocols, understanding that community health workers and care/peer managers will have unique perspectives on engaging this population	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Begin patient outreach, engagement, screening/assessment, navigation activation and education for high priority projects and populations	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Patients are engaged in the integrated delivery system	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 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 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.										
Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.										
Task Identify all Participants in the PPS, including providers and CBOs, and explore options for creation of a Participant database.										
Task As described in the Governance section, finalize Master Services Agreement and distribute to CCB Participants.										
Task Develop a detailed strategy that defines the role and performance expectations (direct patient care, community support, outreach/education, etc.) for each type of CCB										

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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
Participant (medical, community-based, social, behavioral, long-term care, etc.) within identified projects that is tailored to the readiness of CCB Participants and commensurate with CCB goals.										
Task Based on strategies created above, develop and execute contracts (or other mechanisms) with providers to provide specified services.										
Task Begin discussions with payers and social service organizations not already identified as CCB Participants and required to support IDS strategy.										
Task Establish regular meetings or other mechanisms with payers and social service organizations.										
Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.										
Task PPS produces a list of participating HHs and ACOs.										
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.										
Task Identify HHs and ACOs (if applicable) within the CCB network and develop a schedule for recurring meetings.										
Task Assess current state of CCB HH and ACO (if applicable) population health management systems and capabilities										
Task Working with the IT Committee, identify, evaluate, and select IT applications required to supplement existing Dashboard/IT capabilities and incorporate into population health management roadmap										
Task Define coordination strategy for HH and ACOs.										
Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.										

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Maimonides Medical Center (PPS ID:33)

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 Clinically Interoperable System is in place for all participating providers.										
Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.										
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.										
Task PPS trains staff on IDS protocols and processes.										
Task Working with project planning workgroups and the Care Delivery and Quality Committee (which are comprised of clinical and social services providers), develop clinical operations plans for the projects, detailing required protocols, interventions, reporting requirements (including any needed registries for population health management), and other processes.										
Task Identify the role of each Participant in providing services and incorporate feedback from Participants on roles/responsibilities within the projects.										
Task Identify PPS IT requirements and systems to support project implementation, data collection and effective care coordination and management										
Task Identify staff within each Participating organization that will be responsible for project implementation (e.g. following project protocols, directing patients through care transitions, etc.)										
Task Establish rapid cycle evaluation programs and other project-appropriate quality improvement mechanisms (such as audits of patient care management plans, assessments of quality and process measures, focus group feedback, and other mechanisms) to ensure that CCB's patients receive appropriate health care and community supports										
Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of										

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Maimonides Medical Center (PPS ID:33)

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
Demonstration Year (DY) 3.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	40	90	158	158	258
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	20	50	90	130
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	1	2	4	6	6	6
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	25	25	60	60	100
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	5	11	22	22	34
Task PPS uses alerts and secure messaging functionality.										
Task Survey providers to gain understanding of existing data-sharing capabilities with Healthix (RHIO)										
Task Establish partnership with RHIO and CCB Participants who need to receive and/or contribute patient data to serve patient needs										
Task Based on the data sharing roadmap and other information, develop and implement support processes to ensure that all PPS safety net providers are actively sharing health information, including 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	36	44	91	129	201	237	257
Task Assess eligible Participant EHR use and readiness relative to Meaningful Use and PCMH 2014 Level 3 standards										

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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 Develop a work plan/strategy to encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, which may vary based on provider characteristics such as providers' size, services, current status, readiness levels, etc. ; develop Participant education and engagement strategy to facilitate understanding of IT requirements										
Task Recruit or contract for EHR implementation resources as needed										
Task Implement work plan/strategy by providing technical assistance and other supports for Participant EHR implementation and progress towards Meaningful Use and PCMH standards										
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 Working with the IT and Care Delivery and Quality Committees, review the requirements for population health management (PHM) as defined in the clinical operations plans to identify data collection, reporting, and information exchange needs related to patient registries and other PHM tools.										
Task In concert with project planning activities, identify systems or enhancements needed to existing systems to meet identified PHM requirements.										
Task Develop a PHM data collection and reporting roadmap along with mitigation strategies to meet near-term needs for provider participation in PHM										
Task Develop and initiate training for Participants on PHM initiatives, including use of interim data collection and reporting solutions, use of EHRs and other available IT solutions.										
Task Initiate PHM data collection, validation/refinement and analysis as required under the clinical operations plans										
Task Acquire or enhance systems in order to achieve PHM requirements, including the development of patient registries.										

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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 Deploy systems and/or enhancements across CCB Participants, including required training to integrate into ongoing PHM initiatives.										
Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.										
Task Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.										
Task All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.	0	0	0	0	56	79	171	259	374	435
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 Identify current status of CCB Primary Care providers achieving PCMH status.										
Task Identify clinical champions and operational leaders in each primary care provider organization to develop and lead each of their providers/sites along the path to NCQA PCMH 2014 Level 3 recognition										
Task Working with IT and Care Delivery and Quality Committees, develop centralized technical assistance programs to assist primary care practices.										
Task Develop timeline and phased approach to providing technical assistance to primary care practices, taking into consideration the practices' PCMH status as identified in Step #1										
Task Deploy technical assistance program to primary care practices as necessary per the step above and refine program over time.										
Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.										
Task Medicaid Managed Care contract(s) are in place that include										

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Maimonides Medical Center (PPS ID:33)

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
value-based payments.										
Task Working with the Finance and Executive Committees, establish strategy and working relationships with Medicaid MCOs (MCOs) in preparation for discussions relating to establishing value-based payment arrangements										
Task Engage MCOs and Participants to define requirements necessary to support the development of contracts with Medicaid MCOs										
Task Evaluate mechanisms to support contracting with Medicaid MCOs and other payers as an integrated system										
Task Develop value-based payment arrangements for presentation to Medicaid MCOs and other payers										
Task Refine and negotiate at least one value-based payment arrangement with Medicaid MCOs and other payers										
Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.										
Task PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.										
Task Engage the major Medicaid MCOs for participation in CCB activities										
Task In collaboration with the Finance Committee and MCOs, develop reporting processes and tools to collect MCO data										
Task Establish reporting mechanisms to obtain and analyze Medicaid MCO and CCB Participant data relative to utilization, performance, and payment										
Task Develop goals/objectives for Medicaid MCO "workgroup" and convene first meeting										
Task Document Medicaid MCO "workgroup" actions and minutes and provide regular reports to Executive Committee										
Milestone #10 Re-enforce the transition towards value-based payment reform										

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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
by aligning provider compensation to patient outcomes.										
Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation										
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.										
Task Develop provider value-based compensation framework/growth plan through CCB Finance Committee										
Task Develop provider education and engagement strategy to elevate understanding of value-based payments among Participants										
Task Collect and analyze performance and outcomes data by CCB Participants and providers (see the Performance Reporting section for more details regarding data collection)										
Task Working with the Finance Committee and taking into consideration input from the Care Delivery and Quality Committee, develop recommendation for allocation of community good pool funds (provider bonus payments) to reflect CCB Participant and provider performance relative to patient outcomes										
Task Present recommendation for allocation of community good pool funds to Executive Committee.										
Task Issue first provider bonus payments for high-performing Participants exceeding outcome and quality; refine process and payments on a continual basis.										
Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.										
Task Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.										
Task Convene workgroups to develop clinical operations plans, detailing patient flow and engagement strategies										
Task Identify key Participants, including CBOs, for each project and										

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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
ensure Participant information (including information on specific services and cultural/linguistic and ethnic competencies) is updated/accurate in Participant database (mentioned in a previous milestone)										
Task Develop patient engagement and activation protocols for projects, including specific targeted populations or interventions										
Task Develop recruitment plan for community health workers, care/peer managers and others										
Task Recruit initial group of community health workers, care/peer managers and others and train on engagement strategies										
Task Solicit feedback from new staff on patient engagement and activation protocols, understanding that community health workers and care/peer managers will have unique perspectives on engaging this population										
Task Begin patient outreach, engagement, screening/assessment, navigation activation and education for high priority projects and populations										
Task Patients are engaged in the integrated delivery system										

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 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.										
Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.										
Task Identify all Participants in the PPS, including providers and CBOs, and explore options for creation of a Participant database.										
Task As described in the Governance section, finalize Master Services Agreement and distribute to CCB Participants.										

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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 Develop a detailed strategy that defines the role and performance expectations (direct patient care, community support, outreach/education, etc.) for each type of CCB Participant (medical, community-based, social, behavioral, long-term care, etc.) within identified projects that is tailored to the readiness of CCB Participants and commensurate with CCB goals.										
Task Based on strategies created above, develop and execute contracts (or other mechanisms) with providers to provide specified services.										
Task Begin discussions with payers and social service organizations not already identified as CCB Participants and required to support IDS strategy.										
Task Establish regular meetings or other mechanisms with payers and social service organizations.										
Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.										
Task PPS produces a list of participating HHs and ACOs.										
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.										
Task Identify HHs and ACOs (if applicable) within the CCB network and develop a schedule for recurring meetings.										
Task Assess current state of CCB HH and ACO (if applicable) population health management systems and capabilities										
Task Working with the IT Committee, identify, evaluate, and select IT applications required to supplement existing Dashboard/IT capabilities and incorporate into population health management roadmap										
Task Define coordination strategy for HH and ACOs.										

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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 #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.										
Task Clinically Interoperable System is in place for all participating providers.										
Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.										
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.										
Task PPS trains staff on IDS protocols and processes.										
Task Working with project planning workgroups and the Care Delivery and Quality Committee (which are comprised of clinical and social services providers), develop clinical operations plans for the projects, detailing required protocols, interventions, reporting requirements (including any needed registries for population health management), and other processes.										
Task Identify the role of each Participant in providing services and incorporate feedback from Participants on roles/responsibilities within the projects.										
Task Identify PPS IT requirements and systems to support project implementation, data collection and effective care coordination and management										
Task Identify staff within each Participating organization that will be responsible for project implementation (e.g. following project protocols, directing patients through care transitions, etc.)										
Task Establish rapid cycle evaluation programs and other project-appropriate quality improvement mechanisms (such as audits of patient care management plans, assessments of quality and process measures, focus group feedback, and other mechanisms) to ensure that CCB's patients receive appropriate health care and community supports										
Milestone #4 Ensure that all PPS safety net providers are actively sharing										

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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
EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	258	439	439	439	439	439	439	439	439	439
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	170	527	527	527	527	527	527	527	527	527
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	6	17	17	17	17	17	17	17	17	17
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	100	157	157	157	157	157	157	157	157	157
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	34	47	47	47	47	47	47	47	47	47
Task PPS uses alerts and secure messaging functionality.										
Task Survey providers to gain understanding of existing data-sharing capabilities with Healthix (RHIO)										
Task Establish partnership with RHIO and CCB Participants who need to receive and/or contribute patient data to serve patient needs										
Task Based on the data sharing roadmap and other information, develop and implement support processes to ensure that all PPS safety net providers are actively sharing health information, including 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.	294	439	439	439	439	439	439	439	439	439

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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 Assess eligible Participant EHR use and readiness relative to Meaningful Use and PCMH 2014 Level 3 standards										
Task Develop a work plan/strategy to encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, which may vary based on provider characteristics such as providers' size, services, current status, readiness levels, etc. ; develop Participant education and engagement strategy to facilitate understanding of IT requirements										
Task Recruit or contract for EHR implementation resources as needed										
Task Implement work plan/strategy by providing technical assistance and other supports for Participant EHR implementation and progress towards Meaningful Use and PCMH standards										
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 Working with the IT and Care Delivery and Quality Committees, review the requirements for population health management (PHM) as defined in the clinical operations plans to identify data collection, reporting, and information exchange needs related to patient registries and other PHM tools.										
Task In concert with project planning activities, identify systems or enhancements needed to existing systems to meet identified PHM requirements.										
Task Develop a PHM data collection and reporting roadmap along with mitigation strategies to meet near-term needs for provider participation in PHM										
Task Develop and initiate training for Participants on PHM initiatives, including use of interim data collection and reporting solutions, use of EHRs and other available IT solutions.										
Task Initiate PHM data collection, validation/refinement and analysis as required under the clinical operations plans										

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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 Acquire or enhance systems in order to achieve PHM requirements, including the development of patient registries.										
Task Deploy systems and/or enhancements across CCB Participants, including required training to integrate into ongoing PHM initiatives.										
Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.										
Task Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.										
Task All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.	490	1,046	1,046	1,046	1,046	1,046	1,046	1,046	1,046	1,046
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 Identify current status of CCB Primary Care providers achieving PCMH status.										
Task Identify clinical champions and operational leaders in each primary care provider organization to develop and lead each of their providers/sites along the path to NCQA PCMH 2014 Level 3 recognition										
Task Working with IT and Care Delivery and Quality Committees, develop centralized technical assistance programs to assist primary care practices.										
Task Develop timeline and phased approach to providing technical assistance to primary care practices, taking into consideration the practices' PCMH status as identified in Step #1										
Task Deploy technical assistance program to primary care practices as necessary per the step above and refine program over time.										
Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish										

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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
value-based payment arrangements.										
Task Medicaid Managed Care contract(s) are in place that include value-based payments.										
Task Working with the Finance and Executive Committees, establish strategy and working relationships with Medicaid MCOs (MCOs) in preparation for discussions relating to establishing value-based payment arrangements										
Task Engage MCOs and Participants to define requirements necessary to support the development of contracts with Medicaid MCOs										
Task Evaluate mechanisms to support contracting with Medicaid MCOs and other payers as an integrated system										
Task Develop value-based payment arrangements for presentation to Medicaid MCOs and other payers										
Task Refine and negotiate at least one value-based payment arrangement with Medicaid MCOs and other payers										
Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.										
Task PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.										
Task Engage the major Medicaid MCOs for participation in CCB activities										
Task In collaboration with the Finance Committee and MCOs, develop reporting processes and tools to collect MCO data										
Task Establish reporting mechanisms to obtain and analyze Medicaid MCO and CCB Participant data relative to utilization, performance, and payment										
Task Develop goals/objectives for Medicaid MCO "workgroup" and convene first meeting										
Task Document Medicaid MCO "workgroup" actions and minutes and										

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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
provide regular reports to Executive Committee										
Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.										
Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation										
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.										
Task Develop provider value-based compensation framework/growth plan through CCB Finance Committee										
Task Develop provider education and engagement strategy to elevate understanding of value-based payments among Participants										
Task Collect and analyze performance and outcomes data by CCB Participants and providers (see the Performance Reporting section for more details regarding data collection)										
Task Working with the Finance Committee and taking into consideration input from the Care Delivery and Quality Committee, develop recommendation for allocation of community good pool funds (provider bonus payments) to reflect CCB Participant and provider performance relative to patient outcomes										
Task Present recommendation for allocation of community good pool funds to Executive Committee.										
Task Issue first provider bonus payments for high-performing Participants exceeding outcome and quality; refine process and payments on a continual basis.										
Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.										
Task Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.										
Task Convene workgroups to develop clinical operations plans,										

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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
detailing patient flow and engagement strategies										
Task Identify key Participants, including CBOs, for each project and ensure Participant information (including information on specific services and cultural/linguistic and ethnic competencies) is updated/accurate in Participant database (mentioned in a previous milestone)										
Task Develop patient engagement and activation protocols for projects, including specific targeted populations or interventions										
Task Develop recruitment plan for community health workers, care/peer managers and others										
Task Recruit initial group of community health workers, care/peer managers and others and train on engagement strategies										
Task Solicit feedback from new staff on patient engagement and activation protocols, understanding that community health workers and care/peer managers will have unique perspectives on engaging this population										
Task Begin patient outreach, engagement, screening/assessment, navigation activation and education for high priority projects and populations										
Task Patients are engaged in the integrated delivery system										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
and social service organizations, as necessary to support its strategy.	
Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	
Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	
Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	
Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	
Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	
Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	
Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	
Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	

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Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

The major risks to implementing 2.a.iii and corresponding mitigation strategies that will be used are described below:

1. Access to EMRs/Electronic Data Sharing Systems: Many participating providers do not currently have an electronic medical record (EMR). Those who do have an EMR rely on widely different EMR systems with varying capabilities. Additionally, most Participants do not use an electronic care management tool that enables information sharing across providers to effectively manage a patient's services. This lack of information technology (IT)/EMR infrastructure and limited capacity for data exchange creates a risk to achieving effective communication and coordination across CCB Participants. To mitigate this risk, CCB will leverage the GSI Health Coordinator electronic web-based care planning tool, the Dashboard, as a way to designate and connect members of patient care teams and document key elements of a patient's care plan, regardless of EMR used. Subject to patient consent, providers involved in the care of a patient will have access to this shared care plan and population health management platform, which includes key clinical data from the Regional Health Information Organization (RHIO), Healthix.

2. Provider Awareness of Health Homes: Engaging patients in this project will rely heavily on referrals to health homes from PPS providers. It is critical that referring providers are knowledgeable about health homes and care management services available. To mitigate the risk that providers are unaware of health home services, CCB will educate Participants about the specific services health homes offer, how they serve the patient, and create a simple referral process. The Care Delivery and Quality Committee and Care Management Workgroup will oversee development of these protocols, definition of roles and responsibilities with respect to the protocols and the project care model, and monitor progress to assess effectiveness and recommend changes, as needed.

3. Coordinating Care Across Multiple Settings: Most people receive health care and other services from multiple providers. Health home care management helps to connect these providers, bringing together a patient's care team across multiple institutions using a shared care plan. This model of care will be new for some CCB Participants who may be accustomed to providing care exclusively within the four walls of their organizations. To mitigate the risk associated with this change, CCB will expand the use of interdisciplinary team building modules that Maimonides developed with 1199SEIU Training and Employment Funds (TEF) in which PCPs, psychiatrists, care managers and other providers participate together

4. Insufficient Care Management Workforce: As health home enrollment has expanded, it has become clear that there is an insufficient workforce of care management staff to meet the needs of the Brooklyn population. To mitigate this risk, CCB will work with the TEF and others to identify and train capable care management workers.

5. Patient Engagement and Compliance: Actively engaging patients can be challenging, especially when there are language and cultural barriers.

To mitigate this risk, CCB will incorporate cultural competency training into its curriculum for providers. CCB will leverage its experience working with the two health homes in its network that have been successful in engaging and retaining patients in care. CCB will work with them to continue to test new engagement and compliance strategies and spread them to other providers in the PPS. CCB will regularly review performance data to determine which strategies are most effective and tweak less effective strategies as needed.

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "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	77,000

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%	3,850	0.00%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (3,850)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
cpickett	Rosters	33_PMDL2215_1_3_20160201130045_MMC_PPS_Patient_Engagement_Speed.xlsx	MMC PPS Patient Engagement Speed	02/01/2016 01:01 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task A clear strategic plan is in place which includes, at a minimum: - Definition of the Health Home At-Risk Intervention Program - Development of comprehensive care management plan, with definition of roles of PCMH/APC PCPs and HHs	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Convene working group of Participants, including Health Homes (HH) and PCMH PCPs, to participate in project planning.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Create a workplan and timeline to develop the clinical operations plan (COP) and strategy for Health Home at-risk.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify the clinical and social diagnoses/factors that define the HH At Risk Population	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Develop COP to include all Domain 1 requirements and protocols detailing policies and procures, patient and work flows, defined target population, staffing models, roles of CBOs & Health Homes, training and recruitment policies, referral to support services, evidence based guidelines, technology resource requirements, and desired metrics to track performance.	Project		Completed	07/01/2015	03/31/2016	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Create a comprehensive care management plan with definitive roles for the care team members (e.g., HHs and PCMH PCPs) to include in the COP and overall strategy.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Assess workforce requirements and training needs to implement program	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Submit the initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval recognizing that the COP will be modified over time based on findings of rapid cycle evaluation.	Project		Completed	10/01/2015	03/31/2016	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task In collaboration with Finance Committee, develop financial model to support implementation of additional care management requirements.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop training and recruitment strategy to meet project requirements.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Recruit and train new staff and/or retrain existing staff.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task The Health Home At-Risk program is established	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.	Project	N/A	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and APCM standards	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Identify current status of CCB Primary Care providers achieving PCMH status.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify clinical champions and operational leaders in each primary care provider organization to develop and lead each of their providers/sites along the path to NCQA PCMH 2014 Level 3 recognition	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Working with IT and Care Delivery and Quality Committees, develop centralized technical assistance programs to assist	Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2

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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
primary care practices.									
Task Develop timeline and phased approach to providing technical assistance to primary care practices, taking into consideration the practices' PCMH status as identified in Step #1	Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Deploy technical assistance program to primary care practices as necessary per the step above and refine program over time.	Project		Not Started	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #3 Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	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 Practitioner - Non-Primary Care Provider (PCP)	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 Case Management / Health Home	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.	Project		Not Started	01/01/2017	03/31/2018	01/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task Survey providers to gain understanding of existing data-sharing capabilities with Healthix (RHIO)	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish partnership with RHIO and CCB Participants who need to receive and/or contribute patient data to serve patient needs	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Based on the data sharing roadmap and other information, develop and implement support processes to ensure that all PPS safety net providers are actively sharing health information, including alerts and secure messaging.	Project		Not Started	01/01/2017	03/31/2018	01/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Ensure that EHR systems used by participating safety net	Project	N/A	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4

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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
providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.									
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 PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Assess eligible Participant EHR use and readiness relative to Meaningful Use and PCMH 2014 Level 3 standards	Project		In Progress	10/01/2015	03/13/2016	10/01/2015	03/13/2016	03/31/2016	DY1 Q4
Task Develop a work plan/strategy to encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, which may vary based on provider characteristics such as providers' size, services, current status, readiness levels, etc.; develop Participant education and engagement strategy to facilitate understanding of IT requirements	Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Recruit or contract for EHR implementation resources as needed	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Implement work plan/strategy by providing technical assistance and other supports for Participant EHR implementation and progress towards Meaningful Use and PCMH standards	Project		Not Started	01/01/2017	03/31/2018	01/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #5 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Project	N/A	Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Working with the IT and Care Delivery and Quality Committees, review the requirements for population health management (PHM) as defined in the clinical operations plans to identify data collection, reporting, and information exchange needs related to	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1

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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
patient registries and other PHM tools.									
Task In concert with project planning activities, identify systems or enhancements needed to existing systems to meet identified PHM requirements.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop a PHM data collection and reporting roadmap along with mitigation strategies to meet near-term needs for provider participation in PHM	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop and initiate training for Participants on PHM initiatives, including use of interim data collection and reporting solutions, use of EHRs and other available IT solutions.	Project		Not Started	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Initiate PHM data collection, validation/refinement and analysis as required under the clinical operations plans	Project		Not Started	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Acquire or enhance systems in order to achieve PHM requirements, including the development of patient registries.	Project		Not Started	01/01/2017	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task Deploy systems and/or enhancements across CCB Participants, including required training to integrate into ongoing PHM initiatives.	Project		Not Started	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Procedures to engage at-risk patients with care management plan instituted.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Work with project planning work group to review Health Home care management plan for applicability to broader population	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Design outreach/intake/assessment process for HH at Risk population that includes development of written comprehensive care management plan.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Train staff on developing and updating comprehensive care	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

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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
management plans for patients.									
Task Deploy technology solutions that include comprehensive care management plans.	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Comprehensive care management plan developed for each patient.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #7 Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Each identified PCP establish partnerships with the local Health Home for care management services.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Each identified PCP establish partnerships with the local Health Home for care management services.	Provider	Case Management / Health Home	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify participating primary care practices and assess their care management staffing needs to meet care management service needs of target population.	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop care management service standards, provider roles and responsibilities, and information sharing procedures among PCMH and Health Home Providers as part of the COP process described above.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Facilitate partnerships with Brooklyn Health Home and Coordinated Behavioral Care Health Home, their downstream Care Management Agencies (CMAs), and PCPs	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provide training to participating PCPs, HHs, and CMAs on the standards, roles, and information sharing procedures.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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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
departments).									
Task PPS has established partnerships to medical, behavioral health, and social services.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has established partnerships to medical, behavioral health, and social services.	Provider	Case Management / Health Home	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify Participants, including community-based organizations (CBOs) and other relevant local government units, that can provide needed social support services to the HH at Risk population.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task As part of the COP process described above, develop policies and procedures for partnerships between PCPs, CBOs, HHs, and other Participants, to include use of technology solutions that could facilitate and document partnerships.	Project		Completed	07/01/2015	03/31/2016	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop contractual agreements between CCB and PCPs and other Participants to provide needed medical, behavioral, and social support services to patients.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.	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 adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate evidence-based practice guidelines developed and process implemented.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has included social services agencies in development of	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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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
risk reduction and care practice guidelines.									
Task Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Convene a working group to meet regularly to review/develop CCB-wide standard evidence-based practice guidelines for management of chronic diseases.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task As part of the COP process described above, the working group will review/develop collaborative evidence-based practice guidelines for the target population.	Project		Completed	10/01/2015	03/31/2016	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Working with CBOs, develop and identify educational and training materials suitable to the needs, culture, and language of the target populations.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Disseminate evidence-based practice guidelines and educational materials across the CCB network.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	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 a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.										
Task A clear strategic plan is in place which includes, at a minimum: - Definition of the Health Home At-Risk Intervention Program - Development of comprehensive care management plan, with definition of roles of PCMH/APC PCPs and HHs										
Task Convene working group of Participants, including Health Homes (HH) and PCMH PCPs, to participate in project planning.										
Task Create a workplan and timeline to develop the clinical operations plan (COP) and strategy for Health Home at-risk.										
Task Identify the clinical and social diagnoses/factors that define the HH At Risk Population										

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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 Develop COP to include all Domain 1 requirements and protocols detailing policies and procures, patient and work flows, defined target population, staffing models, roles of CBOs & Health Homes, training and recruitment policies, referral to support services, evidence based guidelines, technology resource requirements, and desired metrics to track performance.										
Task Create a comprehensive care management plan with definitive roles for the care team members (e.g., HHs and PCMH PCPs) to include in the COP and overall strategy.										
Task Assess workforce requirements and training needs to implement program										
Task Submit the initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval recognizing that the COP will be modified over time based on findings of rapid cycle evaluation.										
Task In collaboration with Finance Committee, develop financial model to support implementation of additional care management requirements.										
Task Develop training and recruitment strategy to meet project requirements.										
Task Recruit and train new staff and/or retrain existing staff.										
Task The Health Home At-Risk program is established										
Milestone #2 Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and APCM standards	0	0	0	56	79	171	259	374	435	490
Task Identify current status of CCB Primary Care providers achieving PCMH status.										
Task Identify clinical champions and operational leaders in each										

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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 provider organization to develop and lead each of their providers/sites along the path to NCQA PCMH 2014 Level 3 recognition										
Task Working with IT and Care Delivery and Quality Committees, develop centralized technical assistance programs to assist primary care practices.										
Task Develop timeline and phased approach to providing technical assistance to primary care practices, taking into consideration the practices' PCMH status as identified in Step #1										
Task Deploy technical assistance program to primary care practices as necessary per the step above and refine program over time.										
Milestone #3 Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	40	90	158	158	258
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	20	50	90	130
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	3	3	7	7	10
Task PPS uses alerts and secure messaging functionality.										
Task Survey providers to gain understanding of existing data-sharing capabilities with Healthix (RHIO)										
Task Establish partnership with RHIO and CCB Participants who need to receive and/or contribute patient data to serve patient needs										
Task Based on the data sharing roadmap and other information, develop and implement support processes to ensure that all PPS safety net providers are actively sharing health information, including alerts and secure messaging.										
Milestone #4 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards										

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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/or APCM.										
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	36	44	91	129	201	237	257
Task Assess eligible Participant EHR use and readiness relative to Meaningful Use and PCMH 2014 Level 3 standards										
Task Develop a work plan/strategy to encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, which may vary based on provider characteristics such as providers' size, services, current status, readiness levels, etc.; develop Participant education and engagement strategy to facilitate understanding of IT requirements										
Task Recruit or contract for EHR implementation resources as needed										
Task Implement work plan/strategy by providing technical assistance and other supports for Participant EHR implementation and progress towards Meaningful Use and PCMH standards										
Milestone #5 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task Working with the IT and Care Delivery and Quality Committees, review the requirements for population health management (PHM) as defined in the clinical operations plans to identify data collection, reporting, and information exchange needs related to patient registries and other PHM tools.										
Task In concert with project planning activities, identify systems or enhancements needed to existing systems to meet identified PHM requirements.										
Task Develop a PHM data collection and reporting roadmap along with										

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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
mitigation strategies to meet near-term needs for provider participation in PHM										
Task Develop and initiate training for Participants on PHM initiatives, including use of interim data collection and reporting solutions, use of EHRs and other available IT solutions.										
Task Initiate PHM data collection, validation/refinement and analysis as required under the clinical operations plans										
Task Acquire or enhance systems in order to achieve PHM requirements, including the development of patient registries.										
Task Deploy systems and/or enhancements across CCB Participants, including required training to integrate into ongoing PHM initiatives.										
Milestone #6 Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.										
Task Procedures to engage at-risk patients with care management plan instituted.										
Task Work with project planning work group to review Health Home care management plan for applicability to broader population										
Task Design outreach/intake/assessment process for HH at Risk population that includes development of written comprehensive care management plan.										
Task Train staff on developing and updating comprehensive care management plans for patients.										
Task Deploy technology solutions that include comprehensive care management plans.										
Task Comprehensive care management plan developed for each patient.										
Milestone #7 Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.										
Task	0	0	0	0	0	300	600	904	904	904

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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 identified PCP establish partnerships with the local Health Home for care management services.										
Task Each identified PCP establish partnerships with the local Health Home for care management services.	0	0	0	0	0	10	20	31	31	31
Task Identify participating primary care practices and assess their care management staffing needs to meet care management service needs of target population.										
Task Develop care management service standards, provider roles and responsibilities, and information sharing procedures among PCMH and Health Home Providers as part of the COP process described above.										
Task Facilitate partnerships with Brooklyn Health Home and Coordinated Behavioral Care Health Home, their downstream Care Management Agencies (CMAs), and PCPs										
Task Provide training to participating PCPs, HHs, and CMAs on the standards, roles, and information sharing procedures.										
Milestone #8 Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).										
Task PPS has established partnerships to medical, behavioral health, and social services.	0	0	0	0	0	300	600	904	904	904
Task PPS has established partnerships to medical, behavioral health, and social services.	0	0	0	0	0	10	20	31	31	31
Task PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.										
Task Identify Participants, including community-based organizations (CBOs) and other relevant local government units, that can provide needed social support services to the HH at Risk population.										
Task As part of the COP process described above, develop policies and procedures for partnerships between PCPs, CBOs, HHs, and other Participants, to include use of technology solutions that										

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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
could facilitate and document partnerships.										
Task Develop contractual agreements between CCB and PCPs and other Participants to provide needed medical, behavioral, and social support services to patients.										
Milestone #9 Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.										
Task PPS has adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate evidence-based practice guidelines developed and process implemented.										
Task Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.										
Task PPS has included social services agencies in development of risk reduction and care practice guidelines.										
Task Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.										
Task Convene a working group to meet regularly to review/develop CCB-wide standard evidence-based practice guidelines for management of chronic diseases.										
Task As part of the COP process described above, the working group will review/develop collaborative evidence-based practice guidelines for the target population.										
Task Working with CBOs, develop and identify educational and training materials suitable to the needs, culture, and language of the target populations.										
Task Disseminate evidence-based practice guidelines and educational materials across the CCB network.										

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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 a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.										
Task A clear strategic plan is in place which includes, at a minimum: - Definition of the Health Home At-Risk Intervention Program - Development of comprehensive care management plan, with definition of roles of PCMH/APC PCPs and HHs										
Task Convene working group of Participants, including Health Homes (HH) and PCMH PCPs, to participate in project planning.										
Task Create a workplan and timeline to develop the clinical operations plan (COP) and strategy for Health Home at-risk.										
Task Identify the clinical and social diagnoses/factors that define the HH At Risk Population										
Task Develop COP to include all Domain 1 requirements and protocols detailing policies and procures, patient and work flows, defined target population, staffing models, roles of CBOs & Health Homes, training and recruitment policies, referral to support services, evidence based guidelines, technology resource requirements, and desired metrics to track performance.										
Task Create a comprehensive care management plan with definitive roles for the care team members (e.g., HHs and PCMH PCPs) to include in the COP and overall strategy.										
Task Assess workforce requirements and training needs to implement program										
Task Submit the initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval recognizing that the COP will be modified over time based on findings of rapid cycle evaluation.										
Task In collaboration with Finance Committee, develop financial model to support implementation of additional care management requirements.										
Task Develop training and recruitment strategy to meet project requirements.										

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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 Recruit and train new staff and/or retrain existing staff.										
Task The Health Home At-Risk program is established										
Milestone #2 Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and APCM standards	553	904	904	904	904	904	904	904	904	904
Task Identify current status of CCB Primary Care providers achieving PCMH status.										
Task Identify clinical champions and operational leaders in each primary care provider organization to develop and lead each of their providers/sites along the path to NCQA PCMH 2014 Level 3 recognition										
Task Working with IT and Care Delivery and Quality Committees, develop centralized technical assistance programs to assist primary care practices.										
Task Develop timeline and phased approach to providing technical assistance to primary care practices, taking into consideration the practices' PCMH status as identified in Step #1										
Task Deploy technical assistance program to primary care practices as necessary per the step above and refine program over time.										
Milestone #3 Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	258	382	382	382	382	382	382	382	382	382
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	170	431	431	431	431	431	431	431	431	431

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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 EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	10	14	14	14	14	14	14	14	14	14
Task PPS uses alerts and secure messaging functionality.										
Task Survey providers to gain understanding of existing data-sharing capabilities with Healthix (RHIO)										
Task Establish partnership with RHIO and CCB Participants who need to receive and/or contribute patient data to serve patient needs										
Task Based on the data sharing roadmap and other information, develop and implement support processes to ensure that all PPS safety net providers are actively sharing health information, including alerts and secure messaging.										
Milestone #4 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.										
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.	294	382	382	382	382	382	382	382	382	382
Task Assess eligible Participant EHR use and readiness relative to Meaningful Use and PCMH 2014 Level 3 standards										
Task Develop a work plan/strategy to encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, which may vary based on provider characteristics such as providers' size, services, current status, readiness levels, etc.; develop Participant education and engagement strategy to facilitate understanding of IT requirements										
Task Recruit or contract for EHR implementation resources as needed										
Task Implement work plan/strategy by providing technical assistance and other supports for Participant EHR implementation and progress towards Meaningful Use and PCMH standards										
Milestone #5 Perform population health management by actively using EHRs										

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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 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 Working with the IT and Care Delivery and Quality Committees, review the requirements for population health management (PHM) as defined in the clinical operations plans to identify data collection, reporting, and information exchange needs related to patient registries and other PHM tools.										
Task In concert with project planning activities, identify systems or enhancements needed to existing systems to meet identified PHM requirements.										
Task Develop a PHM data collection and reporting roadmap along with mitigation strategies to meet near-term needs for provider participation in PHM										
Task Develop and initiate training for Participants on PHM initiatives, including use of interim data collection and reporting solutions, use of EHRs and other available IT solutions.										
Task Initiate PHM data collection, validation/refinement and analysis as required under the clinical operations plans										
Task Acquire or enhance systems in order to achieve PHM requirements, including the development of patient registries.										
Task Deploy systems and/or enhancements across CCB Participants, including required training to integrate into ongoing PHM initiatives.										
Milestone #6 Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.										
Task Procedures to engage at-risk patients with care management plan instituted.										
Task Work with project planning work group to review Health Home care management plan for applicability to broader population										

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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 Design outreach/intake/assessment process for HH at Risk population that includes development of written comprehensive care management plan.										
Task Train staff on developing and updating comprehensive care management plans for patients.										
Task Deploy technology solutions that include comprehensive care management plans.										
Task Comprehensive care management plan developed for each patient.										
Milestone #7 Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.										
Task Each identified PCP establish partnerships with the local Health Home for care management services.	904	904	904	904	904	904	904	904	904	904
Task Each identified PCP establish partnerships with the local Health Home for care management services.	31	31	31	31	31	31	31	31	31	31
Task Identify participating primary care practices and assess their care management staffing needs to meet care management service needs of target population.										
Task Develop care management service standards, provider roles and responsibilities, and information sharing procedures among PCMH and Health Home Providers as part of the COP process described above.										
Task Facilitate partnerships with Brooklyn Health Home and Coordinated Behavioral Care Health Home, their downstream Care Management Agencies (CMAs), and PCPs										
Task Provide training to participating PCPs, HHs, and CMAs on the standards, roles, and information sharing procedures.										
Milestone #8 Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).										

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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 has established partnerships to medical, behavioral health, and social services.	904	904	904	904	904	904	904	904	904	904
Task PPS has established partnerships to medical, behavioral health, and social services.	31	31	31	31	31	31	31	31	31	31
Task PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.										
Task Identify Participants, including community-based organizations (CBOs) and other relevant local government units, that can provide needed social support services to the HH at Risk population.										
Task As part of the COP process described above, develop policies and procedures for partnerships between PCPs, CBOs, HHs, and other Participants, to include use of technology solutions that could facilitate and document partnerships.										
Task Develop contractual agreements between CCB and PCPs and other Participants to provide needed medical, behavioral, and social support services to patients.										
Milestone #9 Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.										
Task PPS has adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate evidence-based practice guidelines developed and process implemented.										
Task Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.										
Task PPS has included social services agencies in development of risk reduction and care practice guidelines.										
Task Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.										
Task Convene a working group to meet regularly to review/develop CCB-wide standard evidence-based practice guidelines for										

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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
management of chronic diseases.										
Task As part of the COP process described above, the working group will review/develop collaborative evidence-based practice guidelines for the target population.										
Task Working with CBOs, develop and identify educational and training materials suitable to the needs, culture, and language of the target populations.										
Task Disseminate evidence-based practice guidelines and educational materials across the CCB network.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.	
Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.	
Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.	
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.	
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries,	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
for all participating safety net providers.	
Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.	
Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.	
Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).	
Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.	

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	

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

The major risks to implementing 2.b.iii and corresponding mitigation strategies that will be used are described below:

1. Access to Services. Target patients for this project may use the emergency department (ED) for non-emergent care because they do not have an established relationship with a primary care provider (PCP) and/or because they cannot access care in a timely manner when they need it. In addition to primary care practices not operating 24/7, some patients have challenges scheduling timely appointments for more urgent issues. Combined, these barriers to access may increase the likelihood and frequency of ED use. To mitigate these risks, CCB will work with PCPs to achieve PCMH Level 3 designation, a key component of which is offering same-day appointments and open access scheduling. CCB will also work with select primary care practices to extend hours on nights and weekends through a variety of mechanisms including recruitment of new PCPs. CCB has also requested capital to expand capacity via new primary care and urgent care sites.

2. Changing Patient Behavior. As discussed above, CCB will work with Participant providers, especially urgent care centers and PCPs, to make health care services more accessible to beneficiaries outside of the ED. CCB will then engage the target population to educate them about new services available and to promote utilization of these alternatives to the ED. To mitigate the risk that patients may continue to use the ED, CCB will consider connecting patients to care managers who are available 24/7, partnering with urgent care centers that meet CCB's standards, and utilizing the web-based care planning tool, the Dashboard, to coordinate care among providers.

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "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	21,500

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	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
ks614257	Rosters	33_PMDL2715_1_3_20160201122801_MMC_PPS_Patient_Engagement_Speed.xlsx	Patient Engagement Speed	02/01/2016 12:28 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 2.b.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 Establish ED care triage program for at-risk populations	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Stand up program based on project requirements	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Convene working group of Participants to participate in project planning for ED Triage program.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Create a workplan and timeline to develop the clinical operations plan (COP) and strategy for the ED care triage program.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Develop COP to include all Domain 1 requirements and protocols detailing policies and procures, patient and work flows, defined target population, staffing models, roles of CBOs & Health Homes, training and recruitment policies, referral to support services, evidence based guidelines, technology resource requirements, and desired metrics to track performance.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Assess workforce requirements to implement program	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Submit the initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task In collaboration with Finance Committee, develop financial model to support implementation of ED care triage program requirements.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop training and recruitment strategy to meet project	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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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
requirements.									
Task Recruit and train new staff and/or retrain staff where applicable.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	Provider	Safety Net Hospital	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify all participating CCB PCPs for outreach.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify all appropriate CCB PCP's current status of EHR use, PCMH status, and identify clinical champions.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task As discussed in project 2.a.i, CCB will develop and deploy technical assistance programs to assist PCPs in meeting Level 3 NCQA 2014 PCMH recognition and obtaining Meaningful Use Stage 2 certified EHRs.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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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 Convene workgroup of PCPs, practice managers, and ED managers to evaluate technology options and develop process and timeline for establishing connectivity between EDs and PCPs, including real-time encounter notifications to HH care managers.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Deploy technology solutions for ensuring real-time notification between Participant Entities and appropriate Health Home Care Managers.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Train staff on technology used to establish connectivity between EDs and PCPs and real time encounter notification to HH care managers.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Partnerships have been established between EDs and PCMH Level 3 PCPs.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task A defined process for triage of patients from patient navigators to non-emergency PCP and needed community support resources is in place.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Assess current capability and performance within CCB EDs to successfully make timely follow up appointments with PCPs.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify process changes and staffing requirements to achieve project goals.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Develop patient navigator job responsibilities, including any applicable policies & procedures and assessment tools needed to meet project requirements.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify care management agencies for participation.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop an outreach strategy to hire patient navigators; refer to Health Homes and PCMHs.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Recruit and hire patient navigators according to workforce needs.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Provide training to patient navigators on processes and procedures and revise training over time as needed.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Patient navigators are deployed and able to help schedule PCP appointments and connect patients to needed community support resources including Health Homes and social support services.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)	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 protocols and operations in place to transport non-acute patients to appropriate care site. (Optional).	Provider	Safety Net Hospital	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	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		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Review NYS DOH guidance and definitions of patient engagement for this project.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4

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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
Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.									
Task Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	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 Establish ED care triage program for at-risk populations										
Task Stand up program based on project requirements										
Task Convene working group of Participants to participate in project planning for ED Triage program.										
Task Create a workplan and timeline to develop the clinical operations plan (COP) and strategy for the ED care triage program.										
Task Develop COP to include all Domain 1 requirements and protocols detailing policies and procures, patient and work flows, defined target population, staffing models, roles of CBOs & Health Homes, training and recruitment policies, referral to support services, evidence based guidelines, technology resource requirements, and desired metrics to track performance.										

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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 Assess workforce requirements to implement program										
Task Submit the initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation.										
Task In collaboration with Finance Committee, develop financial model to support implementation of ED care triage program requirements.										
Task Develop training and recruitment strategy to meet project requirements.										
Task Recruit and train new staff and/or retrain staff where applicable.										
Milestone #2 Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	0	0	0	19	30	70	114	172	172	172
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 Encounter Notification Service (ENS) is installed in all PCP offices and EDs	0	0	0	0	0	40	90	172	172	172
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	0	0	0	0	1	3	3	6	6	6
Task Identify all participating CCB PCPs for outreach.										
Task Identify all appropriate CCB PCP's current status of EHR use,										

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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
PCMH status, and identify clinical champions.										
Task As discussed in project 2.a.i, CCB will develop and deploy technical assistance programs to assist PCPs in meeting Level 3 NCQA 2014 PCMH recognition and obtaining Meaningful Use Stage 2 certified EHRs.										
Task Convene workgroup of PCPs, practice managers, and ED managers to evaluate technology options and develop process and timeline for establishing connectivity between EDs and PCPs, including real-time encounter notifications to HH care managers.										
Task Deploy technology solutions for ensuring real-time notification between Participant Entities and appropriate Health Home Care Managers.										
Task Train staff on technology used to establish connectivity between EDs and PCPs and real time encounter notification to HH care managers.										
Task Partnerships have been established between EDs and PCMH Level 3 PCPs.										
Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).										
Task A defined process for triage of patients from patient navigators to non-emergency PCP and needed community support resources is in place.										
Task Assess current capability and performance within CCB EDs to successfully make timely follow up appointments with PCPs.										
Task Identify process changes and staffing requirements to achieve										

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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
project goals.										
Task Develop patient navigator job responsibilities, including any applicable policies & procedures and assessment tools needed to meet project requirements.										
Task Identify care management agencies for participation.										
Task Develop an outreach strategy to hire patient navigators; refer to Health Homes and PCMHs.										
Task Recruit and hire patient navigators according to workforce needs.										
Task Provide training to patient navigators on processes and procedures and revise training over time as needed.										
Task Patient navigators are deployed and able to help schedule PCP appointments and connect patients to needed community support resources including Health Homes and social support services.										
Milestone #4 Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)										
Task PPS has protocols and operations in place to transport non-acute patients to appropriate care site. (Optional).	0	0	0	0	0	0	0	0	0	0
Milestone #5 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 Review NYS DOH guidance and definitions of patient engagement for this project.										
Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.										

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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 Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance										
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.										
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.										
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.										

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 Establish ED care triage program for at-risk populations										
Task Stand up program based on project requirements										
Task Convene working group of Participants to participate in project planning for ED Triage program.										
Task Create a workplan and timeline to develop the clinical operations plan (COP) and strategy for the ED care triage program.										
Task Develop COP to include all Domain 1 requirements and protocols detailing policies and procures, patient and work flows, defined target population, staffing models, roles of CBOs & Health Homes, training and recruitment policies, referral to support services, evidence based guidelines, technology resource requirements, and desired metrics to track performance.										
Task Assess workforce requirements to implement program										
Task Submit the initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation.										
Task In collaboration with Finance Committee, develop financial model to support implementation of ED care triage program										

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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
requirements.										
Task Develop training and recruitment strategy to meet project requirements.										
Task Recruit and train new staff and/or retrain staff where applicable.										
Milestone #2 Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	172	172	172	172	172	172	172	172	172	172
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 Encounter Notification Service (ENS) is installed in all PCP offices and EDs	172	172	172	172	172	172	172	172	172	172
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	6	6	6	6	6	6	6	6	6	6
Task Identify all participating CCB PCPs for outreach.										
Task Identify all appropriate CCB PCP's current status of EHR use, PCMH status, and identify clinical champions.										
Task As discussed in project 2.a.i, CCB will develop and deploy technical assistance programs to assist PCPs in meeting Level 3 NCQA 2014 PCMH recognition and obtaining Meaningful Use Stage 2 certified EHRs.										
Task Convene workgroup of PCPs, practice managers, and ED managers to evaluate technology options and develop process										

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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 timeline for establishing connectivity between EDs and PCPs, including real-time encounter notifications to HH care managers.										
Task Deploy technology solutions for ensuring real-time notification between Participant Entities and appropriate Health Home Care Managers.										
Task Train staff on technology used to establish connectivity between EDs and PCPs and real time encounter notification to HH care managers.										
Task Partnerships have been established between EDs and PCMH Level 3 PCPs.										
Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).										
Task A defined process for triage of patients from patient navigators to non-emergency PCP and needed community support resources is in place.										
Task Assess current capability and performance within CCB EDs to successfully make timely follow up appointments with PCPs.										
Task Identify process changes and staffing requirements to achieve project goals.										
Task Develop patient navigator job responsibilities, including any applicable policies & procedures and assessment tools needed to meet project requirements.										
Task Identify care management agencies for participation.										
Task Develop an outreach strategy to hire patient navigators; refer to Health Homes and PCMHs.										

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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 Recruit and hire patient navigators according to workforce needs.										
Task Provide training to patient navigators on processes and procedures and revise training over time as needed.										
Task Patient navigators are deployed and able to help schedule PCP appointments and connect patients to needed community support resources including Health Homes and social support services.										
Milestone #4 Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)										
Task PPS has protocols and operations in place to transport non-acute patients to appropriate care site. (Optional).	0	0	0	0	0	0	0	0	0	0
Milestone #5 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 Review NYS DOH guidance and definitions of patient engagement for this project.										
Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.										
Task Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance										
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.										
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.										
Task Develop, modify, and deploy centralized mechanisms for tracking										

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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
patient engagement and provide ongoing guidance and training for Participants as needed.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish ED care triage program for at-risk populations	
Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable	
For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	
Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
optional.)	
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	

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

The major risks to implementing 2.b.iv and corresponding mitigation strategies that will be used are described below:

1. Effective Linkages to Home-Based and Social Services. There are challenges to effectively linking patients with appropriate home-based and social services post-discharge. This is a risk to this project because success relies on effective linkages to home-based and social services. To mitigate this risk, CCB will develop policies and procedures requiring the use of the LACE or another risk assessment tool and care management follow up for a 30-day period post-discharge, as well as patient education materials that meet the cultural and linguistic needs of our population. CCB is planning to employ Critical Time Intervention aimed at ensuring smooth transitions for individuals with serious mental illness. CCB has developed a close working relationship with many social service CBOs as part of the Brooklyn Health Home program and will build on this base to connect patients with available programs and resources. Lastly, CCB will assess the need for more medically complex units in skilled nursing facilities (SNFs) and SNF staff training to prevent readmissions.

2. Provider Communication and Coordination Around Care Transitions. There are barriers to effective communication and coordination between hospitals and community providers that often complicate patients' transitions. Coordination challenges are often the underlying cause of unnecessary readmissions. To mitigate this risk, care team members will use a web-based care planning tool, the Dashboard, to communicate and coordinate care across the providers involved in a patient's transition. Through the Dashboard, providers in the hospital can communicate with a care manager, community-based organizations (CBO), or the patient's PCP, and other members of the care team. CCB will ensure provider input and buy-in as care transition protocols are developed through the Care Delivery and Quality Committee and planning workgroup, both of which include provider representatives from key project Participants. Participants will be charged with ensuring that the project is implemented as specified in the clinical operations plan and in the contractual agreement which will bind each Participant.

3. Timely Notifications. CCB hospital Participants have varying policies and procedures for notifying care managers or other providers involved in a patient's care about discharge from the hospital. Often, hospitals do not know that a patient has a care manager, and care managers do not know when their patients are admitted to a hospital. These factors create a risk to effective care planning. Automatic alerts about hospital admissions and discharges from the RHIO, provide key information to care team members, enabling them to participate in discharge planning. CCB will work with Participant hospitals and primary care practices not already connect to the RHIO to establish connections. CCB Participant hospitals will use a risk assessment tool to project patients' length of stay/date of discharge.

4. Engaging Medicaid Managed Care Organizations (MCOs). Ensuring the longevity of new care transition protocols will require their financial sustainability; however, under many existing payment arrangements, provider activity to coordinate care transitions would not be recognized and adequately reimbursed by the payer. CCB will mitigate this risk by consulting with MCOs in protocol development and the development of payment models that support the project's care model at the outset of DSRIP implementation. Maimonides will leverage its experiences from the HARP pilot

in which it worked with HealthFirst and the Brooklyn Health Home to establish a total cost of care model and shared savings with participating providers.

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "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	17,500

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	503	31.94%	1,072	2.87%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (1,575)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
ks614257	Rosters	33_PMDL2815_1_3_20160201114713_DY1_Q3_Actively_Engaged_2biv.xlsx	DY1 Q3 Actively Engaged Patient List	02/01/2016 11:50 AM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Convene working group of Participants including hospitals, PCPs, Health Homes, care management agencies, social service agencies and other community-based organizations, to participate in project planning.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Create a workplan and timeline to develop the clinical operations plan (COP) for the care transitions model.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Develop COP to include all Domain 1 requirements and protocols detailing policies and procures, patient and work flows, defined target population, staffing models, roles of CBOs & Health Homes, training and recruitment policies, referral to support services, evidence based guidelines, technology resource requirements, and desired metrics to track performance.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Submit the initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
In collaboration with Finance Committee, develop financial model to support implementation of 30-day care transitions plan requirements.									
Task Develop training and recruitment strategy to meet project requirements.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Identify and engage the major Medicaid MCOs and Health Homes (HHs) and develop regular meeting schedule.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Working in concert with MCOs and as part of the COP, develop data sharing and transition of care protocols, including coordination of care strategies, identification of HH-eligible patients.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Deploy trainings and disseminate training materials to providers.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Working in concert with MCOs, develop payment strategy for transition of care services.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Transition of care protocols including input from Medicaid MCOs and HHs are developed and documented.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #3	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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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
Ensure required social services participate in the project.									
Task Required network social services, including medically tailored home food services, are provided in care transitions.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify appropriate community-based organizations (CBOs) for participation in workgroup.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify social services with greatest impact on preventing readmissions.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Assess the availability and level of engagement of social services in the CCB network.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Via contractual agreements, incorporate social services agencies in planning and implementation of care transitions model.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Practitioner - Non-Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Hospital	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task The COP, discussed previously, includes policies and procedures related to early notification of planned discharges as well as providing care manager access into the hospital	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4

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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
discharge process.									
Task Train transition care managers on transition of care protocols and discharge processes.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task In line with COP, recruit new hires and/or retrain current workforce to occupy role of transition care manager	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Connect transition care managers and transitional care nurses with hospitals' current discharge supervisor and technology needs.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task The COP, discussed previously, will include policies and procedures to include the recording of 30-day care transitions plan to be shared between all approved parties involved.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Evaluate care transition plan requirements and evaluate potential technology solutions.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Deploy interoperable care transition plan technology to all participating Hospitals, care management agencies, and PC practices.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Train providers to use technology to enable care transition team to communicate with assigned PCPs and care management agencies regarding the recorded care transitions plan.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Ensure that a 30-day transition of care period is established.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures reflect the requirement that 30 day	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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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
transition of care period is implemented and utilized.									
Task The COP includes a description of standard content of the comprehensive care transitions plan that covers a 30 day period post discharge.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task As described above, incorporate the 30-day transition of care timeframe into technology solution for care transition plan and provide training to providers.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 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		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Review NYS DOH guidance and definitions of patient engagement for this project.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

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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 standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.										
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.										
Task Convene working group of Participants including hospitals, PCPs, Health Homes, care management agencies, social service agencies and other community-based organizations, to participate in project planning.										
Task Create a workplan and timeline to develop the clinical operations plan (COP) for the care transitions model.										
Task Develop COP to include all Domain 1 requirements and protocols detailing policies and procures, patient and work flows, defined target population, staffing models, roles of CBOs & Health Homes, training and recruitment policies, referral to support services, evidence based guidelines, technology resource requirements, and desired metrics to track performance.										
Task Submit the initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation.										
Task In collaboration with Finance Committee, develop financial model to support implementation of 30-day care transitions plan requirements.										
Task Develop training and recruitment strategy to meet project requirements.										
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.										
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.										
Task Coordination of care strategies focused on care transition are in										

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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
place, in concert with Medicaid Managed Care groups and Health Homes.										
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.										
Task Identify and engage the major Medicaid MCOs and Health Homes (HHs) and develop regular meeting schedule.										
Task Working in concert with MCOs and as part of the COP, develop data sharing and transition of care protocols, including coordination of care strategies, identification of HH-eligible patients.										
Task Deploy trainings and disseminate training materials to providers.										
Task Working in concert with MCOs, develop payment strategy for transition of care services.										
Task Transition of care protocols including input from Medicaid MCOs and HHs are developed and documented.										
Milestone #3 Ensure required social services participate in the project.										
Task Required network social services, including medically tailored home food services, are provided in care transitions.										
Task Identify appropriate community-based organizations (CBOs) for participation in workgroup.										
Task Identify social services with greatest impact on preventing readmissions.										
Task Assess the availability and level of engagement of social services in the CCB network.										
Task Via contractual agreements, incorporate social services agencies in planning and implementation of care transitions model.										
Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.										
Task	0	0	0	0	50	125	225	373	373	373

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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
Policies and procedures are in place for early notification of planned discharges.										
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	0	0	30	80	1,314	1,314	1,314
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	0	1	3	3	6	6	6
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.										
Task The COP, discussed previously, includes policies and procedures related to early notification of planned discharges as well as providing care manager access into the hospital discharge process.										
Task Train transition care managers on transition of care protocols and discharge processes.										
Task In line with COP, recruit new hires and/or retrain current workforce to occupy role of transition care manager										
Task Connect transition care managers and transitional care nurses with hospitals' current discharge supervisor and technology needs.										
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.										
Task Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.										
Task The COP, discussed previously, will include policies and procedures to include the recording of 30-day care transitions plan to be shared between all approved parties involved.										
Task Evaluate care transition plan requirements and evaluate potential technology solutions.										
Task Deploy interoperable care transition plan technology to all										

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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
participating Hospitals, care management agencies, and PC practices.										
Task Train providers to use technology to enable care transition team to communicate with assigned PCPs and care management agencies regarding the recorded care transitions plan.										
Milestone #6 Ensure that a 30-day transition of care period is established.										
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.										
Task The COP includes a description of standard content of the comprehensive care transitions plan that covers a 30 day period post discharge.										
Task As described above, incorporate the 30-day transition of care timeframe into technology solution for care transition plan and provide training to providers.										
Milestone #7 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 Review NYS DOH guidance and definitions of patient engagement for this project.										
Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.										
Task Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance										
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.										
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.										
Task										

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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
Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.										

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 standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.										
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.										
Task Convene working group of Participants including hospitals, PCPs, Health Homes, care management agencies, social service agencies and other community-based organizations, to participate in project planning.										
Task Create a workplan and timeline to develop the clinical operations plan (COP) for the care transitions model.										
Task Develop COP to include all Domain 1 requirements and protocols detailing policies and procures, patient and work flows, defined target population, staffing models, roles of CBOs & Health Homes, training and recruitment policies, referral to support services, evidence based guidelines, technology resource requirements, and desired metrics to track performance.										
Task Submit the initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation.										
Task In collaboration with Finance Committee, develop financial model to support implementation of 30-day care transitions plan requirements.										
Task Develop training and recruitment strategy to meet project requirements.										
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will										

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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
ensure appropriate post-discharge protocols are followed.										
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.										
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.										
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.										
Task Identify and engage the major Medicaid MCOs and Health Homes (HHs) and develop regular meeting schedule.										
Task Working in concert with MCOs and as part of the COP, develop data sharing and transition of care protocols, including coordination of care strategies, identification of HH-eligible patients.										
Task Deploy trainings and disseminate training materials to providers.										
Task Working in concert with MCOs, develop payment strategy for transition of care services.										
Task Transition of care protocols including input from Medicaid MCOs and HHs are developed and documented.										
Milestone #3 Ensure required social services participate in the project.										
Task Required network social services, including medically tailored home food services, are provided in care transitions.										
Task Identify appropriate community-based organizations (CBOs) for participation in workgroup.										
Task Identify social services with greatest impact on preventing readmissions.										
Task Assess the availability and level of engagement of social services in the CCB network.										
Task Via contractual agreements, incorporate social services agencies										

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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
in planning and implementation of care transitions model.										
Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.										
Task Policies and procedures are in place for early notification of planned discharges.	373	373	373	373	373	373	373	373	373	373
Task Policies and procedures are in place for early notification of planned discharges.	1,314	1,314	1,314	1,314	1,314	1,314	1,314	1,314	1,314	1,314
Task Policies and procedures are in place for early notification of planned discharges.	6	6	6	6	6	6	6	6	6	6
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.										
Task The COP, discussed previously, includes policies and procedures related to early notification of planned discharges as well as providing care manager access into the hospital discharge process.										
Task Train transition care managers on transition of care protocols and discharge processes.										
Task In line with COP, recruit new hires and/or retrain current workforce to occupy role of transition care manager										
Task Connect transition care managers and transitional care nurses with hospitals' current discharge supervisor and technology needs.										
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.										
Task Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.										

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Maimonides Medical Center (PPS ID:33)

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 COP, discussed previously, will include policies and procedures to include the recording of 30-day care transitions plan to be shared between all approved parties involved.										
Task Evaluate care transition plan requirements and evaluate potential technology solutions.										
Task Deploy interoperable care transition plan technology to all participating Hospitals, care management agencies, and PC practices.										
Task Train providers to use technology to enable care transition team to communicate with assigned PCPs and care management agencies regarding the recorded care transitions plan.										
Milestone #6 Ensure that a 30-day transition of care period is established.										
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.										
Task The COP includes a description of standard content of the comprehensive care transitions plan that covers a 30 day period post discharge.										
Task As described above, incorporate the 30-day transition of care timeframe into technology solution for care transition plan and provide training to providers.										
Milestone #7 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 Review NYS DOH guidance and definitions of patient engagement for this project.										
Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.										
Task Identify any gaps between existing tracking capabilities and										

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Maimonides Medical Center (PPS ID:33)

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
those required per the NYS DOH guidance										
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.										
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.										
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	
Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	
Ensure required social services participate in the project.	
Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	
Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	
Ensure that a 30-day transition of care period is established.	
Use EHRs and other technical platforms to track all patients engaged in the project.	

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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	

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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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.

The major risks to implementing 3.a.i and corresponding mitigation strategies that will be used are described below:

1. Participant Resources to Effectively Co-locate Services: There are significant barriers to co-location, including: costs; disruption of services at practices if construction is required and the administrative/time demands of reconfiguring workflows and schedules. To mitigate these risks, CCB will pair organizations that have successfully co-located with Participants who are new to co-location. This partnership will facilitate information sharing, technical assistance and coaching to the Participants' staff new to co-location. CCB will leverage lessons learned through the Brooklyn Health Home and promote virtual co-location of primary care and behavioral health services through the use of the GSI Health Coordinator web-based care planning tool, the Dashboard

2. Participant Resources to Effectively Implement the IMPACT Model: Time and resource constraints will affect Participants' ability to implement the IMPACT model. To mitigate this risk, CCB will offer participating providers and their staff training on the IMPACT model and screening tools. Training consultants will assist practices in adopting the IMPACT model and work to minimize burdens for providers, such as offering access to care management services and connectivity through the Dashboard.

3. Shortage of Psychiatrists. The Brooklyn Community Needs Assessment identified a shortage of psychiatrists in Brooklyn. To mitigate this risk, CCB will promote the use of the IMPACT model. The use of the collaborative care model significantly improves the availability of psychiatrists, as the role of the psychiatrist shifts from providing direct care to consultant for the most prevalent behavioral health disorders in the population. CCB recognizes potential to expand the use of collaborative care beyond the management of mild to moderate depression, and will seek to manage other chronic behavioral health disorders through the collaborative care model after successful implementation of IMPACT. As part of broader workforce efforts, CCB will focus recruitment efforts to attract and retain nurses, licensed social workers, and psychologists who are qualified to perform therapist and depression care manager roles at participating sites. CCB will reach out to other PPSs in the region to collaborate on workforce issues that may impact recruitment strategies. CCB anticipates that the shift to value-based care will mitigate the shortage of psychiatrists, as the current system of care promotes a higher volume of visits than would be needed in a value-based system.

4. Stigma Associated with Behavioral Health Conditions. For the target patient population, social stigma related to lack of understanding about the medical model of mental illness may result in poor adherence with behavioral health recommendations. PCPs unfamiliar with managing and working with individuals with behavioral health conditions may have a hard time adopting all three care models. To mitigate this risk, CCB will undertake education and outreach for both patients and providers. Patient education will focus on increasing knowledge about mental illness and the importance of adherence to care. Resources, including peer coaches, will be used to provide education and support to patients. Provider education and training will be specific to the care models providers are adopting (IMPACT or physical co-location). In all models, ongoing case conferencing between PCPs and behavioral health specialists will help reduce stigma and continuously educate and train PCPs about individuals

with behavioral health conditions and their needs. The adoption of IMPACT model mitigates the identified risks because it has been shown to effectively reduce the stigma associated with behavioral health conditions.

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "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	83,000

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	1,323	15.94%	6,977	1.59%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (8,300)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
cpickett	Rosters	33_PMDL3715_1_3_20160201123634_DY1_Q3_Actively_Engaged_3ai.xlsx	DY1 Q3 Actively Engaged 3ai	02/01/2016 12:37 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

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)	Not Started	01/01/2016	03/31/2018	01/01/2016	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	Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Convene working group of Participants to participate in project planning and develop regular meeting schedule.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Create and collect surveys to identify practices with interest and capacity (space, panel size) for behavioral health co-location, as well as status of technical assistance to meet NCQA PCMH Level 3 Recognition under 2014 standards.		Project		In Progress	04/01/2015	12/31/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Create a clinical operations plan (COP) for implementing behavioral health co-location.		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task In collaboration with the Finance Committee, create and regularly update a strategy for financing project implementation.		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Submit initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the		Project		Completed	10/01/2015	03/31/2016	10/01/2015	12/31/2015	12/31/2015	DY1 Q3

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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
COP will be modified over time based on findings of rapid cycle evaluation, and share final COP with all project participants.										
Task As referenced in project 2ai, develop and implement technical assistance to participating practices as needed to achieve NCQA 2014 Level 3 recognition .		Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Provide assistance to participating practices as needed to implement behavioral health co-location as outlined in COP. Assistance may include advising around or providing practices with staffing to ensure availability of behavioral health services.		Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Develop training for participants in behavioral health co-location, based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices.		Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Deliver training to participants in behavioral health co-location and develop a process for assessing the effectiveness of training.		Project		Not Started	06/30/2016	03/31/2018	06/30/2016	03/31/2018	03/31/2018	DY3 Q4
Task Revise COP and provide updated implementation support as needed.		Project		Not Started	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 1	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.		Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task		Project		Completed	07/01/2015	03/31/2016	07/01/2015	12/31/2015	12/31/2015	DY1 Q3

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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
Incorporate collaborative care practice guidelines and protocols into the COP, described previously.										
Task Use survey or engage partners to assess need for training in evidence-based care protocols, including medication management and care engagement processes.		Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task As referenced above, provide training and technical assistance to participating practices on evidence-based care protocols, including medication management and care engagement processes.		Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Develop policies and procedures for updating guidelines, protocols, and training, based on feedback and project performance.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	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	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Policies and procedures are in place to facilitate and document completion of screenings.		Project		Not Started	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Screenings are documented in Electronic Health Record.		Project		Not Started	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		Not Started	10/01/2016	03/31/2018	10/01/2016	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)	Not Started	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Incorporate screening and warm transfer guidelines and protocols into the COP, as described above.		Project		Completed	07/01/2015	03/31/2016	07/01/2015	12/31/2015	12/31/2015	DY1 Q3

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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 Use survey or engage partners to assess need for technical support and training in screening protocols, including documentation and warm transfer		Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Explore technology options for documenting behavioral health screenings and warm transfers in EHRs or care management platforms.		Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task As referenced earlier, provide training and technical assistance to participating practices to implement screening protocols and document warm transfer, as outlined in COP.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Develop performance reporting structure in order to ensure that 90% of patients are receiving behavioral health screenings, and adjust protocols on an ongoing basis and as necessary based on performance.		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		Not Started	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Review NYS DOH guidance and definitions of patient engagement for this project		Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4

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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 Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Evaluate options for integrating medical and behavioral records within EHRs or other platforms on the basis of co-location and collaboration arrangement including consideration of regulatory issues.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Provide training and technical assistance to participating providers to integrate medical and behavioral health records within EHR or other platforms.		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	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	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.		Provider	Practitioner - Primary Care Provider (PCP)	Not Started	01/01/2016	03/31/2018	01/01/2016	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	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Mental Health	Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Convene working group of Participants to participate in project planning and develop regular meeting schedule.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	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 Create and collect surveys to identify practices with interest and capacity (space that meets regulatory requirements, panel size) for primary care co-location, as well as status of technical assistance to meet NCQA PCMH Level 3 Recognition under 2014 standards.		Project		In Progress	04/01/2015	12/31/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Create a clinical operations plan (COP) for implementing primary care co-location.		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task In collaboration with the Finance Committee, create and regularly update a strategy for financing project implementation.		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Submit initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation, and share final COP with all project participants.		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task As referenced in project 2ai, develop and implement technical assistance to participating practices as needed to achieve NCQA 2014 Level 3 recognition .		Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Provide assistance to participating practices as needed to implement primary care co-location as outlined in COP. Assistance may include advising around or providing practices with staffing to ensure availability of behavioral health services and/or providing guidance on regulatory issues surrounding co-location such as integrating medical and behavioral health records.		Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Develop training strategy for participants in primary care co-location, based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices. Strategy will include resources for evaluation, ongoing training, and onboarding of new staff.		Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1

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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 Implement and train interested participants in primary care co-location based on the COP, and revise as needed.		Project		Not Started	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	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 Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.		Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Incorporate collaborative care practice guidelines and protocols into the COP, described previously.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Use survey or engage partners to assess need for training in evidence-based care protocols, including medication management and care engagement processes.		Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task As referenced above, provide training and technical assistance to participating practices on evidence-based care protocols, including medication management and care engagement processes.		Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Develop policies and procedures for updating guidelines, protocols, and training, based on feedback and project performance.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Model 2	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to		Project		Not Started	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4

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Maimonides Medical Center (PPS ID:33)

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
implement and document screenings.										
Task Screenings are documented in Electronic Health Record.		Project		Not Started	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		Not Started	10/01/2016	03/31/2018	10/01/2016	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)	Not Started	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Incorporate screening and warm transfer guidelines and protocols into the COP, as described above.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Use survey or engage partners to assess need for technical support and training in screening protocols, including documentation and warm transfer		Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Explore technology options for documenting preventive care screenings and warm transfers in EHRs or care management platforms.		Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task As referenced earlier, provide training and technical assistance to participating practices to implement screening protocols and document warm transfer, as outlined in COP.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Develop performance reporting structure in order to ensure that 90% of patients are receiving preventive care screenings, and adjust protocols on an ongoing basis and as necessary based on performance.		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		Not Started	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4

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health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Review NYS DOH guidance and definitions of patient engagement for this project.		Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Evaluate options for integrating medical and behavioral records within EHRs or other platforms on the basis of co-location and collaboration arrangement including consideration of regulatory issues.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Provide training and technical assistance to participating providers to integrate medical and behavioral health records within EHR or other platforms.		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Milestone #9 Implement IMPACT Model at Primary Care Sites.	Model 3	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has implemented IMPACT Model at Primary Care Sites.		Provider	Practitioner - Primary Care Provider (PCP)	Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Convene working group of Participants to participate in project planning and develop regular meeting schedule.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Create and collect surveys to identify practices interested in using IMPACT and need for technical assistance to implement IMPACT Model.		Project		In Progress	04/01/2015	12/31/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Create a clinical operations plan (COP) for implementing IMPACT Model as developed in the workgroup, including plans and resources for staffing.		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task In collaboration with the Finance Committee, create and regularly update a strategy for financing project implementation.		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Submit initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation, and share final COP with all partners.		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task As referenced in project 2ai, develop and implement technical assistance to participating practices as needed to achieve NCQA 2014 Level 3 recognition .		Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Provide assistance to participating practices as needed to implement IMPACT Model as outlined in COP. Assistance may include: 1) advising around or providing practices with staffing, including a trained Depression Care Manager and Consulting Psychiatrist meeting requirements of the IMPACT Model to ensure availability of behavioral health services, or 2) providing guidance on regulatory issues		Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	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
surrounding collaboration such as integrating medical and behavioral health records to facilitate communication between primary care sites and other care team staff (depression care manager, psychiatrist, etc.).										
Task Develop training strategy for participants in IMPACT Model, based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices. Strategy will include resources for evaluation, ongoing training, and onboarding of new staff.		Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Implement and train interested participants in IMPACT Model based on the COP, including how to provide "stepped care", and revise as needed.		Project		Not Started	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Model 3	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures include process for consulting with Psychiatrist.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task The COP includes coordinated evidence-based care standards and policies, including collaboration with a depression care manager, the process for consulting with a psychiatrist, medication management, and procedures for care engagement.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Use survey or engage partners to assess need for training in evidence-based care protocols, including medication management and care engagement processes.		Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Task As referenced above, provide training and technical assistance to participating practices on the IMPACT model standards and guidelines, including medication management and care engagement processes.		Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Develop policies and procedures for updating guidelines, protocols, and training, based on feedback and project performance.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Model 3	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify or develop as necessary Depression Care Manager training in IMPACT Model, including coaching patients in behavioral activation, relapse, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan, and share with care management partners.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Work with participating care management agencies as needed to provide IMPACT Model training.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify and establish referral agreements with care management organizations to provide qualified Depression Care Managers and psychiatrists to work with PCMH care team in implementing IMPACT model protocols.		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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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 Explore and implement technology options for identifying Depression Care Managers in EHRs or other IT platforms.		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	Model 3	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task All IMPACT participants in PPS have a designated Psychiatrist.		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Work with PPS partners to identify consulting psychiatrists.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Identify or develop as necessary IMPACT Model training for consulting psychiatrists, and share with care management and primary care partners.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Work with care management organizations and practices to develop standardized agreements with consulting psychiatrists to work with primary care teams in implementing IMPACT model protocols.		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Work with participating Psychiatrists as needed to provide IMPACT Model training.		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #13 Measure outcomes as required in the IMPACT Model.	Model 3	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Identify and assess capabilities of existing mechanisms for tracking outcomes and actively engaged patients through the project and identify additional tracking platforms, as necessary.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop and implement an IT strategy for tracking outcomes and actively engaged patients for all projects,		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

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including training for Participants, as needed.										
Task Develop protocols to ensure that 90% of patients are receiving behavioral health screenings, and adjust protocols on an ongoing basis and as necessary based on performance.		Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #14 Provide "stepped care" as required by the IMPACT Model.	Model 3	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.		Project		Not Started	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Incorporate stepped care guidelines and protocols into the COP, as described above.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Incorporate stepped care guidelines in design of documentation and tools for use in EHRs or care management platforms.		Project		In Progress	07/01/2015	12/31/2017	07/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task Implement and train interested participants as needed in stepped care, including regular assessment at intervals and appropriate steps for treatment adjustment as outlined in the COP.		Project		Not Started	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 3	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		Not Started	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Review NYS DOH guidance and definitions of patient engagement for this project.		Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.										
Task Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Evaluate options for integrating medical and behavioral records within EHRs or other platforms on the basis of co-location and collaboration arrangement including consideration of regulatory issues.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Provide training and technical assistance to participating providers to integrate medical and behavioral health records within EHR or other platforms.		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	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 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.										

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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 All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.	0	0	0	0	0	0	6	13	20	29
Task Behavioral health services are co-located within PCMH/APC practices and are available.	0	0	0	0	0	0	2	5	8	12
Task Convene working group of Participants to participate in project planning and develop regular meeting schedule.										
Task Create and collect surveys to identify practices with interest and capacity (space, panel size) for behavioral health co-location, as well as status of technical assistance to meet NCQA PCMH Level 3 Recognition under 2014 standards.										
Task Create a clinical operations plan (COP) for implementing behavioral health co-location.										
Task In collaboration with the Finance Committee, create and regularly update a strategy for financing project implementation.										
Task Submit initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation, and share final COP with all project participants.										
Task As referenced in project 2ai, develop and implement technical assistance to participating practices as needed to achieve NCQA 2014 Level 3 recognition .										
Task Provide assistance to participating practices as needed to implement behavioral health co-location as outlined in COP. Assistance may include advising around or providing practices with staffing to ensure availability of behavioral health services.										
Task Develop training for participants in behavioral health co-location, based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices.										
Task Deliver training to participants in behavioral health co-location and develop a process for assessing the effectiveness of training.										
Task Revise COP and provide updated implementation support as										

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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
needed.										
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 Incorporate collaborative care practice guidelines and protocols into the COP, described previously.										
Task Use survey or engage partners to assess need for training in evidence-based care protocols, including medication management and care engagement processes.										
Task As referenced above, provide training and technical assistance to participating practices on evidence-based care protocols, including medication management and care engagement processes.										
Task Develop policies and procedures for updating guidelines, protocols, and training, based on feedback and project performance.										
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	0	0	0	0	0	0	6	13	20	29

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
provider as measured by documentation in Electronic Health Record.										
Task Incorporate screening and warm transfer guidelines and protocols into the COP, as described above.										
Task Use survey or engage partners to assess need for technical support and training in screening protocols, including documentation and warm transfer										
Task Explore technology options for documenting behavioral health screenings and warm transfers in EHRs or care management platforms.										
Task As referenced earlier, provide training and technical assistance to participating practices to implement screening protocols and document warm transfer, as outlined in COP.										
Task Develop performance reporting structure in order to ensure that 90% of patients are receiving behavioral health screenings, and adjust protocols on an ongoing basis and as necessary based on performance.										
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 Review NYS DOH guidance and definitions of patient engagement for this project										
Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.										
Task Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance										
Task Work with Participants and IT vendors using phased strategy to										

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remedy identified gaps in tracking and reporting capabilities.										
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.										
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.										
Task Evaluate options for integrating medical and behavioral records within EHRs or other platforms on the basis of co-location and collaboration arrangement including consideration of regulatory issues.										
Task Provide training and technical assistance to participating providers to integrate medical and behavioral health records within EHR or other platforms.										
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	0	0	0	0	0	0
Task Primary care services are co-located within behavioral Health practices and are available.	0	0	0	0	0	0	0	0	0	0
Task Primary care services are co-located within behavioral Health practices and are available.	0	0	0	0	0	0	0	0	0	0
Task Convene working group of Participants to participate in project planning and develop regular meeting schedule.										
Task Create and collect surveys to identify practices with interest and capacity (space that meets regulatory requirements, panel size) for primary care co-location, as well as status of technical assistance to meet NCQA PCMH Level 3 Recognition under 2014 standards.										
Task Create a clinical operations plan (COP) for implementing primary care co-location.										
Task In collaboration with the Finance Committee, create and regularly update a strategy for financing project implementation.										

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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 Submit initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation, and share final COP with all project participants.										
Task As referenced in project 2ai, develop and implement technical assistance to participating practices as needed to achieve NCQA 2014 Level 3 recognition .										
Task Provide assistance to participating practices as needed to implement primary care co-location as outlined in COP. Assistance may include advising around or providing practices with staffing to ensure availability of behavioral health services and/or providing guidance on regulatory issues surrounding co-location such as integrating medical and behavioral health records.										
Task Develop training strategy for participants in primary care co-location, based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices. Strategy will include resources for evaluation, ongoing training, and onboarding of new staff.										
Task Implement and train interested participants in primary care co-location based on the COP, and revise 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 Incorporate collaborative care practice guidelines and protocols into the COP, described previously.										
Task Use survey or engage partners to assess need for training in evidence-based care protocols, including medication management and care engagement processes.										

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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 As referenced above, provide training and technical assistance to participating practices on evidence-based care protocols, including medication management and care engagement processes.										
Task Develop policies and procedures for updating guidelines, protocols, and training, based on feedback and project performance.										
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 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	0	0	0
Task Incorporate screening and warm transfer guidelines and protocols into the COP, as described above.										
Task Use survey or engage partners to assess need for technical support and training in screening protocols, including documentation and warm transfer										
Task Explore technology options for documenting preventive care screenings and warm transfers in EHRs or care management platforms.										
Task As referenced earlier, provide training and technical assistance to participating practices to implement screening protocols and document warm transfer, as outlined in COP.										
Task Develop performance reporting structure in order to ensure that										

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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
90% of patients are receiving preventive care screenings, and adjust protocols on an ongoing basis and as necessary based on performance.										
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 Review NYS DOH guidance and definitions of patient engagement for this project.										
Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.										
Task Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance										
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.										
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.										
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.										
Task Evaluate options for integrating medical and behavioral records within EHRs or other platforms on the basis of co-location and collaboration arrangement including consideration of regulatory issues.										
Task Provide training and technical assistance to participating providers to integrate medical and behavioral health records within EHR or other platforms.										
Milestone #9 Implement IMPACT Model at Primary Care Sites.										

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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 implemented IMPACT Model at Primary Care Sites.	0	0	0	0	0	0	50	110	170	250
Task Convene working group of Participants to participate in project planning and develop regular meeting schedule.										
Task Create and collect surveys to identify practices interested in using IMPACT and need for technical assistance to implement IMPACT Model.										
Task Create a clinical operations plan (COP) for implementing IMPACT Model as developed in the workgroup, including plans and resources for staffing.										
Task In collaboration with the Finance Committee, create and regularly update a strategy for financing project implementation.										
Task Submit initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation, and share final COP with all partners.										
Task As referenced in project 2ai, develop and implement technical assistance to participating practices as needed to achieve NCQA 2014 Level 3 recognition .										
Task Provide assistance to participating practices as needed to implement IMPACT Model as outlined in COP. Assistance may include: 1) advising around or providing practices with staffing, including a trained Depression Care Manager and Consulting Psychiatrist meeting requirements of the IMPACT Model to ensure availability of behavioral health services, or 2) providing guidance on regulatory issues surrounding collaboration such as integrating medical and behavioral health records to facilitate communication between primary care sites and other care team staff (depression care manager, psychiatrist, etc.).										
Task Develop training strategy for participants in IMPACT Model, based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices. Strategy will include resources for evaluation, ongoing training, and onboarding of new staff.										
Task Implement and train interested participants in IMPACT Model based on the COP, including how to provide "stepped care", and										

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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
revise as needed.										
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.										
Task The COP includes coordinated evidence-based care standards and policies, including collaboration with a depression care manager, the process for consulting with a psychiatrist, medication management, and procedures for care engagement.										
Task Use survey or engage partners to assess need for training in evidence-based care protocols, including medication management and care engagement processes.										
Task As referenced above, provide training and technical assistance to participating practices on the IMPACT model standards and guidelines, including medication management and care engagement processes.										
Task Develop policies and procedures for updating guidelines, protocols, and training, based on feedback and project performance.										
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.										

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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 Identify or develop as necessary Depression Care Manager training in IMPACT Model, including coaching patients in behavioral activation, relapse, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan, and share with care management partners.										
Task Work with participating care management agencies as needed to provide IMPACT Model training.										
Task Identify and establish referral agreements with care management organizations to provide qualified Depression Care Managers and psychiatrists to work with PCMH care team in implementing IMPACT model protocols.										
Task Explore and implement technology options for identifying Depression Care Managers in EHRs or other IT platforms.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Task Work with PPS partners to identify consulting psychiatrists.										
Task Identify or develop as necessary IMPACT Model training for consulting psychiatrists, and share with care management and primary care partners.										
Task Work with care management organizations and practices to develop standardized agreements with consulting psychiatrists to work with primary care teams in implementing IMPACT model protocols.										
Task Work with participating Psychiatrists as needed to provide IMPACT Model training.										
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).										

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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 Identify and assess capabilities of existing mechanisms for tracking outcomes and actively engaged patients through the project and identify additional tracking platforms, as necessary.										
Task Develop and implement an IT strategy for tracking outcomes and actively engaged patients for all projects, including training for Participants, as needed.										
Task Develop protocols to ensure that 90% of patients are receiving behavioral health screenings, and adjust protocols on an ongoing basis and as necessary based on performance.										
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.										
Task Incorporate stepped care guidelines and protocols into the COP, as described above.										
Task Incorporate stepped care guidelines in design of documentation and tools for use in EHRs or care management platforms.										
Task Implement and train interested participants as needed in stepped care, including regular assessment at intervals and appropriate steps for treatment adjustment as outlined in the COP.										
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.										
Task Review NYS DOH guidance and definitions of patient engagement for this project.										
Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify										

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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
additional tracking platforms, as necessary.										
Task Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance										
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.										
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.										
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.										
Task Evaluate options for integrating medical and behavioral records within EHRs or other platforms on the basis of co-location and collaboration arrangement including consideration of regulatory issues.										
Task Provide training and technical assistance to participating providers to integrate medical and behavioral health records within EHR or other platforms.										

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.	40	60	60	60	60	60	60	60	60	60
Task Behavioral health services are co-located within PCMH/APC practices and are available.	17	26	26	26	26	26	26	26	26	26
Task Convene working group of Participants to participate in project planning and develop regular meeting schedule.										
Task Create and collect surveys to identify practices with interest and capacity (space, panel size) for behavioral health co-location, as										

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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
well as status of technical assistance to meet NCQA PCMH Level 3 Recognition under 2014 standards.										
Task Create a clinical operations plan (COP) for implementing behavioral health co-location.										
Task In collaboration with the Finance Committee, create and regularly update a strategy for financing project implementation.										
Task Submit initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation, and share final COP with all project participants.										
Task As referenced in project 2ai, develop and implement technical assistance to participating practices as needed to achieve NCQA 2014 Level 3 recognition .										
Task Provide assistance to participating practices as needed to implement behavioral health co-location as outlined in COP. Assistance may include advising around or providing practices with staffing to ensure availability of behavioral health services.										
Task Develop training for participants in behavioral health co-location, based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices.										
Task Deliver training to participants in behavioral health co-location and develop a process for assessing the effectiveness of training.										
Task Revise COP and provide updated implementation support as needed.										
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.										

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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 Incorporate collaborative care practice guidelines and protocols into the COP, described previously.										
Task Use survey or engage partners to assess need for training in evidence-based care protocols, including medication management and care engagement processes.										
Task As referenced above, provide training and technical assistance to participating practices on evidence-based care protocols, including medication management and care engagement processes.										
Task Develop policies and procedures for updating guidelines, protocols, and training, based on feedback and project performance.										
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.	40	60	60	60	60	60	60	60	60	60
Task Incorporate screening and warm transfer guidelines and protocols into the COP, as described above.										
Task Use survey or engage partners to assess need for technical support and training in screening protocols, including documentation and warm transfer										
Task Explore technology options for documenting behavioral health screenings and warm transfers in EHRs or care management platforms.										

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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 As referenced earlier, provide training and technical assistance to participating practices to implement screening protocols and document warm transfer, as outlined in COP.										
Task Develop performance reporting structure in order to ensure that 90% of patients are receiving behavioral health screenings, and adjust protocols on an ongoing basis and as necessary based on performance.										
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 Review NYS DOH guidance and definitions of patient engagement for this project										
Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.										
Task Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance										
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.										
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.										
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.										
Task Evaluate options for integrating medical and behavioral records within EHRs or other platforms on the basis of co-location and collaboration arrangement including consideration of regulatory issues.										

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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 Provide training and technical assistance to participating providers to integrate medical and behavioral health records within EHR or other platforms.										
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.	3	6	6	6	6	6	6	6	6	6
Task Primary care services are co-located within behavioral Health practices and are available.	3	6	6	6	6	6	6	6	6	6
Task Primary care services are co-located within behavioral Health practices and are available.	1	3	3	3	3	3	3	3	3	3
Task Convene working group of Participants to participate in project planning and develop regular meeting schedule.										
Task Create and collect surveys to identify practices with interest and capacity (space that meets regulatory requirements, panel size) for primary care co-location, as well as status of technical assistance to meet NCQA PCMH Level 3 Recognition under 2014 standards.										
Task Create a clinical operations plan (COP) for implementing primary care co-location.										
Task In collaboration with the Finance Committee, create and regularly update a strategy for financing project implementation.										
Task Submit initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation, and share final COP with all project participants.										
Task As referenced in project 2ai, develop and implement technical assistance to participating practices as needed to achieve NCQA 2014 Level 3 recognition .										
Task Provide assistance to participating practices as needed to implement primary care co-location as outlined in COP. Assistance may include advising around or providing practices with staffing to ensure availability of behavioral health services and/or providing guidance on regulatory issues surrounding co-										

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
location such as integrating medical and behavioral health records.										
Task Develop training strategy for participants in primary care co-location, based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices. Strategy will include resources for evaluation, ongoing training, and onboarding of new staff.										
Task Implement and train interested participants in primary care co-location based on the COP, and revise 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 Incorporate collaborative care practice guidelines and protocols into the COP, described previously.										
Task Use survey or engage partners to assess need for training in evidence-based care protocols, including medication management and care engagement processes.										
Task As referenced above, provide training and technical assistance to participating practices on evidence-based care protocols, including medication management and care engagement processes.										
Task Develop policies and procedures for updating guidelines, protocols, and training, based on feedback and project performance.										
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										

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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 Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	3	6	6	6	6	6	6	6	6	6
Task Incorporate screening and warm transfer guidelines and protocols into the COP, as described above.										
Task Use survey or engage partners to assess need for technical support and training in screening protocols, including documentation and warm transfer										
Task Explore technology options for documenting preventive care screenings and warm transfers in EHRs or care management platforms.										
Task As referenced earlier, provide training and technical assistance to participating practices to implement screening protocols and document warm transfer, as outlined in COP.										
Task Develop performance reporting structure in order to ensure that 90% of patients are receiving preventive care screenings, and adjust protocols on an ongoing basis and as necessary based on performance.										
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 Review NYS DOH guidance and definitions of patient engagement for this project.										

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Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.										
Task Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance										
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.										
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.										
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.										
Task Evaluate options for integrating medical and behavioral records within EHRs or other platforms on the basis of co-location and collaboration arrangement including consideration of regulatory issues.										
Task Provide training and technical assistance to participating providers to integrate medical and behavioral health records within EHR or other platforms.										
Milestone #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	350	533	533	533	533	533	533	533	533	533
Task Convene working group of Participants to participate in project planning and develop regular meeting schedule.										
Task Create and collect surveys to identify practices interested in using IMPACT and need for technical assistance to implement IMPACT Model.										
Task Create a clinical operations plan (COP) for implementing IMPACT Model as developed in the workgroup, including plans and resources for staffing.										
Task In collaboration with the Finance Committee, create and regularly										

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update a strategy for financing project implementation.										
Task Submit initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation, and share final COP with all partners.										
Task As referenced in project 2ai, develop and implement technical assistance to participating practices as needed to achieve NCQA 2014 Level 3 recognition .										
Task Provide assistance to participating practices as needed to implement IMPACT Model as outlined in COP. Assistance may include: 1) advising around or providing practices with staffing, including a trained Depression Care Manager and Consulting Psychiatrist meeting requirements of the IMPACT Model to ensure availability of behavioral health services, or 2) providing guidance on regulatory issues surrounding collaboration such as integrating medical and behavioral health records to facilitate communication between primary care sites and other care team staff (depression care manager, psychiatrist, etc.).										
Task Develop training strategy for participants in IMPACT Model, based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices. Strategy will include resources for evaluation, ongoing training, and onboarding of new staff.										
Task Implement and train interested participants in IMPACT Model based on the COP, including how to provide "stepped care", and revise as needed.										
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.										

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Task The COP includes coordinated evidence-based care standards and policies, including collaboration with a depression care manager, the process for consulting with a psychiatrist, medication management, and procedures for care engagement.										
Task Use survey or engage partners to assess need for training in evidence-based care protocols, including medication management and care engagement processes.										
Task As referenced above, provide training and technical assistance to participating practices on the IMPACT model standards and guidelines, including medication management and care engagement processes.										
Task Develop policies and procedures for updating guidelines, protocols, and training, based on feedback and project performance.										
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.										
Task Identify or develop as necessary Depression Care Manager training in IMPACT Model, including coaching patients in behavioral activation, relapse, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan, and share with care management partners.										
Task Work with participating care management agencies as needed to provide IMPACT Model training.										
Task Identify and establish referral agreements with care management organizations to provide qualified Depression Care Managers and psychiatrists to work with PCMH care team in implementing										

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IMPACT model protocols.										
Task Explore and implement technology options for identifying Depression Care Managers in EHRs or other IT platforms.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Task Work with PPS partners to identify consulting psychiatrists.										
Task Identify or develop as necessary IMPACT Model training for consulting psychiatrists, and share with care management and primary care partners.										
Task Work with care management organizations and practices to develop standardized agreements with consulting psychiatrists to work with primary care teams in implementing IMPACT model protocols.										
Task Work with participating Psychiatrists as needed to provide IMPACT Model training.										
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).										
Task Identify and assess capabilities of existing mechanisms for tracking outcomes and actively engaged patients through the project and identify additional tracking platforms, as necessary.										
Task Develop and implement an IT strategy for tracking outcomes and actively engaged patients for all projects, including training for Participants, as needed.										
Task Develop protocols to ensure that 90% of patients are receiving behavioral health screenings, and adjust protocols on an ongoing basis and as necessary based on performance.										
Milestone #14 Provide "stepped care" as required by the IMPACT Model.										

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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 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.										
Task Incorporate stepped care guidelines and protocols into the COP, as described above.										
Task Incorporate stepped care guidelines in design of documentation and tools for use in EHRs or care management platforms.										
Task Implement and train interested participants as needed in stepped care, including regular assessment at intervals and appropriate steps for treatment adjustment as outlined in the COP.										
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.										
Task Review NYS DOH guidance and definitions of patient engagement for this project.										
Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.										
Task Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance										
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.										
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.										
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.										

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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 Evaluate options for integrating medical and behavioral records within EHRs or other platforms on the basis of co-location and collaboration arrangement including consideration of regulatory issues.										
Task Provide training and technical assistance to participating providers to integrate medical and behavioral health records within EHR or other platforms.										

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.	
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.	
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.	
Use EHRs or other technical platforms to track all patients engaged in this project.	
Implement IMPACT Model at Primary Care Sites.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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	
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	

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #15	Pass & Ongoing	

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

The major risks to implementing 3.b.i and corresponding mitigation strategies that will be used are described below:

1. Competing Demands: Providers have limited time to spend on routine screenings and preventive advice. To mitigate this risk, and to help providers work at the top of their licenses, CCB will support a care model that trains medical assistants and care managers to conduct blood pressure monitoring and other screenings. CCB plans to develop centralized registries to track at-risk patients and trigger outreach and follow up; offer new incentives to providers for screening and education; and use home-based tele-monitoring where appropriate.

2. EMRs and Documentation: CCB Participant providers and care team members either do not use EMRs or use different EMRs, some of which do not enable documentation of patient self-management goals. This is a risk because documentation of self-management goals in a patient record is a project requirement. To address this risk, CCB plans to make available the Dashboard as a mechanism for documenting patients' self-management goals. CCB will provide Participant providers with training on the Dashboard and develop workflows to ensure the burden associated with documentation is minimized. Members of the care team will also be trained on documentation. To the extent possible, the care team will also work with patients to document their own self-management goals in a personal health record.

3. Lack of PCMHs. CCB estimates that over half of CCB's PCPs have not yet achieved any level of NCQA PCMH recognition. There is a risk that some of these barriers (e.g., level of staff support, technology infrastructure, level of investment, etc.) might be difficult to overcome. To mitigate this risk, Central Services Organization staff has been actively engaging community physicians and plans to provide technical support to assist with meeting NCQA requirements. CCB plans to make population health management tools (e.g., registries, patient tracking, patient care plans) available to PCPs and assign care managers to assist their chronically ill patients as needed.

4. Managed Care Organization (MCO) Formularies: Some patients in the target population switch Medicaid MCOs frequently, which often requires that they switch medications due to different plan formularies. Current MCO policies do not allow for 90 day refills, which can also pose a challenge to patient compliance. To mitigate these risks, CCB will work with MCOs to institute policy changes that will promote medication adherence. A MCO representative will sit on the Executive Committee.

5. Patient Diversity. Brooklyn is home to a diverse population which may affect a patient's attitude toward how they manage their condition. Patients may decline, be unable, or be hesitant to access health care services because they do not understand the long term effects of hypertension. Patients also have competing needs (e.g., food or housing) that may take precedence over their health care, or face cultural and socioeconomic barriers to accessing services. To mitigate this risk, CCB will engage CBOs that are known and trusted in the communities they serve to engage and provide education to the target population. CCB will work with partners to recruit community residents to serve as peer educators to provide patient education through evidence-based models and ensure its workforce undergoes cultural competency training. CCB will

monitor data with respect to patient outcomes and seek feedback from patients, CBOs, and peer coaches to determine whether interventions are successful and make adjustments as appropriate.

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "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	34,500

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%	5,175	0.00%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (5,175)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
cpickett	Rosters	33_PMDL4215_1_3_20160201130841_MMC_PPS_Patient_Engagement_Speed.xlsx	MMC PPS Patient Engagement Speed	02/01/2016 01:09 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Establish workgroup to develop evidence-based standards and policies based on the Stanford Model for chronic diseases and the PCMH Model.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Create a clinical operations plan (COP) for implementation of evidence-based management of cardiovascular disease as developed in the workgroup and based on the PCMH Model. The COP will include: 1) procedures for tracking all patients engaged in this project 2)Standards and policies, including the 5 As of Tobacco Control; standardized treatment protocols for hypertension and hyperlipidemia; care coordination teams and processes; blood pressure measurement and monitoring (including population-level monitoring using registries and risk assessment); prescribing practices to increase medication adherence; and person-centered methods, such as setting self-management goals.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task In collaboration with the Finance Committee, create and regularly update a strategy for financing project implementation.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Create and administer survey to identify practices' relevant	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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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
resources, current operations, and capabilities.									
Task Collect and analyze surveys to identify practices' need for technical assistance to implement a comprehensive cardiovascular disease management program.	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Submit initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation, and share final COP with all project participants.	Project		Completed	10/01/2015	03/31/2016	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Provide assistance to participating practices as needed to implement comprehensive, evidence-based cardiovascular disease management, as outlined in COP. Assistance may include helping practices create care coordination teams that include nursing staff, pharmacists, dietitians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Develop training strategy for participants based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices. Strategy will include resources for evaluation, ongoing training, and onboarding of new staff.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Implement and train interested participants in evidence-based, comprehensive cardiovascular disease management based on the COP, and revise as needed.	Project		Not Started	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Develop a rapid improvement process for reviewing and revising COP.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	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 Practitioner - Non-Primary Care Provider (PCP)	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 Mental Health	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.	Project		Not Started	01/01/2017	03/31/2018	01/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task Survey providers to gain understanding of existing data-sharing capabilities with Healthix (RHIO)	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish partnership with RHIO and CCB Participants who need to receive and/or contribute patient data to serve patient needs	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Based on the data sharing roadmap and other information, develop and implement support processes to ensure that all PPS safety net providers are actively sharing health information, including alerts and secure messaging.	Project		Not Started	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Project	N/A	In Progress	10/01/2015	03/31/2018	10/01/2015	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 PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Assess eligible Participant EHR use and readiness relative to Meaningful Use and PCMH 2014 Level 3 standards	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop a work plan/strategy to encourage, track and support eligible safety net providers in acquiring/implementing certified	Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2

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EHR systems, which may vary based on provider characteristics such as providers' size, services, current status, readiness levels, etc. ; develop Participant education and engagement strategy to facilitate understanding of IT requirements									
Task Recruit or contract for EHR implementation resources as needed	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Implement work plan/strategy by providing technical assistance and other supports for Participant EHR implementation and progress towards Meaningful Use and PCMH standards	Project		Not Started	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	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		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Review NYS DOH guidance and definitions of patient engagement for this project.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.	Project		Completed	10/01/2015	03/31/2016	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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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
Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).									
Task PPS has implemented an automated scheduling system to facilitate tobacco control protocols.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Assess capabilities of existing mechanisms for prompting completion of the 5 A's of tobacco control, including through participant survey. Identify other platforms offering automated or work driver scheduling system for facilitating tobacco control protocols, as necessary.	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Based on results of assessment, develop plans for using EHRs to prompt providers to complete the 5 A's of tobacco control and include in the COP.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop and provide training to staff on the 5 A's of tobacco control.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Utilizing workgroup, develop standardized treatment protocols for hypertension and elevated cholesterol that are aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF) and incorporate into the COP.	Project		Completed	07/01/2015	03/31/2016	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop tools and/or training materials, as needed, to help practices implement standardized treatment protocols for hypertension and elevated cholesterol as outlined in COP.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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As described earlier, provide technical assistance and/or training to participating practices as needed to implement protocols as outlined in COP.									
Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination processes are in place.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Utilizing workgroup, develop policies and procedures outlining composition and roles of a care coordination teams, including which functions and provider types, e.g., pharmacists, dieticians, care managers, and outreach workers, can be shared across coordination teams, and incorporate into the COP. COP will include guidance on how nursing staff, pharmacists, dieticians and community health workers can address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Project		Completed	10/01/2015	03/31/2016	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify technology solution to support communication between care coordination teams and deploy a Clinically Interoperable System to all relevant providers	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Develop tools, e.g., staffing models, as needed, to help practices implement care coordination teams as outlined in COP.	Project		Completed	07/01/2015	03/31/2016	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Provide technical assistance, e.g., consultation on staffing models, to participating practices as needed to implement care	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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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
coordination teams as outlined in COP.									
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	Provider	Practitioner - Primary Care Provider (PCP)	Not Started	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Incorporate policies for providing access to blood pressure checks without copayment or appointment, and plan for training and developing any required staff, in the COP.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Meet with MCOs regarding co-payment for BP checks and DME allowance for home blood pressure monitoring as needed	Project		Not Started	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Incorporate plan for training staff on correct blood pressure measurement techniques in the COP.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop tools, e.g., training materials, as needed, to help practices implement care coordination teams as outlined in COP.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Disseminate training materials to participating practices to ensure blood pressure measurements are taken correctly with the correct equipment, and track training of targeted personnel as applicable.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses a patient stratification system to identify patients who	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
have repeated elevated blood pressure but no diagnosis of hypertension.									
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Incorporate in the COP guidelines for identifying patients with repeated elevated blood pressure readings (without hypertension diagnosis) and develop protocols for following up with these patients, including an automated or work driver scheduling system for targeted patients. Guidelines will include suggested registry and stratification methods.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop tools, e.g., training materials, as needed, to help practices implement patient identification, stratification and tracking guidelines.	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Provide technical assistance, e.g., training on population health management, to participating practices, as needed, to implement guidelines for identifying and tracking patients with repeated elevated blood pressure readings and no hypertension diagnosis as outlined in COP.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Incorporate in the COP guidelines for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop tools, e.g., sample protocols, as needed, to help practices implement prescribing guidelines, such as once-daily	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

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regimens or fixed-dose combination pills, as outlined in the COP.									
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Self-management goals are documented in the clinical record.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Identify and assess capabilites of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop and implement an IT strategy for tracking actively engaged patients for all projects, including training for Participants, as needed.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provide technical assistance and training to participating practices as needed to implement documentation and review of patient-driven self-management goals.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has developed referral and follow-up process and adheres to process.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff on warm referral and follow-up process.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Survey and conduct assessment of Participants to identify capabilities of existing mechanisms for making and following up with referrals to community-based programs, to document	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4

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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
participation and behavioral and health status changes, and to identify community-based programs. Identify other platforms offering functionality, as necessary.									
Task Utilizing workgroup, develop policies on warm hand-offs and tracking referrals to community-based programs, including training strategy, and incorporate in the COP.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Create and facilitate agreements with CBOs and incorporate processes to facilitate feedback to and from CBOs in the COP.	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Provide technical assistance, e.g., guidance on referral tracking, to participating practices, as needed, to implement tracking of referrals to CBOs, including documenting participation and behavioral and health status changes, as outlined in COP.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed and implemented protocols for home blood pressure monitoring.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff on warm referral and follow-up process.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Utilizing workgroup, develop policies and procedures outlining protocols for home blood pressure monitoring and incorporate in the COP.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop tools, e.g., training materials, as needed, to help practices implement protocols for home blood pressure monitoring with follow-up support.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Provide technical assistance, e.g., training, as needed, to implement home blood pressure monitoring, including equipment	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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evaluation and follow-up if blood pressure results are abnormal.									
Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Incorporate guidelines for identifying patients with hypertension and no recent visit, and protocols for following with these patients, including an automated or work driver scheduling system for targeted patients, in the COP. Guidelines include suggested registry and stratification methods.	Project		Completed	07/01/2015	03/31/2016	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop tools, e.g., training materials, as needed, to help practices implement patient identification, stratification and tracking guidelines, and automated scheduling for targeted patients as outlined in the COP.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Provide technical assistance, e.g., training on population health management, to participating practices, as needed, to implement guidelines for identifying, tracking and scheduling patients with hypertension as outlined in COP.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	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 developed referral and follow-up process and adheres to process.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Use participant survey and conduct assessment to identify capabilities of existing mechanisms for facilitating referrals to NYS Smoker's Quitline. Identify other platforms offering functionality, as necessary.	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Incorporate policy and procedure for facilitating referrals to NYS Smoker's Quitline, including training strategy, in the COP.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Provide technical assistance, e.g., guidance on referral tracking, to participating practices, as needed, to implement referral and	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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follow-up process.									
Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task If applicable, PPS has established linkages to health homes for targeted patient populations.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Identify Health Homes and community-based programs using the Stanford Model for targeted patient populations and assess, including through survey, capabilities of existing mechanisms for performing "hot spotting", such as collecting REAL data, linking high risk populations to Health Homes, and group visits. Identify other platforms offering functionality, as necessary.	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Utilizing workgroup, develop and incorporate policies on identifying high risk patients, warm hand-offs to Health Homes, and group visits, including training strategy, in the COP.	Project		Completed	07/01/2015	03/31/2016	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop tools, e.g., linkages to health homes or training materials, as needed, to help practices implement guidelines for identification of high-risk patients and the Stanford Model for chronic disease management as outlined in the COP.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provide technical assistance, e.g., training on population health management, to participating practices, as needed, to implement guidelines for identifying high risk patients and the Stanford Model for chronic diseases as outlined in COP.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4

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Milestone #18 Adopt strategies from the Million Hearts Campaign.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Practitioner - Primary Care Provider (PCP)	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Practitioner - Non-Primary Care Provider (PCP)	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Mental Health	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Utilizing workgroup, develop policies and procedures which reflect principles and initiatives of Million Lives Campaign, such as blood pressure follow-up contacts, and incorporate in COP.	Project		Completed	07/01/2015	03/31/2016	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop tools, e.g., training materials, as needed to help practices adopt strategies from the Million Hearts Campaign as outlined in COP.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Provide technical assistance, e.g., training, as needed, to help practices implement policies and procedures that include strategies from the Million Hearts Campaign.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	Project	N/A	Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.	Project		Not Started	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Meet with the major Medicaid MCOs to engage them in strategies for increasing opportunities across the PPS in preventive services.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4

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Task Form agreements with MCOs to work jointly to coordinate services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Continue meetings with MCOs on an ongoing basis to discuss performance and opportunities for improvement.	Project		Not Started	03/31/2017	03/31/2018	03/31/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #20 Engage a majority (at least 80%) of primary care providers in this 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 engaged at least 80% of their PCPs in this activity.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Maintain accurate database of participating providers and ongoing outreach to ensure continued participation of at least 80% in DSRIP project	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Use participant survey and conduct assessment to identify primary care providers' readiness to implement a program of evidence-based cardiovascular disease management based on NCQA PCMH 2014 standards and elements, and stratify to inform implementation strategy.	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 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 program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task Establish workgroup to develop evidence-based standards and policies based on the Stanford Model for chronic diseases and the PCMH Model.										
Task Create a clinical operations plan (COP) for implementation of										

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evidence-based management of cardiovascular disease as developed in the workgroup and based on the PCMH Model. The COP will include: 1) procedures for tracking all patients engaged in this project 2)Standards and policies, including the 5 As of Tobacco Control; standardized treatment protocols for hypertension and hyperlipidemia; care coordination teams and processes; blood pressure measurement and monitoring (including population-level monitoring using registries and risk assessment); prescribing practices to increase medication adherence; and person-centered methods, such as setting self-management goals.										
Task In collaboration with the Finance Committee, create and regularly update a strategy for financing project implementation.										
Task Create and administer survey to identify practices' relevant resources, current operations, and capabilities.										
Task Collect and analyze surveys to identify practices' need for technical assistance to implement a comprehensive cardiovascular disease management program.										
Task Submit initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation, and share final COP with all project participants.										
Task Provide assistance to participating practices as needed to implement comprehensive, evidence-based cardiovascular disease management, as outlined in COP. Assistance may include helping practices create care coordination teams that include nursing staff, pharmacists, dietitians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.										
Task Develop training strategy for participants based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices. Strategy will include resources for evaluation, ongoing training, and onboarding of new staff.										
Task Implement and train interested participants in evidence-based, comprehensive cardiovascular disease management based on the COP, and revise as needed.										

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Task Develop a rapid improvement process for reviewing and revising COP.										
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	40	90	158	158	258
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	2	5	8	13
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	4	4	8	8	12
Task PPS uses alerts and secure messaging functionality.										
Task Survey providers to gain understanding of existing data-sharing capabilities with Healthix (RHIO)										
Task Establish partnership with RHIO and CCB Participants who need to receive and/or contribute patient data to serve patient needs										
Task Based on the data sharing roadmap and other information, develop and implement support processes to ensure that all PPS safety net providers are actively sharing health information, including alerts and secure messaging.										
Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.										
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	56	79	171	259	374	435	490
Task Assess eligible Participant EHR use and readiness relative to Meaningful Use and PCMH 2014 Level 3 standards										

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Task Develop a work plan/strategy to encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, which may vary based on provider characteristics such as providers' size, services, current status, readiness levels, etc. ; develop Participant education and engagement strategy to facilitate understanding of IT requirements										
Task Recruit or contract for EHR implementation resources as needed										
Task Implement work plan/strategy by providing technical assistance and other supports for Participant EHR implementation and progress towards Meaningful Use and PCMH standards										
Milestone #4 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 Review NYS DOH guidance and definitions of patient engagement for this project.										
Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.										
Task Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance										
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.										
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.										
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.										
Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).										

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Task PPS has implemented an automated scheduling system to facilitate tobacco control protocols.										
Task PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.										
Task Assess capabilities of existing mechanisms for prompting completion of the 5 A's of tobacco control, including through participant survey. Identify other platforms offering automated or work driver scheduling system for facilitating tobacco control protocols, as necessary.										
Task Based on results of assessment, develop plans for using EHRs to prompt providers to complete the 5 A's of tobacco control and include in the COP.										
Task Develop and provide training to staff on the 5 A's of tobacco control.										
Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.										
Task Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).										
Task Utilizing workgroup, develop standardized treatment protocols for hypertension and elevated cholesterol that are aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF) and incorporate into the COP.										
Task Develop tools and/or training materials, as needed, to help practices implement standardized treatment protocols for hypertension and elevated cholesterol as outlined in COP.										
Task As described earlier, provide technical assistance and/or training to participating practices as needed to implement protocols as outlined in COP.										
Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.										

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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 Clinically Interoperable System is in place for all participating providers.										
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.										
Task Care coordination processes are in place.										
Task Utilizing workgroup, develop policies and procedures outlining composition and roles of a care coordination teams, including which functions and provider types, e.g., pharmacists, dieticians, care managers, and outreach workers, can be shared across coordination teams, and incorporate into the COP. COP will include guidance on how nursing staff, pharmacists, dieticians and community health workers can address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.										
Task Identify technology solution to support communication between care coordination teams and deploy a Clinically Interoperable System to all relevant providers										
Task Develop tools, e.g., staffing models, as needed, to help practices implement care coordination teams as outlined in COP.										
Task Provide technical assistance, e.g., consultation on staffing models, to participating practices as needed to implement care coordination teams as outlined in COP.										
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.										
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	0	0	0	0	0	20	90	184	334	484
Task Incorporate policies for providing access to blood pressure checks without copayment or appointment, and plan for training and developing any required staff, in the COP.										
Task Meet with MCOs regarding co-payment for BP checks and DME allowance for home blood pressure monitoring as needed										
Milestone #9 Ensure that all staff involved in measuring and recording blood										

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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
pressure are using correct measurement techniques and equipment.										
Task PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.										
Task Incorporate plan for training staff on correct blood pressure measurement techniques in the COP.										
Task Develop tools, e.g., training materials, as needed, to help practices implement care coordination teams as outlined in COP.										
Task Disseminate training materials to participating practices to ensure blood pressure measurements are taken correctly with the correct equipment, and track training of targeted personnel as applicable.										
Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.										
Task PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.										
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.										
Task PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.										
Task Incorporate in the COP guidelines for identifying patients with repeated elevated blood pressure readings (without hypertension diagnosis) and develop protocols for following up with these patients, including an automated or work driver scheduling system for targeted patients. Guidelines will include suggested registry and stratification methods.										
Task Develop tools, e.g., training materials, as needed, to help practices implement patient identification, stratification and tracking guidelines.										
Task Provide technical assistance, e.g., training on population health management, to participating practices, as needed, to implement										

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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 for identifying and tracking patients with repeated elevated blood pressure readings and no hypertension diagnosis as outlined in COP.										
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.										
Task PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.										
Task Incorporate in the COP guidelines for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.										
Task Develop tools, e.g., sample protocols, as needed, to help practices implement prescribing guidelines, such as once-daily regimens or fixed-dose combination pills, as outlined in the COP.										
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.										
Task Self-management goals are documented in the clinical record.										
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.										
Task Identify and assess capabilites of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.										
Task Develop and implement an IT strategy for tracking actively engaged patients for all projects, including training for Participants, as needed.										
Task Provide technical assistance and training to participating practices as needed to implement documentation and review of patient-driven self-management goals.										
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.										
Task PPS has developed referral and follow-up process and adheres to process.										

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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 provides periodic training to staff on warm referral and follow-up process.										
Task Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.										
Task Survey and conduct assessment of Participants to identify capabilities of existing mechanisms for making and following up with referrals to community-based programs, to document participation and behavioral and health status changes, and to identify community-based programs. Identify other platforms offering functionality, as necessary.										
Task Utilizing workgroup, develop policies on warm hand-offs and tracking referrals to community-based programs, including training strategy, and incorporate in the COP.										
Task Create and facilitate agreements with CBOs and incorporate processes to facilitate feedback to and from CBOs in the COP.										
Task Provide technical assistance, e.g., guidance on referral tracking, to participating practices, as needed, to implement tracking of referrals to CBOs, including documenting participation and behavioral and health status changes, as outlined in COP.										
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.										
Task PPS has developed and implemented protocols for home blood pressure monitoring.										
Task PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.										
Task PPS provides periodic training to staff on warm referral and follow-up process.										
Task Utilizing workgroup, develop policies and procedures outlining protocols for home blood pressure monitoring and incorporate in the COP.										
Task Develop tools, e.g., training materials, as needed, to help										

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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
practices implement protocols for home blood pressure monitoring with follow-up support.										
Task Provide technical assistance, e.g., training, as needed, to implement home blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.										
Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.										
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.										
Task Incorporate guidelines for identifying patients with hypertension and no recent visit, and protocols for following with these patients, including an automated or work driver scheduling system for targeted patients, in the COP. Guidelines include suggested registry and stratification methods.										
Task Develop tools, e.g., training materials, as needed, to help practices implement patient identification, stratification and tracking guidelines, and automated scheduling for targeted patients as outlined in the COP.										
Task Provide technical assistance, e.g., training on population health management, to participating practices, as needed, to implement guidelines for identifying, tracking and scheduling patients with hypertension as outlined in COP.										
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task Use participant survey and conduct assessment to identify capabilities of existing mechanisms for facilitating referrals to NYS Smoker's Quitline. Identify other platforms offering functionality, as necessary.										
Task Incorporate policy and procedure for facilitating referrals to NYS Smoker's Quitline, including training strategy, in the COP.										
Task Provide technical assistance, e.g., guidance on referral tracking, to participating practices, as needed, to implement referral and follow-up process.										

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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 #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.										
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.										
Task If applicable, PPS has established linkages to health homes for targeted patient populations.										
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.										
Task Identify Health Homes and community-based programs using the Stanford Model for targeted patient populations and assess, including through survey, capabilities of existing mechanisms for performing "hot spotting", such as collecting REAL data, linking high risk populations to Health Homes, and group visits. Identify other platforms offering functionality, as necessary.										
Task Utilizing workgroup, develop and incorporate policies on identifying high risk patients, warm hand-offs to Health Homes, and group visits, including training strategy, in the COP.										
Task Develop tools, e.g., linkages to health homes or training materials, as needed, to help practices implement guidelines for identification of high-risk patients and the Stanford Model for chronic disease management as outlined in the COP.										
Task Provide technical assistance, e.g., training on population health management, to participating practices, as needed, to implement guidelines for identifying high risk patients and the Stanford Model for chronic diseases as outlined in COP.										
Milestone #18 Adopt strategies from the Million Hearts Campaign.										
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	0	0	20	90	290	540	834	834	834
Task Provider can demonstrate implementation of policies and	0	0	0	0	0	16	46	126	126	126

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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
procedures which reflect principles and initiatives of Million Hearts Campaign.										
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	0	0	0	0	0	14	29	29	29
Task Utilizing workgroup, develop policies and procedures which reflect principles and initiatives of Million Lives Campaign, such as blood pressure follow-up contacts, and incorporate in COP.										
Task Develop tools, e.g., training materials, as needed to help practices adopt strategies from the Million Hearts Campaign as outlined in COP.										
Task Provide technical assistance, e.g., training, as needed, to help practices implement policies and procedures that include strategies from the Million Hearts Campaign.										
Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.										
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.										
Task Meet with the major Medicaid MCOs to engage them in strategies for increasing opportunities across the PPS in preventive services.										
Task Form agreements with MCOs to work jointly to coordinate services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services										
Task Continue meetings with MCOs on an ongoing basis to discuss performance and opportunities for improvement.										
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.										
Task PPS has engaged at least 80% of their PCPs in this activity.	0	0	0	20	90	290	540	834	834	834

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Task Maintain accurate database of participating providers and ongoing outreach to ensure continued participation of at least 80% in DSRIP project										
Task Use participant survey and conduct assessment to identify primary care providers' readiness to implement a program of evidence-based cardiovascular disease management based on NCQA PCMH 2014 standards and elements, and stratify to inform implementation strategy.										

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 program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task Establish workgroup to develop evidence-based standards and policies based on the Stanford Model for chronic diseases and the PCMH Model.										
Task Create a clinical operations plan (COP) for implementation of evidence-based management of cardiovascular disease as developed in the workgroup and based on the PCMH Model. The COP will include: 1) procedures for tracking all patients engaged in this project 2)Standards and policies, including the 5 As of Tobacco Control; standardized treatment protocols for hypertension and hyperlipidemia; care coordination teams and processes; blood pressure measurement and monitoring (including population-level monitoring using registries and risk assessment); prescribing practices to increase medication adherence; and person-centered methods, such as setting self-management goals.										
Task In collaboration with the Finance Committee, create and regularly update a strategy for financing project implementation.										
Task Create and administer survey to identify practices' relevant resources, current operations, and capabilities.										

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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 Collect and analyze surveys to identify practices' need for technical assistance to implement a comprehensive cardiovascular disease management program.										
Task Submit initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation, and share final COP with all project participants.										
Task Provide assistance to participating practices as needed to implement comprehensive, evidence-based cardiovascular disease management, as outlined in COP. Assistance may include helping practices create care coordination teams that include nursing staff, pharmacists, dietitians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.										
Task Develop training strategy for participants based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices. Strategy will include resources for evaluation, ongoing training, and onboarding of new staff.										
Task Implement and train interested participants in evidence-based, comprehensive cardiovascular disease management based on the COP, and revise as needed.										
Task Develop a rapid improvement process for reviewing and revising COP.										
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	258	351	351	351	351	351	351	351	351	351
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	18	45	45	45	45	45	45	45	45	45
Task EHR meets connectivity to RHIO's HIE and SHIN-NY	12	16	16	16	16	16	16	16	16	16

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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
requirements.										
Task PPS uses alerts and secure messaging functionality.										
Task Survey providers to gain understanding of existing data-sharing capabilities with Healthix (RHIO)										
Task Establish partnership with RHIO and CCB Participants who need to receive and/or contribute patient data to serve patient needs										
Task Based on the data sharing roadmap and other information, develop and implement support processes to ensure that all PPS safety net providers are actively sharing health information, including alerts and secure messaging.										
Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.										
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.	553	834	834	834	834	834	834	834	834	834
Task Assess eligible Participant EHR use and readiness relative to Meaningful Use and PCMH 2014 Level 3 standards										
Task Develop a work plan/strategy to encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, which may vary based on provider characteristics such as providers' size, services, current status, readiness levels, etc. ; develop Participant education and engagement strategy to facilitate understanding of IT requirements										
Task Recruit or contract for EHR implementation resources as needed										
Task Implement work plan/strategy by providing technical assistance and other supports for Participant EHR implementation and progress towards Meaningful Use and PCMH standards										
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.										

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Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Review NYS DOH guidance and definitions of patient engagement for this project.										
Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.										
Task Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance										
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.										
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.										
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.										
Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).										
Task PPS has implemented an automated scheduling system to facilitate tobacco control protocols.										
Task PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.										
Task Assess capabilities of existing mechanisms for prompting completion of the 5 A's of tobacco control, including through participant survey. Identify other platforms offering automated or work driver scheduling system for facilitating tobacco control protocols, as necessary.										
Task Based on results of assessment, develop plans for using EHRs to prompt providers to complete the 5 A's of tobacco control and include in the COP.										

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Task Develop and provide training to staff on the 5 A's of tobacco control.										
Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.										
Task Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).										
Task Utilizing workgroup, develop standardized treatment protocols for hypertension and elevated cholesterol that are aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF) and incorporate into the COP.										
Task Develop tools and/or training materials, as needed, to help practices implement standardized treatment protocols for hypertension and elevated cholesterol as outlined in COP.										
Task As described earlier, provide technical assistance and/or training to participating practices as needed to implement protocols as outlined in COP.										
Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.										
Task Clinically Interoperable System is in place for all participating providers.										
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.										
Task Care coordination processes are in place.										
Task Utilizing workgroup, develop policies and procedures outlining composition and roles of a care coordination teams, including which functions and provider types, e.g., pharmacists, dieticians, care managers, and outreach workers, can be shared across coordination teams, and incorporate into the COP. COP will include guidance on how nursing staff, pharmacists, dieticians										

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and community health workers can address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.										
Task Identify technology solution to support communication between care coordination teams and deploy a Clinically Interoperable System to all relevant providers										
Task Develop tools, e.g., staffing models, as needed, to help practices implement care coordination teams as outlined in COP.										
Task Provide technical assistance, e.g., consultation on staffing models, to participating practices as needed to implement care coordination teams as outlined in COP.										
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.										
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	634	834	834	834	834	834	834	834	834	834
Task Incorporate policies for providing access to blood pressure checks without copayment or appointment, and plan for training and developing any required staff, in the COP.										
Task Meet with MCOs regarding co-payment for BP checks and DME allowance for home blood pressure monitoring as needed										
Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.										
Task PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.										
Task Incorporate plan for training staff on correct blood pressure measurement techniques in the COP.										
Task Develop tools, e.g., training materials, as needed, to help practices implement care coordination teams as outlined in COP.										
Task Disseminate training materials to participating practices to ensure blood pressure measurements are taken correctly with the correct equipment, and track training of targeted personnel as										

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applicable.										
Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.										
Task PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.										
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.										
Task PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.										
Task Incorporate in the COP guidelines for identifying patients with repeated elevated blood pressure readings (without hypertension diagnosis) and develop protocols for following up with these patients, including an automated or work driver scheduling system for targeted patients. Guidelines will include suggested registry and stratification methods.										
Task Develop tools, e.g., training materials, as needed, to help practices implement patient identification, stratification and tracking guidelines.										
Task Provide technical assistance, e.g., training on population health management, to participating practices, as needed, to implement guidelines for identifying and tracking patients with repeated elevated blood pressure readings and no hypertension diagnosis as outlined in COP.										
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.										
Task PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.										
Task Incorporate in the COP guidelines for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.										

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Task Develop tools, e.g., sample protocols, as needed, to help practices implement prescribing guidelines, such as once-daily regimens or fixed-dose combination pills, as outlined in the COP.										
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.										
Task Self-management goals are documented in the clinical record.										
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.										
Task Identify and assess capabilites of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.										
Task Develop and implement an IT strategy for tracking actively engaged patients for all projects, including training for Participants, as needed.										
Task Provide technical assistance and training to participating practices as needed to implement documentation and review of patient-driven self-management goals.										
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task PPS provides periodic training to staff on warm referral and follow-up process.										
Task Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.										
Task Survey and conduct assessment of Participants to identify capabilities of existing mechanisms for making and following up with referrals to community-based programs, to document participation and behavioral and health status changes, and to identify community-based programs. Identify other platforms offering functionality, as necessary.										

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Task Utilizing workgroup, develop policies on warm hand-offs and tracking referrals to community-based programs, including training strategy, and incorporate in the COP.										
Task Create and facilitate agreements with CBOs and incorporate processes to facilitate feedback to and from CBOs in the COP.										
Task Provide technical assistance, e.g., guidance on referral tracking, to participating practices, as needed, to implement tracking of referrals to CBOs, including documenting participation and behavioral and health status changes, as outlined in COP.										
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.										
Task PPS has developed and implemented protocols for home blood pressure monitoring.										
Task PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.										
Task PPS provides periodic training to staff on warm referral and follow-up process.										
Task Utilizing workgroup, develop policies and procedures outlining protocols for home blood pressure monitoring and incorporate in the COP.										
Task Develop tools, e.g., training materials, as needed, to help practices implement protocols for home blood pressure monitoring with follow-up support.										
Task Provide technical assistance, e.g., training, as needed, to implement home blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.										
Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.										
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.										
Task Incorporate guidelines for identifying patients with hypertension										

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and no recent visit, and protocols for following with these patients, including an automated or work driver scheduling system for targeted patients, in the COP. Guidelines include suggested registry and stratification methods.										
Task Develop tools, e.g., training materials, as needed, to help practices implement patient identification, stratification and tracking guidelines, and automated scheduling for targeted patients as outlined in the COP.										
Task Provide technical assistance, e.g., training on population health management, to participating practices, as needed, to implement guidelines for identifying, tracking and scheduling patients with hypertension as outlined in COP.										
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task Use participant survey and conduct assessment to identify capabilities of existing mechanisms for facilitating referrals to NYS Smoker's Quitline. Identify other platforms offering functionality, as necessary.										
Task Incorporate policy and procedure for facilitating referrals to NYS Smoker's Quitline, including training strategy, in the COP.										
Task Provide technical assistance, e.g., guidance on referral tracking, to participating practices, as needed, to implement referral and follow-up process.										
Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.										
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.										
Task If applicable, PPS has established linkages to health homes for targeted patient populations.										

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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 If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.										
Task Identify Health Homes and community-based programs using the Stanford Model for targeted patient populations and assess, including through survey, capabilities of existing mechanisms for performing "hot spotting", such as collecting REAL data, linking high risk populations to Health Homes, and group visits. Identify other platforms offering functionality, as necessary.										
Task Utilizing workgroup, develop and incorporate policies on identifying high risk patients, warm hand-offs to Health Homes, and group visits, including training strategy, in the COP.										
Task Develop tools, e.g., linkages to health homes or training materials, as needed, to help practices implement guidelines for identification of high-risk patients and the Stanford Model for chronic disease management as outlined in the COP.										
Task Provide technical assistance, e.g., training on population health management, to participating practices, as needed, to implement guidelines for identifying high risk patients and the Stanford Model for chronic diseases as outlined in COP.										
Milestone #18 Adopt strategies from the Million Hearts Campaign.										
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	834	834	834	834	834	834	834	834	834	834
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	126	126	126	126	126	126	126	126	126	126
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	29	29	29	29	29	29	29	29	29	29
Task Utilizing workgroup, develop policies and procedures which reflect principles and initiatives of Million Lives Campaign, such as blood pressure follow-up contacts, and incorporate in COP.										
Task Develop tools, e.g., training materials, as needed to help practices adopt strategies from the Million Hearts Campaign as										

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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
outlined in COP.										
Task Provide technical assistance, e.g., training, as needed, to help practices implement policies and procedures that include strategies from the Million Hearts Campaign.										
Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.										
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.										
Task Meet with the major Medicaid MCOs to engage them in strategies for increasing opportunities across the PPS in preventive services.										
Task Form agreements with MCOs to work jointly to coordinate services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services										
Task Continue meetings with MCOs on an ongoing basis to discuss performance and opportunities for improvement.										
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.										
Task PPS has engaged at least 80% of their PCPs in this activity.	834	834	834	834	834	834	834	834	834	834
Task Maintain accurate database of participating providers and ongoing outreach to ensure continued participation of at least 80% in DSRIP project										
Task Use participant survey and conduct assessment to identify primary care providers' readiness to implement a program of evidence-based cardiovascular disease management based on NCQA PCMH 2014 standards and elements, and stratify to inform implementation strategy.										

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	
Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	
Use EHRs or other technical platforms to track all patients engaged in this project.	
Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	
Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	
Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	
Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	
Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	
Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	
Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Document patient driven self-management goals in the medical record and review with patients at each visit.	
Follow up with referrals to community based programs to document participation and behavioral and health status changes.	
Develop and implement protocols for home blood pressure monitoring with follow up support.	
Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	
Facilitate referrals to NYS Smoker's Quitline.	
Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	
Adopt strategies from the Million Hearts Campaign.	
Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	
Engage a majority (at least 80%) of primary care providers in this project.	

Milestone 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	

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #10	Pass & Ongoing	
Milestone #11	Pass & Ongoing	
Milestone #12	Pass & Ongoing	
Milestone #13	Pass & Ongoing	
Milestone #14	Pass & Ongoing	
Milestone #15	Pass & Ongoing	
Milestone #16	Pass & Ongoing	
Milestone #17	Pass & Ongoing	
Milestone #18	Pass & Ongoing	
Milestone #19	Pass & Ongoing	
Milestone #20	Pass & Ongoing	

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

The major risks to implementing 3.d.ii and corresponding mitigation strategies that will be used are described below:

1. Patient Support of Home Visits. Patients with asthma, or parents of children with asthma, are often reluctant to allow a health care professional into their homes to assess the presence of environmental asthma triggers. According to our partner, a.i.r.nyc, approximately 50% of the patients and families they reach out to refuse an initial home visit, with higher refusal rates among undocumented populations. This refusal rate is a risk to successful project implementation because our approach relies heavily on community health workers conducting home visits to inspect for asthma triggers and to engage and educate patients and their families about the impact of environmental conditions on exacerbations that result in emergency department (ED) and inpatient admissions. To mitigate this risk, CCB must build trust with the target population which requires time, persistence, and deployment of culturally appropriate strategies that address patients' and families' needs. To tackle this challenge, a.i.r.nyc recruits community health workers from the target geographic and ethnic communities that CCB is serving and collaborates with trusted and highly regarded community-based organizations (CBOs) on community outreach and educational materials. One tactic may include co-branding the materials with CBO logos and disseminating materials through CBOs. CCB will monitor patient and process outcomes associated with home visits to ensure its approach is effective and adjust it as needed. CCB and OneCity PPS have already begun meeting to share best practices and address common environmental and social issues impacting patients across the borough.

2. New Workforce Integration. Today, in many hospitals, new workforce members, like care managers and community health workers, are not integrated with the ED or discharge planning teams, two critical points of contact between asthma patients and providers. Furthermore, care managers and community health workers may offer valuable services and establish trusted relationships with patients while they are in the hospital or ED which may lead to a home visit shortly after discharge. To mitigate this risk, CCB will undertake a communication and education plan to ensure ED and discharge planning teams are aware of the project's goals, strategies, and proven role and value of care managers and community health workers. The plan will foster acceptance of care managers and community health workers in the ED and hospital environment so they may reach asthma patients most likely to benefit from this project.

3. Care Manager and Community Health Worker Communication and Collaboration with Primary Care Providers. Often, primary care providers (PCPs) are notified of their patient's visit to an ED or hospital only after the patient is discharged and presents for a post-ED/hospital follow-up visit. PCPs may also not be aware of referrals made by the ED/inpatient team to specialty or community-based services, leading to poor coordination of services and follow-up. CCB will establish protocols to ensure appropriate communication occurs between care managers, community health workers, and patients' PCPs during a hospital stay or ED visit. Establishing this link will be critical to both creating effective care teams and ensuring patients have the best support possible to guide their recovery and maintenance.

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "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	17,000

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	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
ks614257	Rosters	33_PMDL4715_1_3_20160201123406_MMC_PPS_Patient_Engagement_Speed.xlsx	Patient Engagement Speed	02/01/2016 12:34 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	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 developed a strategy for the collaboration of community medical and social services providers to assess a patient's home and provide self-management education for the appropriate control of asthma.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify home-based asthma self-management programs across the CCB network, including education on home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task In collaboration with the Finance Committee, create and regularly update a strategy for financing project implementation.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Contract with identified participants to provide home assessment, and education on asthma self-management and environmental trigger reduction, including mitigation strategies.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Establish referral and follow-up procedures between asthma programs and Emergency Departments and primary care practices.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop training strategy for participants based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices. Strategy will include resources for evaluation, ongoing training, and onboarding of	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
new staff.									
Task Implement and train participants in identification and referral of patients with asthma to home-based self-management programs based on the COP, and revise as needed.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	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 developed intervention protocols and identified resources in the community to assist patients with needed evidence-based trigger reduction interventions.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Convene working group of key CCB Participants to participate in project planning and develop regular meeting schedule.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop a clinical operations plan (COP) that includes guidelines for identifying patients with asthma and need for self-management support and protocols for: referral to home-based self-management programs, patient tracking requirements, and use of registries and stratification methods.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Submit the initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation, and share final COP with all partners.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Facilitate referrals to Integrated Pest Management and other environmental 'trigger' mitigation services to target families.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provide assistance to participating practices as needed to implement program as outlined in COP. Assistance may include providing training on self-management education and population health management protocols for asthma or helping establish agreements with community-based asthma self-management	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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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
programs									
Milestone #3 Develop and implement evidence-based asthma management guidelines.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS incorporates evidence-based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Workgroup will review and incorporate evidence-based asthma management guidelines and protocols into the COP.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Workgroup annually evaluates and revises evidence-based guidelines, based on project outcomes and implementation feedback.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed training and comprehensive asthma self-management education, to include basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify and contract with experienced community organizations to provide evidence based asthma self-management program	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Meet with the Northern Brooklyn Asthma Action Alliance and collaborate on Brooklyn-wide asthma education efforts, including consideration of certified asthma educator (AE-C) training and credentialing for qualified healthcare staff.	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Engage participants across the CCB in developing Clinical Operations Plans that includes systems for asthma education	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
and self-management support at the providers' office / clinic as well as warm handoffs to community organizations to deliver home- based asthma education and self-management services.									
Task Using national standards and best practices on asthma self-management education and iIn collaboration with providers and CBOs, CCB will create and disseminate patient training and comprehensive asthma self-management education that includes facts about asthma, medication use, identification and avoidance of environmental triggers, self-monitoring of symptoms and asthma control, and how to use written asthma action plans	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Ensure coordinated care for asthma patients includes social services and support.	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 developed and conducted training of all providers, including social services and support.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task All practices in PPS have a Clinical Interoperability System in place for all participating providers.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has assembled a care coordination team that includes use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task As part of the COP, the workgroup will develop policies and procedures outlining composition and roles of care coordination teams, including which functions and provider types (such as which nursing staff, pharmacists, dieticians and community health workers can be shared across coordination teams).	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify technology solution to support communication between care coordination teams and deploy a Clinically Interoperable System to all relevant providers.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task	Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2

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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 and conduct training of relevant providers on coordination of care standards.									
Task Work with partners, including social services providers and schools, as needed to develop staffing needs for care coordination teams as outlined in COP, including nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's family.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task The COP includes protocols for asthma patient tracking and root cause analysis during care transitions (e.g., ED and inpatient visits), and process for sharing root cause analysis with patient's family.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Work with participating partners as needed to develop staffing needs, including referral agreements with asthma self-management programs and training, to ensure post-discharge follow-up services, such as root cause analysis to avoid future events.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	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 established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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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 Identify and meet with the major Medicaid MCOs and Health Homes providers on regular basis to engage them in strategies for increasing opportunities across the PPS in preventive services and to develop coordination/ communication strategy.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Form agreements with MCOs to work jointly to coordinate services for patients with asthma health issues and establish written agreements with MCOs, health home care managers, PCPs and specialty providers that address the coverage of these patients	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 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		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Review NYS DOH guidance and definitions of patient engagement for this project.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

Maimonides Medical Center (PPS ID:33)

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 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.										
Task PPS has developed a strategy for the collaboration of community medical and social services providers to assess a patient's home and provide self-management education for the appropriate control of asthma.										
Task Identify home-based asthma self-management programs across the CCB network, including education on home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.										
Task In collaboration with the Finance Committee, create and regularly update a strategy for financing project implementation.										
Task Contract with identified participants to provide home assessment, and education on asthma self-management and environmental trigger reduction, including mitigation strategies.										
Task Establish referral and follow-up procedures between asthma programs and Emergency Departments and primary care practices.										
Task Develop training strategy for participants based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices. Strategy will include resources for evaluation, ongoing training, and onboarding of new staff.										
Task Implement and train participants in identification and referral of patients with asthma to home-based self-management programs based on the COP, and revise as needed.										
Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.										
Task PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence-based trigger reduction interventions.										

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

DSRIP Implementation Plan Project

Maimonides Medical Center (PPS ID:33)

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 Convene working group of key CCB Participants to participate in project planning and develop regular meeting schedule.										
Task Develop a clinical operations plan (COP) that includes guidelines for identifying patients with asthma and need for self-management support and protocols for: referral to home-based self-management programs, patient tracking requirements, and use of registries and stratification methods.										
Task Submit the initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation, and share final COP with all partners.										
Task Facilitate referrals to Integrated Pest Management and other environmental 'trigger' mitigation services to target families.										
Task Provide assistance to participating practices as needed to implement program as outlined in COP. Assistance may include providing training on self-management education and population health management protocols for asthma or helping establish agreements with community-based asthma self-management programs										
Milestone #3 Develop and implement evidence-based asthma management guidelines.										
Task PPS incorporates evidence-based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management.										
Task Workgroup will review and incorporate evidence-based asthma management guidelines and protocols into the COP.										
Task Workgroup annually evaluates and revises evidence-based guidelines, based on project outcomes and implementation feedback.										
Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.										

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Maimonides Medical Center (PPS ID:33)

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 developed training and comprehensive asthma self-management education, to include basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.										
Task Identify and contract with experienced community organizations to provide evidence based asthma self-management program										
Task Meet with the Northern Brooklyn Asthma Action Alliance and collaborate on Brooklyn-wide asthma education efforts, including consideration of certified asthma educator (AE-C) training and credentialing for qualified healthcare staff.										
Task Engage participants across the CCB in developing Clinical Operations Plans that includes systems for asthma education and self-management support at the providers' office / clinic as well as warm handoffs to community organizations to deliver home- based asthma education and self-management services.										
Task Using national standards and best practices on asthma self-management education and iIn collaboration with providers and CBOs, CCB will create and disseminate patient training and comprehensive asthma self-management education that includes facts about asthma, medication use, identification and avoidance of environmental triggers, self-monitoring of symptoms and asthma control, and how to use written asthma action plans										
Milestone #5 Ensure coordinated care for asthma patients includes social services and support.										
Task PPS has developed and conducted training of all providers, including social services and support.										
Task All practices in PPS have a Clinical Interoperability System in place for all participating providers.										
Task PPS has assembled a care coordination team that includes use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.										

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DSRIP Implementation Plan Project

Maimonides Medical Center (PPS ID:33)

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 As part of the COP, the workgroup will develop policies and procedures outlining composition and roles of care coordination teams, including which functions and provider types (such as which nursing staff, pharmacists, dieticians and community health workers can be shared across coordination teams).										
Task Identify technology solution to support communication between care coordination teams and deploy a Clinically Interoperable System to all relevant providers.										
Task Develop and conduct training of relevant providers on coordination of care standards.										
Task Work with partners, including social services providers and schools, as needed to develop staffing needs for care coordination teams as outlined in COP, including nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.										
Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.										
Task Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's family.										
Task The COP includes protocols for asthma patient tracking and root cause analysis during care transitions (e.g., ED and inpatient visits), and process for sharing root cause analysis with patient's family.										
Task Work with participating partners as needed to develop staffing needs, including referral agreements with asthma self-management programs and training, to ensure post-discharge follow-up services, such as root cause analysis to avoid future events.										
Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.										
Task PPS has established agreements with MCOs that address the										

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Maimonides Medical Center (PPS ID:33)

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
coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers.										
Task Identify and meet with the major Medicaid MCOs and Health Homes providers on regular basis to engage them in strategies for increasing opportunities across the PPS in preventive services and to develop coordination/ communication strategy.										
Task Form agreements with MCOs to work jointly to coordinate services for patients with asthma health issues and establish written agreements with MCOs, health home care managers, PCPs and specialty providers that address the coverage of these patients										
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 Review NYS DOH guidance and definitions of patient engagement for this project.										
Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary										
Task Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance										
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.										
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.										
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.										

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Maimonides Medical Center (PPS ID:33)

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 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.										
Task PPS has developed a strategy for the collaboration of community medical and social services providers to assess a patient's home and provide self-management education for the appropriate control of asthma.										
Task Identify home-based asthma self-management programs across the CCB network, including education on home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.										
Task In collaboration with the Finance Committee, create and regularly update a strategy for financing project implementation.										
Task Contract with identified participants to provide home assessment, and education on asthma self-management and environmental trigger reduction, including mitigation strategies.										
Task Establish referral and follow-up procedures between asthma programs and Emergency Departments and primary care practices.										
Task Develop training strategy for participants based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices. Strategy will include resources for evaluation, ongoing training, and onboarding of new staff.										
Task Implement and train participants in identification and referral of patients with asthma to home-based self-management programs based on the COP, and revise as needed.										
Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.										
Task PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence-based trigger reduction interventions.										

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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 Convene working group of key CCB Participants to participate in project planning and develop regular meeting schedule.										
Task Develop a clinical operations plan (COP) that includes guidelines for identifying patients with asthma and need for self-management support and protocols for: referral to home-based self-management programs, patient tracking requirements, and use of registries and stratification methods.										
Task Submit the initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation, and share final COP with all partners.										
Task Facilitate referrals to Integrated Pest Management and other environmental 'trigger' mitigation services to target families.										
Task Provide assistance to participating practices as needed to implement program as outlined in COP. Assistance may include providing training on self-management education and population health management protocols for asthma or helping establish agreements with community-based asthma self-management programs										
Milestone #3 Develop and implement evidence-based asthma management guidelines.										
Task PPS incorporates evidence-based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management.										
Task Workgroup will review and incorporate evidence-based asthma management guidelines and protocols into the COP.										
Task Workgroup annually evaluates and revises evidence-based guidelines, based on project outcomes and implementation feedback.										
Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.										

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Maimonides Medical Center (PPS ID:33)

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 has developed training and comprehensive asthma self-management education, to include basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.										
Task Identify and contract with experienced community organizations to provide evidence based asthma self-management program										
Task Meet with the Northern Brooklyn Asthma Action Alliance and collaborate on Brooklyn-wide asthma education efforts, including consideration of certified asthma educator (AE-C) training and credentialing for qualified healthcare staff.										
Task Engage participants across the CCB in developing Clinical Operations Plans that includes systems for asthma education and self-management support at the providers' office / clinic as well as warm handoffs to community organizations to deliver home- based asthma education and self-management services.										
Task Using national standards and best practices on asthma self-management education and iIn collaboration with providers and CBOs, CCB will create and disseminate patient training and comprehensive asthma self-management education that includes facts about asthma, medication use, identification and avoidance of environmental triggers, self-monitoring of symptoms and asthma control, and how to use written asthma action plans										
Milestone #5 Ensure coordinated care for asthma patients includes social services and support.										
Task PPS has developed and conducted training of all providers, including social services and support.										
Task All practices in PPS have a Clinical Interoperability System in place for all participating providers.										
Task PPS has assembled a care coordination team that includes use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.										

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Maimonides Medical Center (PPS ID:33)

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 As part of the COP, the workgroup will develop policies and procedures outlining composition and roles of care coordination teams, including which functions and provider types (such as which nursing staff, pharmacists, dieticians and community health workers can be shared across coordination teams).										
Task Identify technology solution to support communication between care coordination teams and deploy a Clinically Interoperable System to all relevant providers.										
Task Develop and conduct training of relevant providers on coordination of care standards.										
Task Work with partners, including social services providers and schools, as needed to develop staffing needs for care coordination teams as outlined in COP, including nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.										
Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.										
Task Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's family.										
Task The COP includes protocols for asthma patient tracking and root cause analysis during care transitions (e.g., ED and inpatient visits), and process for sharing root cause analysis with patient's family.										
Task Work with participating partners as needed to develop staffing needs, including referral agreements with asthma self-management programs and training, to ensure post-discharge follow-up services, such as root cause analysis to avoid future events.										
Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.										
Task PPS has established agreements with MCOs that address the										

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Maimonides Medical Center (PPS ID:33)

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
coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers.										
Task Identify and meet with the major Medicaid MCOs and Health Homes providers on regular basis to engage them in strategies for increasing opportunities across the PPS in preventive services and to develop coordination/ communication strategy.										
Task Form agreements with MCOs to work jointly to coordinate services for patients with asthma health issues and establish written agreements with MCOs, health home care managers, PCPs and specialty providers that address the coverage of these patients										
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 Review NYS DOH guidance and definitions of patient engagement for this project.										
Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary										
Task Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance										
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.										
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.										
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.										

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Maimonides Medical Center (PPS ID:33)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	
Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	
Develop and implement evidence-based asthma management guidelines.	
Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	
Ensure coordinated care for asthma patients includes social services and support.	
Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	
Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	
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	

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
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	

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Maimonides Medical Center (PPS ID:33)

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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DSRIP Implementation Plan Project

Maimonides Medical Center (PPS ID:33)

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

Instructions :

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Maimonides Medical Center (PPS ID:33)

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

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

Instructions :

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

The major risks to implementing 3.g.i and corresponding mitigation strategies that will be used are described below:

1. Palliative Care in the Primary Care Setting. Many primary care providers (PCPs) do not recognize when palliative care is appropriate or are not comfortable addressing patients and family members about palliative care services since very few PCPs or their staffs have been adequately and appropriately trained on palliative care. To mitigate these risks, CCB will develop and offer training to PCPs and other care team members with the ultimate goal of integrating palliative into primary care well enough so that palliative care is no longer synonymous with end-of-life care. CCB has partnered with key Participants including palliative care specialists, PCPs and social services organizations and will develop a standard training curriculum for members of the primary care team. This training will prepare care team members (PCPs, care managers, nursing personnel) to discuss palliative care and end of life concerns, prepare a palliative care plan and link caregivers and patients to the medical and social support services they need to relieve pain and remain in the community setting for as long as possible. CCB will also support referrals to participating Health Homes (Brooklyn Health Home and Coordinated Behavioral Care) that have care managers who can further support coordination activities.

2. Patient Comprehension of Palliative Care. The second risk to this project is patients' poor understanding of palliative care. Often, patients associate palliative with end-of-life care, which can lead to fear, anxiety, and poor patient engagement. To mitigate this risk, CCB has already initiated discussions with community based organizations (CBOs) on how best to provide emotional support, education, and training to patients and their family caregivers. CCB plans to develop a resource center where providers and staff can direct caregivers for nonmedical services related to palliative care needs. These efforts, along with CCB plans to integrate palliative care into the primary care setting will further normalize activities around palliative care.

Cultural competency training for staff will also play a large role in patient engagement. Receptivity to receiving palliative care services may vary by many factors, including ethnicity, religion and cultural characteristics of the population, which will uniquely impact their interactions with providers. To ensure that the workforce is culturally competent, recruitment will draw from the communities to be served and cultural competency training will be provided. CCB also plans to engage with CBOs working on the social determinants of health and with religious organizations to help understand and appropriately address cultural factors that influence how patients receive this care.

3. Communication Gaps. Patients who require palliative care are vulnerable and often transition from their homes to hospitals and skilled nursing facilities, then back to their homes, sometimes with a repeating pattern. Communication across care teams in these various settings have been known to be challenging. There is no existing protocol on how and when providers engage and communicate with other facilities regarding patients' palliative care needs. CCB recognizes that there is an acute need for clear and comprehensive communication between hospitals, nursing homes, and primary care providers, so that patients receive the best possible care, and the care they desire. CCB will work with these

stakeholders to develop standards which will leverage the Dashboard to establish and maintain relationships between providers.

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "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	20,000

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	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
ks614257	Rosters	33_PMDL5115_1_3_20160201124137_MMC_PPS_Patient_Engagement_Speed.xlsx	Patient Engagement Speed	02/01/2016 12:42 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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Maimonides Medical Center (PPS ID:33)

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	04/01/2015	03/31/2018	04/01/2015	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	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Convene workgroup of CCB Participants to develop palliative care clinical guidelines including services and eligibility.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Create and collect surveys to identify practices that will participate in Palliative care project and will meet PCMH NCQA recognition requirement, as well as identify practices' need for technical assistance to meet NCQA PCMH Recognition.	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Create a clinical operations plan (COP) for implementing palliative care procedures at PCMHs.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task In collaboration with the Finance Committee, create and regularly update a strategy for financing project implementation.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Submit initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation, and share final COP with all partners.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task As discussed in project 2ai, develop and provide technical assistance to participating sites as needed to meet timeline of NCQA PCMH 2014 Recognition and receive agreement from participating PCPs to become at least Level 1 2014 NCQA PCMH by the end of DY3.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Develop training strategy for participants in palliative care integration, based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices. Strategy will include resources for evaluation, ongoing training, and onboarding of new staff.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Implement and train participants in palliative care integration in the PCMH based on the COP and feedback from Participants.	Project		Not Started	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify community and provider resources including Hospice (using surveys, feedback from Participants, etc.) to bring the palliative care supports and services into the PCP practice.	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Facilitate agreements between the PPS and community and provider resources (including Hospice).	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	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	07/01/2015	03/31/2017	07/01/2015	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	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

Maimonides Medical Center (PPS ID:33)

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
palliative care skills.									
Task Incorporate clinical guidelines, including services and eligibility, and implementation of the DOH-5003 Medical Orders for Life Sustaining Treatment form (MOLST) form where appropriate into the COP, described above.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task As described above, develop and implement training that incorporates clinical guidelines and role-appropriate competence in palliative care skills.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	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	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Staff has received appropriate palliative care skills training, including training on PPS care protocols.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task As described above, develop and implement training that incorporates palliative care skills and protocols (consistent with the COP).	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	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	07/01/2015	03/31/2018	07/01/2015	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		Not Started	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Identify and engage the major Medicaid MCOs in project planning.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Discuss options for covering palliative care supports and services with Medicaid MCOs and establish agreements.	Project		Not Started	03/31/2016	03/31/2018	03/31/2016	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		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Review NYS DOH guidance and definitions of patient engagement for this project.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	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 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	56	79	171	259	374	435	490
Task Convene workgroup of CCB Participants to develop palliative care clinical guidelines including services and eligibility.										

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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 Create and collect surveys to identify practices that will participate in Palliative care project and will meet PCMH NCQA recognition requirement, as well as identify practices' need for technical assistance to meet NCQA PCMH Recognition.										
Task Create a clinical operations plan (COP) for implementing palliative care procedures at PCMHs.										
Task In collaboration with the Finance Committee, create and regularly update a strategy for financing project implementation.										
Task Submit initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation, and share final COP with all partners.										
Task As discussed in project 2ai, develop and provide technical assistance to participating sites as needed to meet timeline of NCQA PCMH 2014 Recognition and receive agreement from participating PCPs to become at least Level 1 2014 NCQA PCMH by the end of DY3.										
Task Develop training strategy for participants in palliative care integration, based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices. Strategy will include resources for evaluation, ongoing training, and onboarding of new staff.										
Task Implement and train participants in palliative care integration in the PCMH based on the COP and feedback from Participants.										
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 Identify community and provider resources including Hospice (using surveys, feedback from Participants, etc.) to bring the palliative care supports and services into the PCP practice.										
Task Facilitate agreements between the PPS and community and										

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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
provider resources (including Hospice).										
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 Incorporate clinical guidelines, including services and eligibility, and implementation of the DOH-5003 Medical Orders for Life Sustaining Treatment form (MOLST) form where appropriate into the COP, described above.										
Task As described above, develop and implement training that incorporates clinical guidelines and role-appropriate competence in palliative care skills.										
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 As described above, develop and implement training that incorporates palliative care skills and protocols (consistent with the COP).										
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 Identify and engage the major Medicaid MCOs in project planning.										
Task Discuss options for covering palliative care supports and services with Medicaid MCOs and establish agreements.										

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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 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 Review NYS DOH guidance and definitions of patient engagement for this project.										
Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.										
Task Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance										
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.										
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.										
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.										

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.	553	834	834	834	834	834	834	834	834	834
Task Convene workgroup of CCB Participants to develop palliative										

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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
care clinical guidelines including services and eligibility.										
Task Create and collect surveys to identify practices that will participate in Palliative care project and will meet PCMH NCQA recognition requirement, as well as identify practices' need for technical assistance to meet NCQA PCMH Recognition.										
Task Create a clinical operations plan (COP) for implementing palliative care procedures at PCMHs.										
Task In collaboration with the Finance Committee, create and regularly update a strategy for financing project implementation.										
Task Submit initial COP to the Care Delivery and Quality (CDQ) Committee for review and approval, recognizing that the COP will be modified over time based on findings of rapid cycle evaluation, and share final COP with all partners.										
Task As discussed in project 2ai, develop and provide technical assistance to participating sites as needed to meet timeline of NCQA PCMH 2014 Recognition and receive agreement from participating PCPs to become at least Level 1 2014 NCQA PCMH by the end of DY3.										
Task Develop training strategy for participants in palliative care integration, based on the COP, and recruit or contract staff to provide training and technical assistance to participating practices. Strategy will include resources for evaluation, ongoing training, and onboarding of new staff.										
Task Implement and train participants in palliative care integration in the PCMH based on the COP and feedback from Participants.										
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 Identify community and provider resources including Hospice (using surveys, feedback from Participants, etc.) to bring the palliative care supports and services into the PCP practice.										

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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 Facilitate agreements between the PPS and community and provider resources (including Hospice).										
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 Incorporate clinical guidelines, including services and eligibility, and implementation of the DOH-5003 Medical Orders for Life Sustaining Treatment form (MOLST) form where appropriate into the COP, described above.										
Task As described above, develop and implement training that incorporates clinical guidelines and role-appropriate competence in palliative care skills.										
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 As described above, develop and implement training that incorporates palliative care skills and protocols (consistent with the COP).										
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 Identify and engage the major Medicaid MCOs in project planning.										
Task Discuss options for covering palliative care supports and services with Medicaid MCOs and establish agreements.										

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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 #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 Review NYS DOH guidance and definitions of patient engagement for this project.										
Task Using CCB Participant Survey, provider engagement meetings, and project planning and implementation discussions, identify and assess capabilities of existing mechanisms for tracking actively engaged patients through the project and identify additional tracking platforms, as necessary.										
Task Identify any gaps between existing tracking capabilities and those required per the NYS DOH guidance										
Task Work with Participants and IT vendors using phased strategy to remedy identified gaps in tracking and reporting capabilities.										
Task Develop CCB policies and procedures on reporting patient engagement in the Clinical Operations Plans.										
Task Develop, modify, and deploy centralized mechanisms for tracking patient engagement and provide ongoing guidance and training for Participants as needed.										

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.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	
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	

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

1. Silos between Substance Abuse and Mental Health Services. One risk that CCB confronts is that programs may not be able to overcome the existing silos between substance abuse and mental health services, and hence will primarily focus on mental health needs, while overlooking substance use needs. The CNA identified pronounced silos in care, despite the co-morbidities of MHSA conditions. Further, various evidence-based trainings focus exclusively on mental health concerns. To mitigate this risk, CCB and its MHSA Collaborative Workgroup PPS partners – Bronx Partners for Healthy Communities, OneCity Health, and Bronx Health Access – have agreed to build substance use trainings and materials that address prevention of overdose and unprotected sex and other risky behaviors into core programming. Additionally, the Workgroup includes substance use and mental health experts who will continue to ensure that the project addresses both needs in an integrated manner, and also addresses MHSA needs holistically, together with other health needs.

2. Partnership with the Department of Education. Another risk is that PPS partners will not be able to forge a constructive partnership with the Department of Education (DOE) in order to successfully pursue the school-based interventions. The PPSs have identified strong synergies between this project and DOE programming, such as DOE's investments in mental health infrastructure in approximately 100 community/renewal schools City-wide, but they will need to actively engage DOE to succeed in DSRIP-related transformations. The Workgroup has already been addressing this risk by engaging the Director of School Mental Health Services with the City's Office of School Health and individuals with the New York City Department of Health and Mental Hygiene (DOHMH) as advisory members of the Workgroup. The PPS partners will continue to engage both DOE and DOHMH in developing their approach to programming and staffing.

3. Measurement and Sustainability. Additional risks are that PPSs will lack the robust data set required to measure progress against goals and serve as an evidence base to demonstrate the cost-effectiveness of the activities and, relatedly, that MHSA activities will not be sustainable beyond the demonstration period. The PPSs will address these risks in several ways. First, the intervention aims to develop long-standing, sustainable school-based infrastructure to address MHSA needs. The project design utilizes cost-effective staffing plans and trainings to prepare non-MD school-based staff to serve as effective coaches. Further, the PPSs have committed to working together to build an evidence base to document results and cost-effectiveness. The PPSs have identified certain performance metrics, such as reductions in schools suspensions and 911 calls that they will track during the intervention. They will engage MCOs, SDOH, and DOE in discussions regarding the program's cost-effectiveness and how to finance DSRIP staff and their related school-based activities like "coaching" and referrals under a value based payment system post-DSRIP.

4. Engagement of School Staff. Another possible risk is that school-based staff will be disengaged, based on their own biases or misunderstanding of MHSA-related disease, or fears of being held responsible for individual student outcomes related to MHSA issues. To mitigate this risk, PPSs will build partnerships with teachers and school staff at the ground level. Staff trainings will address issues like bias and stigma and will educate staff about the nature of MHSA conditions. The PPSs will also train school-based staff on when to refer students with potentially more serious

problems to available referral channels and help to ensure warm handoffs to appropriate community-based MHSA services.

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Organize and convene citywide MHSA Workgroup meetings	Completed	Organize and convene citywide MHSA Workgroup meetings	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Form MHSA Work Group composed of representatives of the four collaborating PPSs, including community-based representatives	Completed	Form MHSA Work Group composed of representatives of the four collaborating PPSs, including community-based representatives	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify PPS subject matter experts to join Work Group	Completed	Identify PPS subject matter experts to join Work Group	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Invite representatives from DOE-affiliated Office of School Health and DOHMH to join Workgroup as advisory members	Completed	Invite representatives from DOE-affiliated Office of School Health and DOHMH to join Workgroup as advisory members	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Convene Citywide MHSA Workgroup meetings under the standing structure	Completed	Convene Citywide MHSA Workgroup meetings under the standing structure	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Milestone Establish formalized structure for cross-PPS collaboration on governance and implementation of MHSA project	Completed	Establish formalized structure for cross-PPS collaboration on governance and implementation of MHSA project	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Confirm commitment of four collaborating PPSs to partner in City-wide implementation of MHSA Project	Completed	Confirm commitment of four collaborating PPSs to partner in City-wide implementation of MHSA Project	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Develop governance structure and process among collaborating PPSs to oversee the implementation and ongoing operation of the MHSA project, and document functions, roles,	Completed	Develop governance structure and process among collaborating PPSs to oversee the implementation and ongoing operation of the MHSA project, and document functions, roles, and responsibilities for parties including Workgroup	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
and responsibilities for parties including Workgroup								
Milestone Review existing programs and CBOs providing MHSA services, as well as adaptations of CC based model.	In Progress	Review existing programs and CBOs providing MHSA services, as well as adaptations of CC based model.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Conduct baseline analysis of existing programs and CBOs providing MHSA services to adolescents in schools	Completed	Conduct baseline analysis of existing programs and CBOs providing MHSA services to adolescents in schools	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Review evidence-based adaptations of Collaborative Care (CC) model that have targeted adolescents	Completed	Review evidence-based adaptations of Collaborative Care (CC) model that have targeted adolescents	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Incorporate findings into MHSA project concept document	In Progress	Incorporate findings into MHSA project concept document	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone Develop detailed MHSA project operational plan for Collaborative Care Adaptation in schools	In Progress	Develop detailed MHSA project operational plan for Collaborative Care Adaptation in schools	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Engage MHSA Workgroup to develop concept paper describing the approach to strengthening the MHSA infrastructure in schools	Completed	Engage MHSA Workgroup to develop concept paper describing the approach to strengthening the MHSA infrastructure in schools	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Design/implement process to select well qualified Lead agency to manage detailed program planning and implementation of the MHSA initiative	Completed	Design/implement process to select well qualified Lead agency to manage detailed program planning and implementation of the MHSA initiative	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Contract with selected Lead Agency to manage all aspects of the MHSA project including developing operational plan, selection of community mental/behavioral health agencies, selection of target schools,	Completed	Contract with selected Lead Agency to manage all aspects of the MHSA project including developing operational plan, selection of community mental/behavioral health agencies, selection of target schools, project staffing structure, and training curriculum	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
project staffing structure, and training curriculum								
Task Develop draft operational plan for MHSA Workgroup review that incorporates development of culturally and linguistically sensitive MEB health promotion and prevention resources, data-collection and evaluation, staffing, training, and referral planning, as needed	In Progress	Develop draft operational plan for MHSA Workgroup review that incorporates development of culturally and linguistically sensitive MEB health promotion and prevention resources, data-collection and evaluation, staffing, training, and referral planning, as needed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize draft operational plan and budget; share with MHSA Collaborative PPS Governance body for approval	Not Started	Finalize draft operational plan and budget; share with MHSA Collaborative PPS Governance body for approval	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone Implement Collaborative Care (CC) Adaptation in schools	Not Started	Implement Collaborative Care (CC) Adaptation in schools	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Design and implement process to select and contract with community mental/behavioral agencies to implement programs in the schools	Not Started	Design and implement process to select and contract with community mental/behavioral agencies to implement programs in the schools	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Solicit DOE input on school selection methodology	Not Started	Solicit DOE input on school selection methodology	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Identify target schools for implementation of CC adaptation	Not Started	Identify target schools for implementation of CC adaptation	04/01/2016	06/30/2017	04/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task Develop schedule for MHSA Project activities, including activities preparatory to launch of CC adaptation in schools such as contracting, staff recruitment and deployment, training	Not Started	Develop schedule for MHSA Project activities, including activities preparatory to launch of CC adaptation in schools such as contracting, staff recruitment and deployment, training	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Launch implementation of MHSA Project CC adaptation in schools	Not Started	Launch implementation of MHSA Project CC adaptation in schools	10/01/2016	09/30/2017	10/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone	Not Started	Design young adult-interfacing MHSA programs (for those ages 21-	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Design young adult-interfacing MHSA programs (for those ages 21-25 yrs)		25 yrs)						
Task Identify target young adult groups, potentially including community college students	Not Started	Identify target young adult groups, potentially including community college students	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Refine MHSA intervention to integrate programming to reach these young adult groups, including by developing culturally and linguistically sensitive MEB health promotion and prevention resources, data-collection and evaluation plan, and staffing and training plans	Not Started	Refine MHSA intervention to integrate programming to reach these young adult groups, including by developing culturally and linguistically sensitive MEB health promotion and prevention resources, data-collection and evaluation plan, and staffing and training plans	07/01/2017	03/31/2018	07/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task Launch young adult programs	Not Started	Launch young adult programs	01/01/2018	03/31/2018	01/01/2018	03/31/2018	03/31/2018	DY3 Q4

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Organize and convene citywide MHSA Workgroup meetings	0294	Meeting Materials	33_PMDL5604_1_3_20160315153212_MHSA_Joint_Planning_Meeting_Notes_11.10.2014.pdf	11/10/2014 citywide MHSA work group joint planning meeting notes	03/15/2016 03:32 PM
	0294	Meeting Materials	33_PMDL5604_1_3_20160315153046_MHSA_Joint_Planning_Meeting_Notes_01.12.2015.pdf	1/12/2015 citywide MHSA work group joint planning meeting notes	03/15/2016 03:30 PM
	0294	Templates	33_PMDL5604_1_3_20160315153010_CCB_MHSA_Meeting_Schedule_DY1_Q3.xlsx	CCB MHSA Meeting Schedule Template	03/15/2016 03:30 PM
Establish formalized structure for cross-PPS collaboration on governance and implementation of MHSA project	0294	Other	33_PMDL5604_1_3_20160315173205_DSRIP_MHSA_Contracting_and_Governance_Structure.pdf	DSRIP MHSA Contracting and Governance Structure	03/15/2016 05:32 PM
	0294	Contracts and Agreements	33_PMDL5604_1_3_20160315170049_DSRIP_MHSA_Signed_Collaboration_Agreement.pdf	DSRIP MHSA signed collaboration agreement	03/15/2016 05:00 PM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Organize and convene citywide MHSA Workgroup meetings	All four Performing Provider Systems ("PPSs") pursuing the MHSA Project in New York City – specifically, Bronx Partners for Healthy Communities ("BPHC"), Community Care of Brooklyn ("CCB"), OneCity Health, and Bronx Health Access ("Bronx Access") – have identified representatives to participate in a Workgroup that is helping to guide project concept development and implementation. Since the beginning of 2015, representatives from the Office of School Health and

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
	DOHMH have participated in Workgroup meetings as advisory members, and the Workgroup has convened regularly to jointly develop a project concept document. As of 7/30/15, MHSA Workgroup meetings have been replaced with Selection Committee meetings to identify a Lead Agency to implement and manage the project. Once the Lead Agency has been selected and is in place, the full Workgroup meetings will resume. The attached Meeting Schedule Template lists the Workgroup meetings that have taken place since this Workgroup was developed. Final meeting minutes for the first two Workgroup meetings are also included.
Establish formalized structure for cross-PPS collaboration on governance and implementation of MHSA project	BPHC, CCB, and OneCity jointly developed their MHSA project applications, committing to convening a cross-PPS collaborative Workgroup of diverse providers to identify and promote programs to strengthen the infrastructure for MHSA prevention, screening, and early intervention. BPHC, CCB, and OneCity also entered into a joint Charter, under which they agreed to continue collaborating on the MHSA project during implementation. Since then, the group has expanded to include Bronx Access and has established a governance and advisory structure consisting of a governing body with representatives from these four PPSs, as well as a workgroup of advisory members that includes DOHMH and OSH representatives. Progress against this milestone has been included in regular reports to CCB's Executive Committee. The attached DSRIP MHSA Contracting and Governance Structure slide deck provides an outline of the formalized structure for cross-PPS collaboration. Due to the involvement of multiple parties, the collaboration agreement, finalized in DY1 Q3, was not fully executed by all parties until DY1 Q4 – the signed collaboration agreement is also included as an attachment.
Review existing programs and CBOs providing MHSA services, as well as adaptations of CC based model.	
Develop detailed MHSA project operational plan for Collaborative Care Adaptation in schools	
Implement Collaborative Care (CC) Adaptation in schools	
Design young adult-interfacing MHSA programs (for those ages 21-25 yrs)	

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	As part of remediation, the PPS provided evidence that it had a formalized structure for cross PPS collaboration that was finalized after the end of DY1Q3. Because they submitted this evidence as part of remediation of the DY1Q3 report, the IA considers milestone 2 to be Pass and Complete.

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

Instructions :

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

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

Instructions :

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

1. The most significant risk is the complexity of HIV and the need to focus simultaneously on both medical and social needs of patients given the history of stigma, discrimination and neglect related to the populations most impacted by the HIV epidemic and complicated by commonly co-occurring risk factors among this population (e.g., poverty, unmet behavioral health needs). To meet DSRIP goals, we will work against negative social determinants to create environments where patients receive the care needed to protect their health.
2. Real or perceived stigma may prevent individuals from accepting offers of HIV testing or PrEP, or from disclosing HIV status or remaining in treatment. While our plan to implement universal, rapid HIV testing in hospital emergency departments, urgent care centers and primary care practices may help to normalize this preventive care screening, we will also improve service delivery to support a more welcoming and understanding environment. For example, we intend to emphasize working with community partners such as Housing Works, CAMBA, Village Centers for Care, AmidaCare, GMHC, God's Love We Deliver, Planned Parenthood, and religious organizations that provide HIV care support and outreach related to specific at-risk populations (e.g., transgender women) or related to specific needs (e.g., homelessness). Working with the city-wide PPS Collaborative on HIV and the NYC DOHMH, we will undertake a multi-layered cultural competency and educational campaign. We will also integrate peers into our work.
Patients may lack general knowledge about HIV and AIDS, as well, for example, risk factors for HIV, availability of PrEP and PEP, or why testing is important. Even among those living with HIV or AIDS, patients may be unaware of the risks associated with poor HAART adherence. CCB will implement interventions across our PPS partners that focus on consistent messaging around the importance of early identification and referral, and retention in care.
3. Another risk is that HIV providers within the PPS may have disparate models and approaches to care and fail to adequately coordinate with one another or that frontline providers may be unaware of the guidelines for universal HIV screening and PrEP and PEP. To mitigate this risk, CCB has committed to close collaboration with HHC and intends to learn from HHC's strong existing models of providing integrated and coordinated HIV services. CCB will also enhance provider coordination through its Dashboard, an IT infrastructure that permits seamless communication across partners for care planning and coordination. We will also incorporate training on CDC guidelines into our provider education strategy.
Another related risk is that PPSs will act in siloes, especially because PPSs must develop processes and metrics to sustain provider engagement and measure progress in lieu of mandated speed and scale commitments. To mitigate this risk, members of the Collaborative have identified areas for collaboration, including patient education, social marketing efforts, peer training and recruitment, and provider cultural competency education. Our collaboration will leverage lessons learned from participation in the NYS Quality of Care Committee, the National Quality Center, HRSA's NYC Ryan White Part A Planning Council, the CDC HIV Prevention Planning Group, and CBO networks. We will use the Collaborative to ensure that we share best practices, make progress toward alignment of common language and approaches whenever possible to promote a consistent standard for HIV providers across the City. By expanding our coordination with community partners, including peers, we will mitigate the challenges posed by the complex network of obstacles that put individuals at high risk for HIV acquisition and preclude efforts to engage them and have them retained in HIV care.

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Convening a PPS HIV Learning Collaborative	In Progress	Convening a PPS HIV Learning Collaborative	07/01/2015	03/31/2020	07/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Confirm PPS participation in HIV Collaborative throughout DSRIP implementation.	Completed	Confirm PPS participation in HIV Collaborative throughout DSRIP implementation.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Contract with DOHMH to convene and support the HIV Collaborative.	Completed	Contract with DOHMH to convene and support the HIV Collaborative.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop agenda for Learning Collaborative meetings and hold meetings.	Not Started	Develop agenda for Learning Collaborative meetings and hold meetings.	01/01/2016	03/31/2020	01/01/2016	03/31/2020	03/31/2020	DY5 Q4
Milestone Establishing a work plan and timeline for project implementation.	In Progress	Establishing a work plan and timeline for project implementation.	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Develop work plan and timeline for projects being implemented jointly across multiple PPSs.	In Progress	Develop work plan and timeline for projects being implemented jointly across multiple PPSs.	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Develop work plan and timeline for additional projects being implemented by CCB.	In Progress	Develop work plan and timeline for additional projects being implemented by CCB.	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Validate work plans and timelines with PPS governance bodies and relevant stakeholders, as needed.	In Progress	Validate work plans and timelines with PPS governance bodies and relevant stakeholders, as needed.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone Developing agreed upon milestones for project implementation.	In Progress	Developing agreed upon milestones for project implementation.	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Develop milestones for projects being	In Progress	Develop milestones for projects being implemented jointly across multiple PPSs.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
implemented jointly across multiple PPSs.								
Task Develop milestones for additional projects being implemented by CCB.	In Progress	Develop milestones for additional projects being implemented by CCB.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Validate milestones with PPS governance bodies and relevant stakeholders, as needed.	Not Started	Validate milestones with PPS governance bodies and relevant stakeholders, as needed.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone Agree on project commonalities and shared resources.	In Progress	Agree on project commonalities and shared resources.	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Determine a structure for sharing resources needed for implementation.	In Progress	Determine a structure for sharing resources needed for implementation.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Validate agreement with PPS governance bodies and relevant stakeholders, as needed.	Not Started	Validate agreement with PPS governance bodies and relevant stakeholders, as needed.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone Agree on a data sharing system to address reporting and implementation needs.	Not Started	Agree on a data sharing system to address reporting and implementation needs.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Determine system for sharing information across PPS and validate decision with PPS governance bodies and relevant stakeholders, as needed.	Not Started	Determine system for sharing information across PPS and validate decision with PPS governance bodies and relevant stakeholders, as needed.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Contract with system developer/administrator, as needed.	Not Started	Contract with system developer/administrator, as needed.	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Convening a PPS HIV Learning Collaborative	
Establishing a work plan and timeline for project implementation.	
Developing agreed upon milestones for project implementation.	
Agree on project commonalities and shared resources.	
Agree on a data sharing system to address reporting and implementation needs.	We have not begun work on this milestone, which was previously marked as "In Progress" due to inability to select the "Not Started" status in MAPP in previous quarterly report submissions.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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Attestation

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

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

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

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

☐ **I here by attest, as the Lead Representative of the 'Maimonides 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:	MAIMONIDES MEDICAL CENTER
Secondary Lead PPS Provider:	
Lead Representative:	David I Cohen
Submission Date:	03/16/2016 01:08 PM

Comments:

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Status Log				
Quarterly Report (DY,Q)	**Status**	**Lead Representative Name**	**User ID**	**Date Timestamp**
DY1, Q3	Adjudicated	David I Cohen	emcgill	03/31/2016 05:16 PM
DY1, Q3	Submitted	David I Cohen	dc314127	03/16/2016 01:08 PM
DY1, Q3	Returned	David I Cohen	emcgill	03/01/2016 05:14 PM
DY1, Q3	Submitted	David I Cohen	dc314127	02/01/2016 03:59 PM
DY1, Q3	In Process		ETL	01/03/2016 08:01 PM

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Comments Log			
Status	**Comments**	**User ID**	**Date Timestamp**
Adjudicated	The IA has adjudicated the DY1 Q3 Quarterly Report.	emcgill	03/31/2016 05:16 PM
Returned	The IA is returning the DY1Q3 Quarterly Report to the PPS for Remediation.	emcgill	03/01/2016 05:14 PM

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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

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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

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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

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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	

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

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

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Section	Module Name / Milestone #	Review Status	
Section 01	Module 1.1 - PPS Budget 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 & Ongoing	
	Milestone #6 Finalize partnership agreements or contracts with CBOs	Pass & Ongoing	
	Milestone #7 Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	Pass & Ongoing	
	Milestone #8 Finalize workforce communication and engagement plan	Pass & Ongoing	
	Milestone #9 Inclusion of CBOs in PPS Implementation.	Pass & Ongoing	
Section 03	Module 3.1 - Prescribed Milestones		
	Milestone #1 Finalize PPS finance structure, including reporting structure	Pass & Complete	
	Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	Pass & Ongoing	
	Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Pass & Complete	
	Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	Pass & Ongoing	
	Milestone #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the	Pass & Ongoing	

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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		
	Milestone #1 Perform a clinical integration 'needs assessment'.	Pass & Ongoing	

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Section	Module Name / Milestone #	Review Status	
	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	

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

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

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

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

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	Pass & Ongoing	
	Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	Pass & Ongoing	
	Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	Pass & Ongoing	
	Milestone #18 Adopt strategies from the Million Hearts Campaign.	Pass & Ongoing	
	Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	Pass & Ongoing	
	Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	Pass & Ongoing	
3.d.ii	Module 3.d.ii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.d.ii.3 - Prescribed Milestones		
	Milestone #1 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	Pass & Ongoing	
	Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	Pass & Ongoing	
	Milestone #3 Develop and implement evidence-based asthma management guidelines.	Pass & Ongoing	
	Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	Pass & Ongoing	
	Milestone #5 Ensure coordinated care for asthma patients includes social services and support.	Pass & Ongoing	
	Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	Pass & Ongoing	
	Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	Pass & Ongoing	
	Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
3.g.i	Module 3.g.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.g.i.3 - Prescribed Milestones		
	Milestone #1 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.	Pass & Ongoing	
	Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	Pass & Ongoing	
	Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	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	IA
4.c.ii	Module 4.c.ii.2 - PPS Defined Milestones	Pass & Ongoing	