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

DSRIP Implementation Plan Project

Mount Sinai PPS, LLC (PPS ID:34)

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Quarterly Report - Implementation Plan for Mount Sinai PPS, LLC

Year and Quarter: DY1, Q2 **Quarterly Report Status:** Adjudicated

Status By Section

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

Status By Project

Project ID	Project Title	Status
2.a.i	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management	Completed
2.b.iv	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions	Completed
2.b.viii	Hospital-Home Care Collaboration Solutions	Completed
2.c.i	Development of community-based health navigation services	Completed
3.a.i	Integration of primary care and behavioral health services	Completed
3.a.iii	Implementation of evidence-based medication adherence programs (MAP) in community based sites for behavioral health medication compliance	Completed
3.b.i	Evidence-based strategies for disease management in high risk/affected populations (adult only)	Completed
3.c.i	Evidence-based strategies for disease management in high risk/affected populations (adults only)	Completed
4.b.ii	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer	Completed
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	21,977,753	23,421,061	37,874,795	33,537,986	21,977,753	138,789,348
Cost of Project Implementation & Administration	**13,190,540**	**5,856,910**	**9,468,903**	**8,382,877**	**5,492,588**	**42,391,818**
Revenue Loss	**0**	**0**	**0**	**0**	**0**	**0**
Internal PPS Provider Bonus Payments	**0**	**0**	**0**	**0**	**0**	**0**
Cost of non-covered services	**0**	**0**	**0**	**0**	**0**	**0**
Other	**8,793,693**	**17,570,731**	**28,406,711**	**25,148,629**	**16,477,766**	**96,397,530**
Sustainability Fund	0	4,685,528	7,575,123	6,706,301	4,394,071	23,361,023
Contingency Fund	5,496,058	2,342,764	3,787,561	3,353,151	2,197,035	17,176,569
Performance-Based Payments	2,857,950	8,199,675	13,256,465	11,736,027	7,689,624	43,739,741
Safety Net and CBO Funds	439,685	1,171,382	1,893,781	1,676,575	1,098,518	6,279,941
Bonus Funds	0	1,171,382	1,893,781	1,676,575	1,098,518	5,840,256
Total Expenditures	**21,984,233**	**23,427,641**	**37,875,614**	**33,531,506**	**21,970,354**	**138,789,348**
Undistributed Revenue	**0**	**0**	**0**	**6,480**	**7,399**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
jh609205	Other	34_MDL0105_1_1_20151215185437_Funds_Flow_Other_12.15.15.pptx	File describes subcategories of "other"	12/15/2015 06:56 PM

Narrative Text :

All budgeted dollars were done according to State guidance and rounded four digits from the decimal. For instance, DY1: 0.1584 DY2: 0.1688 DY3: 0.2729 DY4: 0.2416 and DY5: 0.1583. As a result, waiver revenue calculations may differ with total expenditures.

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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
21,977,753	138,789,348	17,077,753	133,889,348

Budget Items	Quarterly Amount - Update		Remaining Balance in Current DY	Percent Remaining in Current DY	Cumulative Remaining Balance	Percent Remaining of Cumulative Balance
	DY1, Q1 ($)	DY1, Q2 ($)				
Cost of Project Implementation & Administration	**0**	**4,900,000**	**8,290,540**	**62.85%**	**37,491,818**	**88.44%**
Revenue Loss			**0**		**0**	
Internal PPS Provider Bonus Payments			**0**		**0**	
Cost of non-covered services			**0**		**0**	
Other	**0**	**0**	**8,793,693**	**100.00%**	**96,397,530**	**100.00%**
Sustainability Fund						
Contingency Fund						
Performance-Based Payments						
Safety Net and CBO Funds						
Bonus Funds						
Total Expenditures	**0**	**4,900,000**				

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 1.3 - 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	21,977,752.74	23,421,060.99	37,874,795.02	33,537,986.43	21,977,752.74	138,789,348
Practitioner - Primary Care Provider (PCP)	1,007,314	1,073,465	1,735,928	1,537,158	1,007,314	6,361,179
Practitioner - Non-Primary Care Provider (PCP)	1,007,314	1,073,465	1,735,928	1,537,158	1,007,314	6,361,179
Hospital	1,007,314	1,073,465	1,735,928	1,537,158	1,007,314	6,361,179
Clinic	1,007,314	1,073,465	1,735,928	1,537,158	1,007,314	6,361,179
Case Management / Health Home	1,007,314	1,073,465	1,735,928	1,537,158	1,007,314	6,361,179
Mental Health	1,007,314	1,073,465	1,735,928	1,537,158	1,007,314	6,361,179
Substance Abuse	1,007,314	1,073,465	1,735,928	1,537,158	1,007,314	6,361,179
Nursing Home	1,007,314	1,073,465	1,735,928	1,537,158	1,007,314	6,361,179
Pharmacy	1,007,314	1,073,465	1,735,928	1,537,158	1,007,314	6,361,179
Hospice	1,007,314	1,073,465	1,735,928	1,537,158	1,007,314	6,361,179
Community Based Organizations	1,007,314	1,073,465	1,735,928	1,537,158	1,007,314	6,361,179
All Other	10,897,299	11,612,946	18,779,587	16,629,248	10,897,299	68,816,379
Total Funds Distributed	**21,977,753.00**	**23,421,061.00**	**37,874,795.00**	**33,537,986.00**	**21,977,753.00**	**138,789,348**
Undistributed Revenue	**0.00**	**0.00**	**0.02**	**0.43**	**0.00**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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Placeholder figures have been included as required by the implementation template; however the criteria for evaluating funds flow are in development based on provider roles and responsibilities in PPS-wide projects which is a work in progress. MS PPS is not comfortable with submitting formal projections at this time and committing to future payment allocations per type as we will be continuously refining provider incentives to ensure appropriate transition of DSRIP projects into sustainable outcomes. We would also note that according to the implementation plan, we are not required to finalize this work until DY1 Q3, and the list of project participants is now due to DOH in October 2015, which is a huge determinant of funds flow.

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
21,977,753	138,789,348	21,977,753	138,789,348

Funds Flow Items	Quarterly Amount - Update		Percent Spent By Project										DY Adjusted Difference	Cumulative Difference
			Projects Selected By PPS											
	DY1 Q1	DY1 Q2	2.a.i	2.b.iv	2.b.vii i	2.c.i	3.a.i	3.a.iii	3.b.i	3.c.i	4.b.ii	4.c.ii		
Practitioner - Primary Care Provider (PCP)			0	0	0	0	0	0	0	0	0	0	1,007,314	6,361,179
Practitioner - Non-Primary Care Provider (PCP)			0	0	0	0	0	0	0	0	0	0	1,007,314	6,361,179
Hospital			0	0	0	0	0	0	0	0	0	0	1,007,314	6,361,179
Clinic			0	0	0	0	0	0	0	0	0	0	1,007,314	6,361,179
Case Management / Health Home			0	0	0	0	0	0	0	0	0	0	1,007,314	6,361,179
Mental Health			0	0	0	0	0	0	0	0	0	0	1,007,314	6,361,179
Substance Abuse			0	0	0	0	0	0	0	0	0	0	1,007,314	6,361,179
Nursing Home			0	0	0	0	0	0	0	0	0	0	1,007,314	6,361,179
Pharmacy			0	0	0	0	0	0	0	0	0	0	1,007,314	6,361,179
Hospice			0	0	0	0	0	0	0	0	0	0	1,007,314	6,361,179
Community Based Organizations			0	0	0	0	0	0	0	0	0	0	1,007,314	6,361,179
All Other			0	0	0	0	0	0	0	0	0	0	10,897,299	68,816,379
Total Expenditures	**0**	**0**												

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
srodri01	Report(s)	34_MDL0118_1_2_20151023100215_DSRIP Funds Flow Reporting Template for OMIG 10 1 14 - 9 30 15.xlsx	Oct. 2015: Attached file is the DSRIP Peformance Payment Funds Flow template for OMIG	10/23/2015 10:06 AM

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Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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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.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task Step 1. Finalize funds flow and distribution plan. Includes feedback from PPS providers who participate in various multi-disciplinary workgroups and committees.	Completed	Finance workgroup is responsible for assembling the final funds flow after receiving resource requirements from PPS work groups. The executive leadership group has been developing a number of options for funding distribution methodologies to PPS partners. It has been established that the funds will be distributed through performance-based contracts and will be strictly based on partner performance in completing defined milestones and meeting metrics. The finance workgroup is currently in process of narrowing down funding distribution options and data sources for identifying provider award per provider. The next step in the process is for the finance workgroup to review the available options and provide recommendations.	07/15/2015	09/30/2015	07/15/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2. Governance approval of funds flow, criteria for distribution of funds from each budget category and distribution plan	On Hold	Finance Committee and Board of Managers Approval. On Hold as it requires completion of previous step	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 3. Communication of approved Funds Flow and Distribution Plan to PPS providers	On Hold	Funds Flow and Distribution Communication Packet. On Hold as it requires completion of previous step	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	

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IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

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 :

The IA has added guidance to modules 1,2,3, and 4.

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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	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	YES
Task Step 1. Identify the size and number of standing committees	Completed	Step 1. Identify the size and number of standing committees	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 2. Confirm composition and membership of various committees.	Completed	Step 2. Confirm composition and membership of various committees	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 3. Installation of committee co-chairs, and members of the five standing committees (Finance, Clinical, IT, Leadership, Workforce)	Completed	Step 3. Installation of committee co-chairs, and members of the five standing committees (Finance, Clinical, IT, Leadership, Workforce)	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 4. Establish a MSPPS LLC	Completed	Step 4. Establish a MSPPS LLC	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 5. LLC formally adopts existing Leadership committee as its board	Completed	Step 5. LLC formally adopts existing Leadership committee as its board	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 6. LLC adopts existing committee structure including Finance, Workforce, Clinical, Compliance and IT	Completed	Step 6. LLC adopts existing committee structure including Finance, Workforce, Clinical, Compliance and IT	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 7. Complete by-laws/operating agreement of LLC	Completed	Step 7. Complete by-laws/operating agreement of LLC	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task	Completed	Step 8. Establish Compliance Committee and install members	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 8. Establish Compliance Committee and install members									
Task Step 9. Installment of Compliance Officer and Compliance Lead	Completed	Step 9. Installment of Compliance Officer and Compliance Lead	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	In Progress	This milestone must be completed by 12/31/2015. Clinical Quality Committee charter and committee structure chart	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1. Appoint leadership for clinical committee	Completed	Step 1. Appoint leadership for clinical committee	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 2. Recruit partners for Project Working Group membership for 10 MSPPS project-level sub-committees	Completed	Step 2. Recruit partners for Project Working Group membership for 10 MSPPS project-level sub-committees	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 3. Develop regular meeting schedules for Committee and Sub-commitees	Completed	Step 3. Develop regular meeting schedules for Committee and Sub-commitees	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 4. Draft and adopt project working group under clinical committee direction	Completed	Step 4. Draft and adopt project working group under clinical committee direction	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 5. Establish guidelines and protocols and clinical excellence for implementation	In Progress	Step 5. Establish guidelines and protocols and clinical excellence for implementation	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6. Collaborate with MSO to select and develop metrics for tracking performance	In Progress	Step 6. Collaborate with MSO to select and develop metrics for tracking performance	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7. Establish a Program Management Office for operational support and project management	In Progress	Step 7. Establish a Program Management Office for operational support and project management	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 8. Develop PMO structure, operational policies across partners with installation of all members	In Progress	Step 8. Develop PMO structure, operational policies across partners with installation of all members	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task	In Progress	Step 9. Establish PMO relationship with Management	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 9. Establish PMO relationship with Management Services Organization (MSO) to provide operational support and management support with clinical integration and population health management		Services Organization (MSO) to provide operational support and management support with clinical integration and population health management							
Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	Completed	This milestone must be completed by 9/30/2015. Upload of bylaws and policies document or committee guidelines.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task Step 1. Draft and adopt charter for each Committee	Completed	Step 1. Draft and adopt charter for each Committee	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2. Develop draft for governing charter	Completed	Step 2. Develop draft for governing charter	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3. Adopt Charter standards and objectives	Completed	Step 3. Adopt Charter standards and objectives	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4. Adopt MSPPS bylaws	Completed	Step 4. Adopt MSPPS bylaws	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 5. Draft and adopt dispute resolution policies and procedures	Completed	Step 5. Draft and adopt dispute resolution policies and procedures	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 6. Draft and adopt partnership agreements and data sharing	Completed	Step 6. Draft and adopt partnership agreements and data sharing	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 7. Develop service contracts and agreements for the PPS, as needed	Completed	Step 7. Develop service contracts and agreements for the PPS, as needed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 8. Establish approval process for contracts and agreements for the PPS	Completed	Step 8. Establish approval process for contracts and agreements for the PPS	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 9. Establish approval process of DSRIP reporting to the state and CMS	Completed	Step 9. Establish approval process of DSRIP reporting to the state and CMS	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 10. Develop and adopt Compliance policies and procedures	Completed	Step 10. Develop and adopt Compliance policies and procedures	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #4 Establish governance structure reporting and	In Progress	This milestone must be completed by 12/31/2015.	07/20/2015	12/31/2015	07/20/2015	12/31/2015	12/31/2015	DY1 Q3	YES

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
monitoring processes		Governance and committee structure document, including description of two-way reporting processes and governance monitoring processes							
Task Step 1: Develop a process for tracking progress of governance structure and monitoring process.	In Progress	Step 1: Develop a process for tracking progress of governance structure and monitoring process.	07/20/2015	12/31/2015	07/20/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2. Leadership committee receives reports from IT, Clinical, Workforce, Finance and Compliance at each meeting and reports up on deliverables and risks needing mitigation	In Progress	Step 2. Leadership committee receives reports from IT, Clinical, Workforce, Finance and Compliance at each meeting and reports up on deliverables and risks needing mitigation	07/20/2015	12/31/2015	07/20/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3. MS PPS PMO along with DSRIP Management Team (DMT) with direction from Clinical Committee and Clinical Executive Committee provides operational oversight and monitoring of quality care, then reporting to appropriate committees	In Progress	Step 3. MS PPS PMO along with DSRIP Management Team (DMT) provides operational oversight and monitoring of quality care, then reporting to appropriate committees	07/20/2015	12/31/2015	07/20/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4. DMT and PMO identify key program metrics to assess work stream progress in financial management, clinical management, workforce management and IT management	In Progress	Step 4. Identify key program metrics to assess workstream progress in financial management, clinical management, workforce management and IT management	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5. Develop and adopt compliance monitoring process and ensure mitigation of any risks flagged.	In Progress	Step 5. Develop and adopt compliance monitoring process and ensure mitigation of any risks flagged.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6. Develop tools for collection and reporting data from all participating providers	In Progress	Step 6. Develop tools for collection and reporting data from all participating providers	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7. Deploy protocols and tools to all participating providers through MS PMO	In Progress	Step 7. Deploy protocols and tools to all participating providers through MS PMO	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 8: Train all stakeholders involved including	In Progress	Step 8: Train all stakeholders involved including MS PPS PMO and DMT on mointoring and tracking of processes.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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DSRIP Implementation Plan Project

Mount Sinai PPS, LLC (PPS ID:34)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
MS PPS PMO, DMT and clinical on monitoring and tracking of processes.									
Task Step 9: All committees and stakeholders will complete reporting tool and submit to MS PPS PMO for review and to DMT for approval for presentation to governing committees.	In Progress	Step 9: All committees and stakeholders will complete reporting tool and submit to MS PPS PMO for review and to DMT for approval for presentation to governing committees.	08/01/2015	12/31/2015	08/01/2015	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	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1. Identify community resources and organizations participating in activities impacting population health	In Progress	The PPS has identified over 73 partners that are also community-based organizations and represent the full spectrum of clinical and social services that are critical in supporting the Medicaid beneficiary population.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2. Recruit participants from PPS who can support community engagement focusing on CBOs, MH, OASAS and BH	In Progress	As noted above, Mount Sinai has recruited a robust membership for its cross-cutting Stakeholder Engagement Workgroup. 73 community-based organizations were invited to participate with 27 responding interest to join the committee. The first workgroup meeting will take place in August/September 2015	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3. Create a clear strategic community engagement plan	In Progress	The Mount Sinai PPS, in conjunction with the Stakeholder Engagement Workgroup, is establishing a community engagement plan that will include, among other elements, the expectations for partner participation as DSRIP implementation continues, an internal plan for ongoing communications and regular opportunities for engagement with the PPS, clear roles and responsibilities for stakeholders and for the PPS, and a set of goals and milestones that will be achieved through the engagement process. It is our commitment that the PPS cannot be successful in achieving delivery system transformation without the robust participation and buy-in of our partners and stakeholders.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4. Community Engagement Plan developed with input and representation of continuum of	In Progress	The Stakeholder Engagement Workgroup will meet monthly to collaborate and work on key pieces of the community	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Mount Sinai PPS, LLC (PPS ID:34)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
care and geographic representation of stakeholders comprising the PPS		engagement plan to ensure comprehensive representation and robust participation.							
Task Step 5. Leadership committee to approve community engagement plan	In Progress	Once developed, the community engagement plan will be presented to the Stakeholder Engagement Workgroup for review and approval and then forwarded on as a resolution for approval by the Mount Sinai PPS Board of Managers.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6. Distribute communications and events to community organizations (i.e. CBOs, MH, BH, OASAS, etc…)	In Progress	Communication materials are regularly distributed via PPS Newsletters, PPS Update email communications and monthly Town Hall meetings. These communications will continue and will be augmented as additional implementation milestones approach.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 7. Recruit community resources, with ongoing outreach and participation	In Progress	In addition to the Stakeholder Engagement Workgroup, the PPS will benefit from advice and feedback from the Project Advisory Committee (PAC) through quarterly meetings and regular email communications.	07/01/2015	06/30/2016	07/01/2015	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	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1. Draft partnership and vendor agreements with CBOs	Completed	Partnership agreements finalized (June 2015)	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 2. Finalize partnership and vendor agreements with CBOs for review	Completed	Partnership agreement with CBOs finalized; confirmation emails distributed (June 2015); additional contracting arrangements to be determined.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 3. Identify appropriate committees for CBO representation, including finance	Completed	Cross-functional Stakeholder Engagement Workgroup being established and first meeting to take place in August/September. Committee will be comprised of CBO partners and representation from Finance Committee and Workforce Committee to ensure cross functional efforts are incorporated.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4. Contract are distributed, signed and implemented	In Progress	PPS "Partner Profiles" are under development and will be distributed to all PPS partners for confirmation of signed agreements and to confirm interest in individual DSRIP project participation and to identify additional IT and contracting needs. Provider relations team will engage all PPS partners individually to identify and meet IT and other	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
		implementation needs for successful DSRIP implementation.							
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	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Step 1. Identify appropriate public sector agencies to engage in service area	In Progress	The Mount Sinai PPS will work with its Stakeholder Engagement Workgroup to identify the appropriate agencies for engagement with our PPS And begin development of an agency coordination plan in the fall of 2015.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2. Engage selected agencies by recruitment in coordination with municipal authorities	In Progress	Implement a monthly subgroup meeting of representatives from the PPS, the Stakeholder Engagement Work group and public sector agencies to ensure robust communication and adequate policy interactions.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Collaborate with agencies at state and local level in development of coordination plan	In Progress	Work with public sector agencies at state and local levels in design of the plan	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4. Develop action plan for coordinating agency activities for discussion, review and adoption with Municipal authorities and agencies	In Progress	Under development and will be presented for Stakeholder Engagement Workgroup review in August/September	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Milestone #8 Finalize workforce communication and engagement plan	In Progress	Workforce communication & engagement plan, including plans for two-way communication with all levels of the workforce, signed off by PPS workforce governance body (e.g. workforce transformation committee).	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1. Outline objectives, principles, and milestones that must be communicated with the MSPPS workforce.	In Progress	Step 1. Outline objectives, principles, and milestones that must be communicated with the MSPPS workforce.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2. Assessment of workforce needs by partner and evaluate value and interest level, level of commitment	In Progress	Step 2. Assessment of workforce needs by partner and evaluate value and interest level, level of commitment	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 3. Perform Audience and Vehicle Analyses: Define the communication needs and required key messages by audience group, as well as the available communication channels that can be utilized for stakeholder engagement	In Progress	Step 3. Perform Audience and Vehicle Analyses: Define the communication needs and required key messages by audience group, as well as the available communication channels that can be utilized for stakeholder engagement	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4. Create workforce communication and engagement strategy which accomplishes goals identified in Sept 1.	On Hold	Step 4. Create workforce communication and engagement strategy which accomplishes goals identified in Sept 1.	04/01/2015	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 5. Approval of communication engagement strategy by MSPPS governance.	On Hold	Step 5. Approval of communication engagement strategy by MSPPS governance.	04/01/2015	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 6. Finalize/Implement workforce communication and engagement strategy.	In Progress	Step 6. Finalize/Implement workforce communication and engagement strategy.	04/01/2015	06/30/2016	04/01/2015	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	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1: Using the partner network list, identify CBOs to contract within projects.	In Progress	Step 1: Using the partner network list, identify CBOs to contract within projects and in the PPS.	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2: Working with CBOs, assess regularly continuing role in projects and PPS.	In Progress	Step 2: Working with CBOs, assess regularly continuing role in projects.	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Collaborate with stakeholders such as CBOs, Finance Committee and Clinical committee in detailing and finalizing contracts related to CBO role in project and PPS engagement.	In Progress	Step 3: Collaborate with stakeholders such as CBOs, Finance Committee and Clinical committee in detailing and finalizing contracts related to CBO role in project delivery and PPS engagement.	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4: CBOs are involved in PPS implementation.	In Progress	Step 4: CBOs are involved in PPS implementation.	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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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.

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize governance structure and sub-committee structure	dlumbao	Rosters	34_MDL0203_1_2_20151215155330_Workforce_Committee_Approval_by_Board_of_Managers_-_Remediation_Q2(1).pdf	File for DY1Q2 Remediation- Response to IA feedback - (Workforce - Board Approval)	12/15/2015 03:53 PM
	dlumbao	Templates	34_MDL0203_1_2_20151215154939_MS_PPS_Governance_Committee_Template_DY1_Q2_-_Remediation(1).xlsx	File for Remediation of Q2- Response to IA feedback	12/15/2015 03:49 PM
	dlumbao	Quarterly Report (no attachment necessary)	34_MDL0203_1_2_20151029143017_MS PPS Governance Committee Template DY1 Q2.xlsx	Cmtte Contacts	10/29/2015 02:30 PM
	dlumbao	Quarterly Report (no attachment necessary)	34_MDL0203_1_2_20151029142920_MS PPS Meeting Schedule Template DYI Q2.xlsx	Cmtte Meeting Schedule	10/29/2015 02:29 PM
	dlumbao	Quarterly Report (no attachment necessary)	34_MDL0203_1_2_20151029142758_Mount Sinai PPS Governance Structure.pdf	Updated Governance Structure	10/29/2015 02:27 PM
Finalize bylaws and policies or Committee Guidelines where applicable	dlumbao	Other	34_MDL0203_1_2_20151215155659_MS_PPS_Governance_Meeting_Frequency_2015.xlsx	File for DY1Q2 Remediation- Response to IA Feedback (Frequency as of 2015)	12/15/2015 03:56 PM
	dlumbao	Other	34_MDL0203_1_2_20151029142256_Mount Sinai Stakeholder Engagement Charter Final 09.29.15.pdf	SE	10/29/2015 02:22 PM
	dlumbao	Other	34_MDL0203_1_2_20151029142154_Workforce Committee Charter 070915 LR.PDF	workforce	10/29/2015 02:21 PM
	dlumbao	Other	34_MDL0203_1_2_20151029142135_IT Committee Charter Final -PDF.pdf	IT	10/29/2015 02:21 PM
	dlumbao	Other	34_MDL0203_1_2_20151029142120_Finance Committee Charter 140821 - PDF.pdf	finance	10/29/2015 02:21 PM
	dlumbao	Other	34_MDL0203_1_2_20151029142107_Compliance Committee Charter v3 06.08.15.pdf	compliance	10/29/2015 02:21 PM
	dlumbao	Other	34_MDL0203_1_2_20151029142046_Clinical Committee Charter 140905.pdf	clinical	10/29/2015 02:20 PM
	dlumbao	Other	34_MDL0203_1_2_20151029141333_Care Coordination Charter 8 27 15.pdf	CC Charter	10/29/2015 02:13 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	dlumbao	Other	34_MDL0203_1_2_20151029141033_02 - PAC Leadership Committe Charter 140821.pdf	Leadership cmmte	10/29/2015 02:10 PM
	dlumbao	Baseline or Performance Documentation	34_MDL0203_1_2_20151022151229_Mount Sinai PPS LLC Operating Agreement FINAL executed.pdf	Bylaws for Milestone Completion	10/22/2015 03:12 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize governance structure and sub-committee structure	
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	
Finalize bylaws and policies or Committee Guidelines where applicable	This milestone was completed by 9/30/2015. Operating Agreement was reviewed and approved by the Board of Managers. Please reference upload of bylaws and policies document or committee guidelines.
Establish governance structure reporting and monitoring processes	
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	
Finalize partnership agreements or contracts with CBOs	
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 & Ongoing	

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Milestone Review Status

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

Current risks to achieving the above milestones include: financial fragility of many participating providers; the culture of competition rather than cooperation that exists among similar agencies and providers; the ability of the PPS to attain project goals within the proposed budget; the ability of partners to provide up front capital and investments to implement projects; potentially low distribution of DSRIP dollars at the individual provider level; and the lack of understanding DSRIP and impact of payment reform among provider participants. Other risks include ability to develop and share data in a meaningful way to support care coordination, the availability of HIE services by SHIN-NY, availability of capital dollars (including impact of the CRFP awards), and the ability of partners to participate in the planning process (many smaller partners have cited their lack of resources and ability to participate in multiple committees and work groups). The impact of these risk may result in provider partners dropping out of the PPS, not enough capital to launch projects at the partner level that may result in the need to find additional partners, and delaying the PPS's ability to meet DSRIP goals.

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.)

Major dependencies include the ability to complete participating partner contracting, establishing the working relationships between the PPS and provider partners, ability of partners to launch projects and engage in project work groups, availability of HIE services by SHIN-NY to ensure data sharing infrastructure can be established, and the ability/authority of the PPS to implement monitoring and compliance programs and partner's response to those efforts. We anticipate the need for significant partner education and outreach, particularly at the individual community provider level. The primary interdependency is the participating provider contract that will link providers to the PPS and establish the working relationship between the PPS and its provider network. Integral to that network is an IT platform that is available to all PPS participants and establishes a framework for data exchange and management as well as reporting. The Workforce plan will be a key component of transformation for many providers as they move away from traditional facility based activities into community based activities. The PPS will need to have a plan and program in place to retrain a sufficient number of providers to work in community based settings providing case management and care coordination. Additionally, a robust PMO will be necessary to manage the data and report on the activities of each of the projects and the PPS as a whole.

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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 Entity	Arthur Gianelli, Mount Sinai PPS LLC	By law and policy development, funding and staffing resources
PPS Governance and organization	Jill Huck/MS PPS LLC PMO Director	Establish LLC, PMO contract, provider participation agreements/contracts, compliance program
Financial Management and oversight	Finance Committee under co-chairs: Don Scanlon, Mount Sinai PPS LLC and Mark Pancirer, Amsterdam Nursing Home	Financial structure, and management of PPS, treasury and accounting, financial oversight of PPS participating providers
IT Development, information sharing and Implementation	IT Committee under co-chairs: Kumar Chatani, Mount Sinai PPS LLC and Barbara Hood, Ryan Center	IT platform, interconnectivity with PPS partners, data base management, performance reporting management
Clinical Quality	Clinical Committee under co-chairs: Theresa Soriano, Edwidge Thomas -Mount Sinai PPS LLC and Matthew Weissman, Community Healthcare Network NYC	Finalize metrics and milestones for each project, monitor quality of projects, review and approve all quality reports
Workforce Development	Workforce Committee under co-chairs: Jane Maksoud, Mount Sinai PPS LLC Health System and	Develop workforce strategy
Physician Organizations and large practices	All Med IPA	Board and Committee members
Key Advisors, Counselors, attorneys and consultants	Mount Sinai Attorneys, Harbage Consulting, PS PPS LLC PMO staff and COPE	Drafts governance documents, provider agreements, policies and procedures, etc.
Audit and Compliance Committee	Mount Sinai and Partners Compliance members	Oversee compliance to NYSDOH reulations and policies
Edwidge Thomas	Clinical Director of the MS PPS PMO	Oversees clinical quality, monitoring and reporting of all DSRIP Projects.

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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		
Mount Sinai Hospital Group; Art Gianelli; Arthur Klein; Brad Beckstrom; Caryn Scwab; Don Scanlon; Ed Lucy; Frank Cino; Gary Burke; Jane Maksoud; Kelly Cassano; Sabina Lim; Theresa Soriano; Berthe Erisnor	Lead Applicant, Leadership contributor	Funding, leadership, personnel, committee chairs
External Stakeholders		
Affinity Health Plan; Ajhezza Gonzalez	Leadership, participant	Leadership, committee members
1199 SEIU; Saily Cabral	Leadership, participant	Leadership, committee members
Amerigroup; David Ackman	Leadership, participant	Leadership, committee members
The Brooklyn Hospital Center; Joan Clark-Carney	Leadership, participant	Leadership, committee members
ArchCare; Scott La Rue	Leadership, participant	leadership, committee members
VNSNY; Hany Abdelaal	Leadership, participant	Leadership, committee members
William Ryan Center Brian Mcindoe	Leadership, participant	Leadership, committee members
CBC and SUS/Palladia	Leadership, participant	Leadership, committee members

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Donna Colonna		
NYSNA James Ferris	Leadership, participant	Leadership, committee members
Metropolitan Jewish Health System Jay Gormley	Leadership, participant	Leadership, committee members
Amsterdam House Jim Davis	Leadership, participant	Leadership, committee members
Settlement Health (CBO) Mali Trilla	Leadership, participant	Leadership, committee members
CityMd Richard Park	Leadership, participant	Leadership, committee members
Aids Service Center (Substance abuse) Sharen Duke	Leadership, participant	Leadership, committee members
AllMed IPA Rizwan Hameed	Leadership, participant	Leadership, committee members
Phoenix House (Behavioral Health) Peter Scaminaci	Leadership, participant	Leadership, committee members
Settlement Health Mali Trilla	Community Based Organization, Leadership Participant	Involved in CBO engagement and leadership committee
AIDs Service Center Sharen Duke	Leadership Participant,	Involved in leadership committee
Institute Family Health; Neil Calman	Leadership Participant,	Involved in leadership committee
Healthfirst; Tom Meixner	Leadership Participant,	Involved in leadership committee
NYC Mayor's Office; Sarah Samis	Leadership Participant,	Involved in leadership committee

IPQR Module 2.7 - IT Expectations

Instructions :

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

The shared IT infrastructure is key to the development of an integrated delivery system, the foundation of the PPS transformation. Development of the IT infrastructure and the process of linking providers to that system will be a major indicator of the success of the PPS in creating an integrated delivery system.

A crucial functionality of the overall IT strategy will be identifying risks. To do that, the PPS will use dashboards to monitor multiple dimensions of program performance and the ability to gauge progress against milestones for the appropriate allocation of financial and operational resources.

As such, the MS PPS IT infrastructure will allow for PPS-wide data sharing across all provider types through a combination of integration via the RHIO, a user portal for providers, or directly into the MS PPS HIE. The infrastructure to enable data sharing will allow the Board and committees the ability to query key performance indicators for the PPS, by partner type, project and key metrics, both defined by DSRIP and those defined as critical to performance management by each committee. The performance management capability will enable committee members to define key indicators, thresholds (goal charts) and frequency of data collection to monitor partner performance and stability. With relation to DSRIP performance, the MS PPS Rapid Cycle Evaluation (RCE) process will be driven by the data collected and informed by input from the committees and project leads, to ensure timely process improvement initiatives can be put into place to address areas of risk. While performance reporting will be largely informed by claims data, real time or near real-time data will be accessed and utilized for RCE activities and utilization management. This will enable timely feedback loops and course corrections so that improvements aren't limited to quarterly data feeds or otherwise historical data.

CBOs will also be able to engage and connect into the MS PPS IT platforms to share information and report on their performance. MS PPS will implement a data normalization service to consume non-standard data produced by existing CBO systems. CBOs will be able to connect into the care coordination and referrals management platforms between them and partnering organizations, as well as access to other IT services through the MS PPS user portal.

Additionally, the IT workstream overlaps with the work of the Governance workstream. Successful execution of IT policy and process tasks will inform the development of a comprehensive governance framework for the PPS that includes robust data governance components such as data access, data security, and other IT-related policy elements.

Finally, the successful realization of these deliverables will require the shared IT infrastructure to support specific governance milestones such as posting of minutes and agendas on provider and public portals, and soliciting feedback from stakeholders on PPS activities and decisions. These tools will allow the PPS to provide information and technical assistance across its network and service area, thus meeting governance-specific deliverables. In addition, a robust and shared IT infrastructure will minimized the risk for DSRIP under-performance and provide the PPS governing body with data and informatics required to support effective, strategic decision-making.

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IPQR Module 2.8 - Progress Reporting

Instructions :

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

The governance workstream will be successful when the PPS governance structure is fully stood up with timely achievement and establishment of the governance structures. Leadership Committee is operating as the governing board of the PPS and has transitioned to be the Board Of Managers (BoM) in which they will function to approve budgets, distribute funds, contract for services with the PMO, oversee and monitor quality and compliance and foster outreach to providers and beneficiaries. The Leadership committee has transitioned to become the Board of Managers of the MS PPS LLC where the nomination and voting in of the BoM, development and adoption of the bylaws, policies and procedures for all the committees and sub committees along with the development and completion of partner agreements will assist in the operation of the MS PPS. Success will also be determined by the execution of the performance management systems including the data collection, analyses and reporting to support the decision making by the BoM. Having performance management systems ready to collect data and determine the status of each partner in the network will be important for monitoring and reporting of the deliverables set by the PPS.

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	In Progress	This milestone must be completed by 12/31/2015. PPS finance structure chart / document, signed off by PPS Board.	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1. Establish process for nominating and electing finance committee members, to ensure representation from different provider types so that different views and perspectives are considered.	Completed	Finance committee has been formed and includes representation for different provider types across PPS's geographic region. Finance committee members are represent hospitals, primary care practices, community health centers, long-term care centers, home health agencies	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2. Establish Finance Work group to review and assimilate funds flow and other financing policies, procedures and issues.	Completed	Finance work group has been established to include representation from the partner organizations engaged in DSRIP efforts, Mt. Sinai Health System and the Project Management Office. Supported by a consulting team, below are the names of the finance workgroup members to date: Joe Gurracnio, Pat Semenza, Mark Pancirer, Brian McIndoe, Glenn Tolchin, Mike Bruno, Brendan Loughlin, Rachel Amalfitano, Frank Cino, Darrick Fuller, Peter R. Epps, Steve Maggio, Nina Bastian	06/01/2015	07/01/2015	06/01/2015	07/01/2015	09/30/2015	DY1 Q2	
Task Step 3. Finalize accounting GL structure for recognizing revenues and expenses and for completing DSRIP budgets.	In Progress	Mt. Sinai Health System has elected two individuals to lead the accounting structure for DSRIP including budgeting and other functions.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4. Determine the finance function staffing and support services including accounting, financial reporting, budgeting, accounts payable,	In Progress	The MS PPS team has identified staffing needs and costs in relation to carrying out the finance functions for DSRIP. The PMO office staff has also been identified as contributors to the centralized DSRIP efforts.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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and cash management.									
Task Step 5. Establish Funds Flow process that includes a mechanism for review and approval of payments to providers per the funds flow plan by the governance committees.	In Progress	A model of funds flow has been developed that looks at performance payment to partners. The current work being conducted revolves around finalizing project participation per partner, partner list with appropriate service types. The model will be going through finance committee approval process once the input data are finalized. Meanwhile the committee will be approving the principles and thought process behind the funds flow mechanism.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6. Develop guiding principles for funds allocation to establish budget categories.	On Hold	Step 6. Develop guiding principles for funds allocation to establish budget categories.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
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	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task Step 1. Develop criteria for assessing financial health of PPS partners.	In Progress	The finance work group has developed a draft process and guidelines for the next steps in assessing the financial health of PPS partners. A tentative timeline of all current PPS assessments has been designed to determine the best time frame during which the assessments will be disseminated out to the PPS and Financial Health Assessment is likely to be distributed during DY1 Q2 to allow enough time for completion.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2. Develop a process for quarterly submission of financial data/ratios by PPS providers that will require PPS providers to	In Progress	A drat process has been drafted by the finance team to allow for quarterly submision of financial ratio data including definitions of ratios, examples and identifying technical support resources for questions and concerns by partners.	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	AV
submit and attest to data accuracy and financial condition.		The Internal PMO team has been identified for carrying out data collection and analysis process and the finance workgroup will assess data accuracy.							
Task Step 3. Reestablish financial baseline with updated roster of MS PPS partners	On Hold	Step 3. Re-establish financial baseline with updated roster of MSPPS partners	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 4. Initiate quarterly financial monitoring and analysis of MS PPS partners	On Hold	Step 4. Initiate quarterly financial monitoring and analysis of MSPSS partners	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 5. Develop Corrective Action Plan for providers that are deemed fragile.	On Hold	Step 5. Develop Corrective Action Plan for providers that are deemed fragile.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 6. Finance Committee to develop a process for PPS members to request the use of contingency funds.	On Hold	Step 6. Finance Committee to develop a process for PPS members to request the use of contingency funds.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	In Progress	This milestone must be completed by 12/31/2015. Finalized Compliance Plan (for PPS Lead).	05/01/2015	12/31/2015	05/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1. Complete review of NY Social Services Law 363-d, determine scope and requirements of compliance program and plan based upon the DSRIP related requirements that are within the scope of responsibilities of the PPS Lead.	Completed	Step 1. Complete review of NY Social Services Law 363-d, determine scope and requirements of compliance program and plan based upon the DSRIP related requirements that are within the scope of responsibilities of the PPS Lead.	05/01/2015	08/01/2015	05/01/2015	08/01/2015	09/30/2015	DY1 Q2	
Task Step 2. Develop written policies and procedures that define and implement the code of conduct and other required elements of the PPS Lead compliance plan that are within the scope of responsibilities of the PPS Lead.	Completed	Step 2. Develop written policies and procedures that define and implement the code of conduct and other required elements of the PPS Lead compliance plan that are within the scope of responsibilities of the PPS Lead.	06/01/2015	08/01/2015	06/01/2015	08/01/2015	09/30/2015	DY1 Q2	
Task Step 3. Obtain confirmation from PPS network providers that they have implemented a compliance plan consistent with the NY State Social Services Law 363-d.	In Progress	Step 3. Obtain confirmation from PPS network providers that they have implemented a compliance plan consistent with the NY State Social Services Law 363-d.	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task	In Progress	Step 4. Develop requirements to be included in the PPS	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Step 4. Develop requirements to be included in the PPS Provider Operating Agreement that the network providers will maintain a current compliance plan to meet NY State requirements for a provider.		Provider Operating Agreement that the network providers will maintain a current compliance plan to meet NY State requirements for a provider.							
Task Step 5. Obtain Executive Body approval of the Compliance Plan (for the PPS Lead) and Implement	In Progress	Step 5. Obtain Executive Body approval of the Compliance Plan (for the PPS Lead) and Implement	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	In Progress	This milestone must be completed by 3/31/2016. Value-based payment plan, signed off by PPS board	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task Step 1. Develop value-based contracting principles and objectives.	In Progress	Step 1. Develop value-based contracting principles and objectives.	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3	
Task Step 2. Obtain from the providers and stakeholders the following input: Identify services linked to value-based and FFS payments from providers, revenue from value-based contracts, current understanding of value-based care delivery	In Progress	Step 2. Obtain from the providers and stakeholders the following input: Identify services linked to value-based and FFS payments from providers, revenue from value-based contracts, current understanding of value-based care delivery	11/01/2015	12/31/2015	11/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3. Conduct initial meetings with select MCOs to evaluate current and future options in line with requirements for value-based contracting with providers.	In Progress	Step 3. Conduct initial meetings with select MCOs to evaluate current and future options in line with requirements for value-based contracting with providers.	11/01/2015	12/31/2015	11/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4. Identify provider performance metrics to incentivize appropriate behaviors to achieve quality, patient satisfaction and financial goals.	In Progress	In collaboration with select MCOs develop materials to educate partnership on various types of value-based payments and State's goals with MCO contracts	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5. Develop metrics for evaluating success under a risk-based contracts.	In Progress	Hold information sessions with stakeholders, providers and MCOs to share results of partner assessment regarding current understanding and status of value-based arrangements in the PPS	01/01/2016	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
Task Step 6. Develop a contract matrix for cataloging all DSRIP contracts.	In Progress	Information request from partners and MCOs via electronic submission and key informant interviews to evaluate plans and potential strategies toward value-based arrangements	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 7. Complete baseline assessment report and develop value-based purchasing strategies.	In Progress	Using results from information requests, educational session and interviews with stakeholders develop a baseline assessment report to include current value-based revenue for the PPS, likely changes in the revenue from both MCO and provider perspective and future potential arrangements that will drive the shift toward value-based payment mechanisms	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 8. Develop and conduct an education session with providers and other stakeholders on VBP.	In Progress	Socialize baseline assessment report with partnership and key MCOs in the PPS providers for review and feedback Obtain approval of Board of Managers on the final baseline assessment of revenue linked to value-based payments, preferences for development	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	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	YES
Task Step 1. Update services linked to value-based payments and FFS services and collaborate with providers in the network to determine the best approach to contracting with MCOs.	In Progress	Identify services linked to value-based payments and FFS services for feedback by MCOs and providers	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 2. Finalize metrics for evaluating success under a risk-based contract.	In Progress	Identify appropriate metrics required to evaluate success under risk-based contracts using baseline assessment results	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 3. Discuss PPS value-based payment plan with MCOs within the framework of NY DOH Value-Based Payment Roadmap	In Progress	Conduct a series of meetings with MCOs to finalize value-based metrics and pringiples for value-based contracts with PPS Providers	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4. Socialize MCO meeting results with PPS for comments and feedback	In Progress	Step 4. Socialize MCO meeting results with PPS for comments and feedback	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 5. Develop a final plan for achieving 90% value-based payments to include goals for future meeting with MCOs stakeholder engagement	In Progress	Step 5. Develop a final plan for achieving 90% value-based payments to include goals for future meeting with MCOs stakeholder engagement schedule and communication plan, MCO contracting arrangements for the providers in the PPS	10/01/2016	12/31/2016	10/01/2016	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
schedule and communication plan, MCO contracting arrangements for the providers in the PPS network		network							
Milestone #6 Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Milestone #7 Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Milestone #8 >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES

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
Finalize PPS finance structure, including reporting structure	
Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	

NYS Confidentiality – High

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	
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	

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	

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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.

"There may be challenges and risks in 5 key areas:
1) Risk/challenge: Being able to reliably receive quarterly results from providers to monitor financial health. There will be a large volume of materials coming in to review and MSPPS will need to create a standardized submission and review process.
a. Mitigation: Process must include conversations with, and obtain buy-in from, providers to understand why financials may be trending one way or another. There may be unique seasonality at a provider or changes to financial statements may be due to something other than DSRIP. Consider contract terms that permit penalties or sanctions for non-performing providers.
2) Risk/challenge: If a provider is experiencing revenue loss due to DSRIP project implementation, there exists a challenge to evaluate loss due to DSRIP quantified vs. loss due to other reasons and the level of due diligence necessary by MSPPS in evaluating requests for funding to cover revenue loss.
a. Mitigation: Develop a mechanism in evaluating budget vs. actual spending on DSRIP related work as part of assessing overall financial health of PPS partners.
3) Risk/Challenge: There is a need to establish confident estimates of future awards when making financial decisions such as adding PMO staff and setting annual budgets.
a. Mitigation: Work closely with MSPPS IT and Business Intelligence capabilities to continually assess progress against goals for estimating potential awards and progress.
4) Risk/Challenge: Ability to contract with MCOs and get 90% of payments under value-based payment methodologies.
a. Mitigation: Work in close collaboration with the State in incentivizing MCOs to negotiate and work with MSPPS.
5) Risk/Challenge: Performance is hard to define or isn't available initially so payments are based on missing or inaccurate data. In addition, accurate data is required for project attribution for initial valuation of provider commitments.
a. Mitigation: Evaluation mechanism to ensure speed and scale commitments are realistic and achievable) and accurate performance data with provider attribution so that performance can be measured efficiently and fairly.

IPQR Module 3.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

"IT Systems: As part of developing data reporting mechanism to manage the provider data base and performance and process reporting, the finance team would need to ensure the appropriate measures are captured as part of the reporting process and appropriate analytics are built in

over time to allow for real-time dashboard reporting.
Workforce: As part of the workforce strategy budget, the finance workstream would need to consider the impact on the PPS and potential mitigation strategies (i.e. tapping into reserve funds to ensure this workstream is successful).
Governance: Finance Committee is part of the formal governance structure. A number of elements requiring integration are CBO contracting and evolving governance model.
Cultural Competency and Health Literacy: As part of the training or change management programs that the PPS sets out to achieve, integration around cost of those services and monitoring of them brings an essential collaborative opportunity between the two workstreams.
Performance Reporting: Financial health reporting protocols will need to be standard across the PPS in order for the lead organization to be able to make accurate assessment of the overall PPS health. The development of strategies to establish the appropriate reporting structure will be approved by the Finance Committee before being finalized.
Population Health Management: As part of performing provider contracts, outcome measures will drive the majority of the incentive payments earned in the last years of DSRIP. The strategy for population health management and roadmap development must align with the performance contracting process and principles.
Practitioner Engagement: as part of performing provider contracts, provider engagement early in the contracting process and throughout DSRIP period is key to ensure the contractual obligations are met."

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IPQR Module 3.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Finance Committee	Don Scanlon, Chair, Co-Chair Mark Pancirer, Co-Chair	Approve policies and procedures; maintain oversight of management of DSRIP funds; monitor financial performance of MSPPS and all partners; review capital and operating budgets

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Finance Workgroup	PPS Members	Develop guiding principles, define financial performance metrics, accounting processes; define reporting standards and requirements; and develop ongoing partner assessment processes
Compliance Committee	Frank Cino, Chair; PPS Members	Draft a compliance program and monitor performance
Accounting and Treasury Management Services	Mike Bruno, SVP Finance, Mount Sinai	Setup accounting services, GL chart of accounts, and treasury management services for the PPS
Consultants	COPE Health Solutions	Drive Finance Committee deliverables through proven DSRIP experience and project management support

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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		
Art Gianelli	St. Lukes Roosevelt, President	Executive leader of Mount Sinai PPS
PMO	Obtain input regarding resource requirements, DSRIP operating plans, and work force requirements	Feedback and request for resources
Finance Leads	Obtain input regarding funds flow, financial sustainability requirements and MCO / risk based contracting strategy.	Feedback on allocation and request for resources
External Stakeholders		
Skilled Nursing/Housing/Rehabilitation	Rachel Amalfitano, CFO, Village Care	Participate in appropriate committees and provide generalized PPS feedback through townhall forum
Skilled Nursing/Nursing Home	Mark Pancirer, CFO, Amsterdam House	Participate in appropriate committees and provide generalized PPS feedback through townhall forum
Home Care	Glenn Tolchin, CFO, VNSNY	Participate in appropriate committees and provide generalized PPS feedback through townhall forum
Hospital	Joseph Guarracino, CFO, Brooklyn Hospital Center	Participate in appropriate committees and provide generalized PPS feedback through townhall forum
FQHC	Jose Virella, CFO, Ryan Center Health Network	Participate in appropriate committees and provide generalized PPS feedback through townhall forum

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.

At its core, IT services will provide the clinical integration and pop health backbone for the PPS, enabling enhanced care coordination, utilization management and provider integration. This infrastructure design will inherently enable management of PPS and DSRIP project performance across the entire PPS and multiple partners. The partners will be able to collect and submit financial reports directly to the PPS Finance team using an electronic platform. These reports and data will enable PPS leadership and appropriate committees the ability to understand how DSRIP projects are impacting overall utilization, associated Medicaid payments and overhead costs; allowing for the identification of appropriate business and utilization management strategies to minimize any unintended consequences. While it is expected that some providers will experience decreased volume, the intent is to achieve this in an incremental and controlled manner, which will allow providers to adapt over time during DSRIP, adjust to new volumes and financial incentives, and re-align operating models.

MS PPS is also working to establish a customer-relations management tool in order to track all reporting functions of the PPS and all contracts. This will include the reporting of financial metrics on a quarterly basis. The data will be self-reported through easy-to use portal system. The PPS data warehouse containing information from RHIO, providers and payers will serve an essential purpose in evaluating value-based payment options as the PPS matures.

The design of centralized IT services' ultimate goal is to enable more cost-effective health care delivery and minimize duplication and waste through reduced variability in clinical processes and decision-making, ongoing process improvement, reduced avoidable acute care utilization and other high-cost services and expenses. This more cost-effective delivery model will decrease total per patient spending, increase tangible value to patients, providers and payers and ultimately enable the network to engage in shared savings and/or value-based payment models. These new payment models will better incentivize health care transformation and maintenance of cost-effective care delivery across the continuum of care. Decreased per patient costs will in turn generate sufficient operating revenue for partners to further invest in infrastructure development and population health initiatives.

IPQR Module 3.8 - Progress Reporting

Instructions :

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

Once implementation plan is complete, the plan and progress against its milestones will be reviewed by Finance Committee every 3 months. Success will be measured by tracking results of each commitment in the plan.

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The success of Financial Sustainability Plan will be achieved through a number of key elements:

• Creating the funds flow principles, processes, and budgets for distribution of DSRIP funds to support implementation of the Financial Sustainability Plan.

• Evolving Governance structure and participation of key stakeholders and providers in the PPS service area.

• Focused integration of IT information and systems in order to enable accurate and timely information flow across PPS providers necessary for proactive performance monitoring. This information flow will include value-based payment measures.

• Regular review of the implementation plan milestones and progress towards meeting the requirements with a report out to the committee on identified areas of risk and potential mitigation strategies to address them.

• Strong PMO structure to facilitate effective implementation of the DSRIP projects.

IPQR Module 3.9 - IA Monitoring

Instructions :

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Section 04 – Cultural Competency & Health Literacy

IPQR Module 4.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize cultural competency / health literacy strategy.	In Progress	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.	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1: Identify PPS partners with Cultural Competence / Health Literacy expertise and establish work-group.	Completed	Step 1: Identify PPS partners with Cultural Competence / Health Literacy expertise and establish work-group.	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2: Building on the CNA, conduct a gap analysis of cultural competency at the partner and PPS level to: 1) identify populations and practices with greatest health disparities and/or poor patient experience, 2) identify key factors and barriers to improve access to primary,	In Progress	Step 2: Building on the CNA, conduct a gap analysis of cultural competency at the partner and PPS level to: 1) identify populations and practices with greatest health disparities and/or poor patient experience, 2) identify key factors and barriers to improve access to primary, behavioral health and preventive care, and 3) define role/capabilities of	06/01/2015	12/31/2015	06/01/2015	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
behavioral health and preventive care, and 3) define role/capabilities of CBOs in our network to provide supportive services. This analysis will be used to identify key targets and goals for the PPS.		CBOs in our network to provide supportive services. This analysis will be used to identify key targets and goals for the PPS.							
Task Step 3: Inventory best practices, existing resources for training staff and delivering CC/HL - sensitive services. Using this information, establish PPS-wide definition of CC/HL, and standards for culturally and linguistically appropriate services and care.	Completed	Step 3: Inventory best practices, existing resources for training staff and delivering CC/HL - sensitive services. Using this information, establish PPS-wide definition of CC/HL, and standards for culturally and linguistically appropriate services and care.	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4: CC/HL work-group develops and collaborates with the Workforce Committee to present CC/HL Strategy to appropriate committees for approval, including plans for patient-related education and materials (including verbal scripts, print, media, online) with Clinical and Patient Advisory Board. Meet with partners and community groups to get buy-in and support. Collaborate with IT and Finance Committees to outline and finalize financial and IT needs necessary to implement training strategy.	In Progress	Step 4: CC/HL work-group develops and collaborates with the Workforce Committee to present CC/HL Strategy to appropriate committees for approval, including plans for patient-related education and materials (including verbal scripts, print, media, online) with Clinical and Patient Advisory Board. Meet with partners and community groups to get buy-in and support. Collaborate with IT and Finance Committees to outline and finalize financial and IT needs necessary to implement training strategy.	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5: Develop communications and engagement approach designed to get partner and patient buy-in.	In Progress	Step 5: Develop communications and engagement approach designed to get partner and patient buy-in.	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6: Develop metrics to evaluate and monitor ongoing impact of CC/HL initiatives.	In Progress	Step 6: Develop metrics to evaluate and monitor ongoing impact of CC/HL initiatives.	06/01/2015	12/31/2015	06/01/2015	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	06/01/2015	06/30/2016	06/01/2015	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
		-- Training plans for other segments of your workforce (and others as appropriate) regarding specific population needs and effective patient engagement approaches							
Task Step 1: The CC/HL work-group and PMO will create an inventory among network partners in PPS to identify existing training practices.	In Progress	Step 1: The CC/HL work-group and PMO will create an inventory among network partners in PPS to identify existing training practices.	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 1.a: Prioritize and finalize training needs and programs with Workforce Committee and other stakeholders.	In Progress	Step 1.a: Prioritize and finalize training needs and programs with Workforce Committee and other stakeholders.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Develop and test a uniform training and education platform that blends e-learning, self-assessment, and in-person review. This platform will educate both clinicians and non-clinicians on health literacy and cultural competency. The format and delivery of trainings will be consistent for clinicians and non-clinicians, however; content will vary for clinicians and non-clinicians to ensure relevance.	In Progress	Step 2: Develop and test a uniform training and education platform that blends e-learning, self-assessment, and in-person review. This platform will educate both clinicians and non-clinicians on health literacy and cultural competency. The format and delivery of trainings will be consistent for clinicians and non-clinicians, however; content will vary for clinicians and non-clinicians to ensure relevance.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2.a: Identify CC "champions" within each partner and establish corresponding points of contact with CBOs.	In Progress	Step 2.a: Identify CC "champions" within each partner and establish corresponding points of contact with CBOs.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3: Collaborate with IT Committee to create web-enabled training.	In Progress	Step 3: Collaborate with IT Committee to create web-enabled training.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4: Develop tracking mechanism and evaluation mechanism to receive feedback from staff on trainings and possible steps to improve. This may include conducting focus groups with supervisors in open forums.	In Progress	Step 4: Develop tracking mechanism and evaluation mechanism to receive feedback from staff on trainings and possible steps to improve. This may include conducting focus groups with supervisors in open forums.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5: PPS governance will prioritize training and roll out for the following three priority areas,	On Hold	Step 5: PPS governance will prioritize training and roll out for the following three priority areas, using CNA and PPS-led meetings above [see Milestone 1],with the goal of maximizing	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
using CNA and PPS-led meetings above [see Milestone 1],with the goal of maximizing the potential number of patients benefitted by the enhanced training: 1. Primary care sites and providers with identified patients having high specific cultural needs and low health literacy levels. 2. Sites/providers with the largest workforce numbers requiring CC/HL training. 3. Sites/providers/practitioners that have the largest number of patients serviced by the PPS projects.		the potential number of patients benefitted by the enhanced training: 1. Primary care sites and providers with identified patients having high specific cultural needs and low health literacy levels. 2. Sites/providers with the largest workforce numbers requiring CC/HL training. 3. Sites/providers/practitioners that have the largest number of patients serviced by the PPS projects.							

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
Finalize cultural competency / health literacy strategy.	
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	

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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 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.

Risk 1: Timeliness of retraining and redeploying the workforce.
Mitigation: assess needs of individual providers and provide support to assist provider in meeting project timeline. Determine ability of provider and where in the roll out process they would be.
Risk 2: Do organizations have adequate coverage to pull employees into additional training?
Mitigation: work closely with union, identify funding for providers, and develop a broad base workforce via Workforce Committee strategies.
Risk 3: Employee engagement.
Mitigation: assess providers internal activity of employee engagement. Develop resources and programs for PPS providers to assist them with their programs.
Risk 4: Needs of the community exceed the ability of the current workforce.
Mitigation: Identify recruitment strategy for each project. Determine ability of providers to redeploy staff to different communities based on CC and HL.
Risk 5: There is a strong co-dependency between the Clinical and Workforce Committees. The work task that the Clinical Committee creates must dictate the work structure the Workforce Committee supports in order for implementation to be successful. It is a potential risk, that with such a large undertaking, the work may become siloed within functional groups.
Mitigation: the MSPPS will coordinate cross-functional work-groups to ensure collaboration. This will also serve to make estimates more realistic, as workforce will not examine each clinical project in isolation, but rather as part of a larger system change.
Risk 6: The future state analysis of the workforce is similarly dependent on the outcomes of the Clinical Committee work.
Mitigation: Workforce and Clinical leadership will work together to ensure necessary information is provided to the committees in order to achieve milestones.
Risk 7: The MSPPS anticipates significant competition for talent in certain roles with other PPSs as the DSRIP initiative moves forward.
Mitigation: The MSPPS plans on collaborating with other PPSs as well as key stakeholders and educational institutions to reduce potential difficulties.
Risk 8: The MSPPS clinical work will need to scale faster than the training initiatives can support. Once training needs have been identified, curriculum may need to be developed, and the training itself may take time to be done effectively.
Mitigation: The MSPPS will work with training providers to ensure we can scale appropriately, as well as collaborate internally to address clinical needs with the resources available.
Risk 9: Each partner and employees at each partner will join the PPS at differing levels of education, experience, and baseline knowledge.
Mitigation: The training strategy will take into account these different levels in designing training initiatives and timeline.
Risk 10: Preliminary discussions with some of our community-based providers suggest that there may be regulatory issues that impact staffing, roles, and capacity of their work forces.
Mitigation: The PPS will work with its partners and NYS to identify and implement solutions to such issues.
Risk 11: The MSPPS may also face a risk of exposing confidential information as a result of sharing data across the various partners.
Mitigation: There will be strict controls put in place as part of the assessment steps of implementation plan so as to minimize this risk.

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IPQR Module 4.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

Successful planning and implementation of a cultural competency and health literacy strategy and a meaningful training program rests on several closely tied work streams with the PPS leadership, members and other technical committees. Clinical and Workforce committees, in collaboration with stakeholder unions and community advisers must assess existing curricula and develop one standardized training curriculum for multiple disciplines and workforce levels endorsed by the PPS provider organizations. Excellent provider and partner engagement to educate them about the strong linkage between poor cultural competency/health literacy and health outcomes, and the effectiveness of "universal precautions" (Step 1a – milestone 1) will be necessary to achieve buy-in for the importance of training of workforce and modification of current verbal and written communication. Adequate funds must be allocated to the development of these curricular programs and to the creation of different modes of training and evaluation depending on level or workforce and roles. This necessitates working with the IT committee to plan feasible curricular activities and develop a common training platform or alternate strategy that can be tracked within the individual organizations and by PPS leadership.

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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
Clinical Committee Co-Chair	Theresa Soriano, Mount Sinai Health System	Provide input to shape policies and procedures.
Clinical Committee Co-Chair	Matt Weissman, Community Healthcare Network	Provide input to shape policies and procedures.
Clinical Director	Edwidge Thomas, Mount Sinai PPS	Provide input to shape policies and procedures.
IT Committee Co-Chair	Kumar Chatani, Mount Sinai Health System	Provide input to shape policies and procedures.
IT Committee Co-Chair	Barbara Hood, Ryan Center	Provide input to shape policies and procedures.
Workforce Committee Co-Chair	Jane Maksoud, Mount Sinai Health System	Approve policies and procedures; lead and maintain oversight of committee activities and projects.
Workforce Committee Co-Chair Cultural Competence / Health Literacy Workgroup Co-Chair	Linda Reid, VNSNY	Approve policies and procedures; lead and maintain oversight of committee activities and projects.
Workforce and Clinical Committees	PPS Members	Assess and define the current and future states of the workforce; conduct a gap and benefits/compensation analysis; create a transition roadmap and training strategy.
Workforce Project Team	Workforce Committee representative members, including partner and union representation	Complete implementation plan steps; make recommendations to the committee for review and approval.
Workforce Project Management	Daniel Liss, Mount Sinai Health System; MSPPS PMO Members	Drive completion of Implementation Plan deliverables; manage community and stakeholder engagement.
Consultants	Undetermined	Help prepare workforce and training analyses and materials.
Cultural Competence / Health Literacy Workgroup Co-Chair	Emma Sollars, Mount Sinai Health System	Approve policies and procedures; lead and maintain oversight of committee activities and projects.

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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		
Mount Sinai Health System	Lead Applicant	Leadership; operation of centralized functions.
Clinical, Finance, and IT Committees	Key partners in developing workforce goals	Collaborate with Workforce Committee to determine needs, funding, and reporting mechanisms.
Mount Sinai Department of Social Work Services	Cultural Competence and Health Literacy Workgroup Co-Chair - Emma Sollars, Program Coordinator, Training and Education	Leadership.
External Stakeholders		
VNSNY	Workforce Committee Co-chair Partner / Cultural Competence and Health Literacy Workgroup Co-Chair - Linda Reid, Director, Workforce Planning & Diversity	Leadership.
Other MSPPS Partners	Partners in PPS	Participate in Workforce Committee.
Labor Management Project (1199)	Partners in PPS - Michael Shay, Labor Management Consultant	Participate in Workforce Committee; will play prominent role in the coordination of training and other workforce efforts.
NYSNA - TBD as needs are determined.	Partners in PPS	Participate in Workforce Committee
Community Healthcare Network (CHN)	Partners in PPS - Emily Briglia, Health Literacy Program Manager	Provide input and expertise in strategy including training.
City Health Works	Partners in PPS - Jamillah Hoy-Rosas, Director of Health Coaching and Clinical Partnerships	Provide input and expertise in strategy including training and patient education.
NYCDOHMH	Local Collaborator - - TBD as needs are determined.	Provide input and expertise in strategy including training.
NY Legal Assistance Group	Partners in PPS - Beth Breslin, Policy Associate	Provide input and expertise in strategy including patients rights and training.
Other, non-MSPPS, organizations and PPSs	External Stakeholder - TBD as needs are determined.	Potentially collaborate with Workforce Committee and MSPPS on joint activities.
Managed Care Organizations and other Payers	Partners in PPS and external stakeholders - TBD as needs are determined.	Provide input and expertise in strategy including training.

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.

The development of a shared IT infrastructure will support the implementation of the MS PPS cultural competency/health literacy strategy by providing a means for the distribution of consistent, culturally competent materials and training for patients and providers, and by establishing Health Information Exchange (HIE) between the health system and culturally competent Community Based Organizations (CBOs).

A central component of the MS PPS strategic plan, as it relates to cultural competency, is the provision of a myriad of training activities, including foundational instruction on the relationship between culture, stigma and health for the frontline and patient-interacting workforce. This training will be implemented via a core function of the MS PPS IT infrastructure- the Learning Management System (LMS). LMS will allow the PPS to deliver and track cultural competence training across all participating PPS providers and monitor both deficits and improvements, over time.

Simultaneously, the PPS will use elements of its shared IT infrastructure to develop and deliver culturally appropriate information and education to its patient population, taking into account patient health literacy. The IT tool which supports this charge is the Patient Portal, which includes virtual support to assist in completing referrals for clinical and non-clinical services, after-hours care (triage)/warm-line and general PPS-level customer services.

Finally, the IT infrastructure will include flat file/CBO data conversion implementation that will allow culturally competent CBOs participating in the PPS to exchange data and track outcomes, particularly around the provision of services impacting the social determinants of health.

IPQR Module 4.8 - Progress Reporting

Instructions :

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

Staff Training: 1. Percentage of staff members that complete training modules within identified time period. 2. Percentage of staff members that score within target % range (to be identified) on post training competency evaluation. 3. Percentage of staff that receive meets or exceeds expectations on performance appraisals in these topic areas.

Patient Population: 1. Percentage of identified patients that have improved compliance (identify target %) with attending medical appointments (primary care, specialty). 2. Percentage of identified patients that have improved adherence with medication regimen (identify target %). 3. Percentage of identified patients that have reduced unnecessary medical utilization (emergency department visits and hospitalizations).

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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.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1. Develop current state assessment plan to determine the current landscape of EHR deployments, state of implemented interoperability between these systems, and levels of functional data sharing in the MS PPS provider network, including a list of PPS participant organizations to be queried	Completed	Current state assessment planning has begun. We are currently working with other workstreams to coordinate the assessment process and finalize the list of PPS partners	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2. Develop current state assessment plan to determine the current landscape for PPS lead entity to support project and reporting requirements.	Completed	Step 2. Develop current state assessment plan to determine the current landscape for PPS lead entity to support project and reporting requirements.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3. Conduct data collection (survey of partners) for assessment utilizing tools such as email, phone, and in person assessments.	In Progress	Step 3. Conduct data collection (survey of partners) for assessment utilizing tools such as email, phone, and in person assessments.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4. Validation of survey responses from partners	In Progress	Step 4. Validation of survey responses from partners	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task	In Progress	Step 5. Leverage the assessment data collected to conduct	01/01/2016	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
Step 5. Leverage the assessment data collected to conduct an IT gap analysis pertaining to Mount Sinai PPS partner organizations		an IT gap analysis pertaining to Mount Sinai PPS partner organizations							
Task Step 6. Leverage the assessment data collected to conduct an IT gap analysis on internal PPS IT infrastructure	In Progress	Step 6. Leverage the assessment data collected to conduct an IT gap analysis on internal PPS IT infrastructure	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 7. Review and approval of initial findings and gap analyses by PPS leadership	In Progress	Step 7. Review and approval of initial findings and gap analyses by PPS leadership	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #2 Develop an IT Change Management Strategy.	In Progress	IT change management strategy, signed off by PPS Board. The strategy should include: -- Your approach to governance of the change process; -- A communication plan to manage communication and involvement of all stakeholders, including users; -- An education and training plan; -- An impact / risk assessment for the entire IT change process; and -- Defined workflows for authorizing and implementing IT changes	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1. Develop IT governance strategy and framework for centralized PPS	In Progress	Step 1. Develop IT governance strategy and framework for centralized PPS	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2. Develop the IT governance strategy and framework for PPS partners	In Progress	Step 2. Develop the IT governance strategy and framework for PPS partners	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3. Develop IT Change Management Strategy including approach to governance, communication, education and training, IT change management reporting by providers, risk management, and workflows	In Progress	Step 3. Develop IT Change Management Strategy including approach to governance, communication, education and training, IT change management reporting by providers, risk management, and workflows	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4. Review and approval by PPS leadership	In Progress	Step 4. Review and approval by PPS leadership	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #3 Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	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:	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		-- 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).							
Task Step 1. Develop framework for data sharing and interoperability roadmap, including resources responsible for key components	In Progress	The data sharing strategy is currently in development and in the process of refinement and approval with the IT Committee	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2. Develop draft plan for IT standards and infrastructure, including training	In Progress	Draft timelines and project plans are in development for all IT centralized services for the PPS.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3. Develop draft governance and policy framework for data sharing and shared IT infrastructure, including data exchange agreements	In Progress	Step 3. Develop draft governance and policy framework for data sharing and shared IT infrastructure, including data exchange agreements	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4. Solicit stakeholder input on plan for IT standards and infrastructure, including from local RHIOs, and revise as needed	In Progress	Step 4. Solicit stakeholder input on plan for IT standards and infrastructure, including from local RHIOs, and revise as needed	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5. Solicit stakeholder input on draft governance and policy framework, including data exchange agreements, and revise as needed	In Progress	Step 5. Solicit stakeholder input on draft governance and policy framework, including data exchange agreements, and revise as needed	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6. Map IT standards and infrastructure plan to finalized IT Current State Assessment	In Progress	Step 6. Map IT standards and infrastructure plan to finalized IT Current State Assessment	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 7. Review and approval by PPS leadership of roadmap, including governance and policy	In Progress	Step 7. Review and approval by PPS leadership of roadmap, including governance and policy framework, plan for IT standards and infrastructure, and guidance to participants	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
framework, plan for IT standards and infrastructure, and guidance to participants									
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	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1. Perform environmental scan as part of assessments of partners to understand if they have access to the HIE/RHIO and status of MU attestation	In Progress	Step 1. Perform environmental scan as part of assessments of partners to understand if they have access to the HIE/RHIO and status of MU attestation	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2. Develop draft engagement plan for providers in partnership with the QEs	In Progress	Step 2. Develop draft engagement plan for providers in partnership with the QEs	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3. Refine draft plan based on stakeholder input and findings in IT Current State Assessment, including assessment of engagement methodologies that will be most effective in facilitating stakeholder outreach	In Progress	Step 3. Refine draft plan based on stakeholder input and findings in IT Current State Assessment, including assessment of engagement methodologies that will be most effective in facilitating stakeholder outreach	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4. Develop plan for patient engagement	In Progress	Step 4. Develop plan for patient engagement	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5. Review and approval by PPS leadership, including review of cultural competency guidelines developed by the Cultural Competency and Health Literacy workstream	In Progress	Step 5. Review and approval by PPS leadership, including review of cultural competency guidelines developed by the Cultural Competency and Health Literacy workstream	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
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	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1. Define data security and confidentiality guiding principles	In Progress	We are currently working on developing the information security strategy required for the PPS.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2. Incorporate data security guiding	In Progress	Step 2. Incorporate data security guiding principles into draft governance and policy framework and draft IT standards and	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	AV
principles into draft governance and policy framework and draft IT standards and infrastructure plan		infrastructure plan							
Task Step 3. Conduct analysis of information security risks of the technical and policy components fo the IT Data Sharing and Interoperability Roadmap	In Progress	Step 3. Conduct analysis of information security risks of the technical and policy components fo the IT Data Sharing and Interoperability Roadmap	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4. Develop plan for risk mitigation and ongoing security testing and controls	In Progress	Step 4. Develop plan for risk mitigation and ongoing security testing and controls	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5. Review and approval of data security and confidentiality plan by PPS leadership and assignment of responsibility for maintaining adherence across the PPS network	In Progress	Step 5. Review and approval of data security and confidentiality plan by PPS leadership and assignment of responsibility for maintaining adherence across the PPS network	04/01/2016	06/30/2016	04/01/2016	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
Develop a data security and confidentiality plan.	tomfitz	Policies/Procedures	34_MDL0503_1_2_20151215161433_Overview_workbook.docx	Overview Security Workbook, file for DY1 Q2 remediation, response to IA feedback	12/15/2015 04:14 PM
	tomfitz	Policies/Procedures	34_MDL0503_1_2_20151215161341_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(AC_Family)_2....docx	Security Workbook (AC Family), file for DY1 Q2 remediation, response to IA feedback	12/15/2015 04:13 PM
	tomfitz	Policies/Procedures	34_MDL0503_1_2_20151215161302_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(CM_Family)_2....docx	Security Workbook (CM Family), file for DY1 Q2 remediation, response to IA feedback	12/15/2015 04:13 PM
	tomfitz	Policies/Procedures	34_MDL0503_1_2_20151215161216_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(IA_Family)_2....docx	Security Workbook (IA Family), file for DY1 Q2 remediation, response to IA feedback	12/15/2015 04:12 PM

NYS Confidentiality – High

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	tomfitz	Policies/Procedures	34_MDL0503_1_2_20151215161025_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(SC_Family)_2....docx	Security Workbook (SC Family), file for DY1 Q2 remediation, response to IA feedback	12/15/2015 04:10 PM
	tomfitz	Documentation/Certification	34_MDL0503_1_2_20151029114621_OHIP DOS System Security Plan (SSP) Moderate Plus Workbook (SC Family).docx	Security Workbook (SC family)	10/29/2015 11:46 AM
	tomfitz	Documentation/Certification	34_MDL0503_1_2_20151029114531_OHIP DOS System Security Plan (SSP) Moderate Plus Workbook (IA Family).docx	Security Workbook (IA family)	10/29/2015 11:45 AM
	tomfitz	Documentation/Certification	34_MDL0503_1_2_20151029114439_OHIP DOS System Security Plan (SSP) Moderate Plus Workbook (CM Family).docx	Security Workbook (CM family)	10/29/2015 11:44 AM
	tomfitz	Documentation/Certification	34_MDL0503_1_2_20151029114249_OHIP DOS System Security Plan (SSP) Moderate Plus Workbook (AC Family).docx	Security Workbook (AC family)	10/29/2015 11:42 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	
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	

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #3	Pass & Ongoing	
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	This milestone is Pass and Ongoing pending final review of security workbooks by DOH.

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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.

Risk 1: PPS partners not fully comprehending the IT requirements
Mitigation Strategy: Engage in comprehensive community-based partner education through workshops, web-based learning tools and 1:1 interaction at partner sites; development of education materials by provider type to clearly state expectations and requirements.
Risk 2: Partners inability to achieve meaningful adoption of IT capabilities to connect to centralized IT services and engage in data sharing
Mitigation Strategy: PPS has planned for provision of technical assistance with relation to EHR adoption and PCMH certification. PPS will establish incremental IT adoption milestones and site visits to ensure progress towards defined requirements and performance objectives. Financial incentives will be put into place to encourage IT adoption by partners with DSRIP dollars.
Risk 3: Breadth of EHRs and electronic platforms currently in use may pose significant barrier and/or cost for development of interfaces by vendors for HIE connectivity
Mitigation Strategy: PPS IT committee will conduct a deeper assessment to better understand vendors within PPS, work to negotiate interfaces for top volume platforms first; as well as work with partners without IT platforms to adopt software from a select set of vendors.
Risk 4: Consent process may inhibit ability to access and share pertinent patient data
Mitigation Strategy: Continue to coordinate with GNYHA, other PPSs, RHIOs and stakeholders to drive policy change and consent education for patients through providers to continually improve level of consent and mitigate policy barriers.
Risk 5: As with any collaborative, stakeholders may not reach consensus on strategic, business or governance decisions in a timely manner
Mitigation Strategy: Implementation plan will carefully map out deliverable/decision points and risks of indecision will be raised immediately to PPS leadership for arbitration; PPS will leverage State guidance on key business and technical decisions where appropriate.
Risk 6: RHIO and SHIN NY implementation and upgrade timelines may be delayed or may experience unforeseen barriers, which may cause any intended functionality to be implemented by the PPS that depends on these core infrastructure components to be delayed.
Mitigation Strategy: MS PPS will work closely with RHIO partners and with NYSDOH to continuously gauge performance benchmarks as set by SHIN NY for RHIO system upgrades, and by NYSDOH for core functionality components of the MAPP. The PPS will be specifically including a RHIO gap analysis as part of the current state IT assessment in DY1 to help mitigate this risk. Additionally, MS PPS and RHIO will have overlap with Boards of both organizations to promote alignment.
Risk 7: Funding challenge to attain resources to help realize IT strategy and investments
Mitigation Strategy: MS PPS has already submitted a capital request to help fund the IT needs for the PPS. Partners have also been encouraged to apply for a capital request, which many have done. Additionally, the PPS is providing information for alternative funding sources, such as PCIP, for partners to connect with.
Risk 8: Assure data security is upheld across all partners
Mitigation Strategy: MS PPS will develop data security protocols and policies that will be vetted through compliance to ensure patient data remains protected while data sharing is promoted to help us achieve DSRIP milestones.

IPQR Module 5.4 - Major Dependencies on Organizational Workstreams

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Instructions :

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

The IT Systems and Processes developed by the MS PPS are are highly interdependent with other organizational workstreams:
Workforce: The proposed IT infrastructure will support workforce transformation through the inclusion of a Learning Management System that will allow the PPS to deploy and track workforce training and understanding of PPS-developed project-driven protocols.
Governance and Financial Sustainability: The proposed IT infrastructure will support PPS governance and financial sustainability by providing the governing board with timely access to clinical, financial and provider-related information, that they might make informed and accurate decisions.
Cultural Competence and Health Literacy: The proposed IT infrastructure will support cultural competence and health literacy by providing a means for the distribution of consistent, culturally competent materials and training for patients and providers, and by establishing Health Information Exchange (HIE) between the health system and culturally competent Community Based Organizations (CBOs).

Performance Reporting: The proposed IT infrastructure will put in place the IT systems necessary to gather, store and analyze information across all PPS providers to facilitate efficient and valid performance reporting.

Practitioner Engagement: The proposed IT infrastructure will support practitioner engagement through implementation of the MS PPS User Portal, offering wide-spread access to the MS PPS data warehouse, including analytic functionality, dashboards, care management tools, Learning Management System modules and DSRIP performance reporting support.

Population Health Management: The proposed IT infrastructure will support population health management through the deployment of a centralized data warehouse and associated analytic platforms that will include critical functions, such as clinical decision support, population health metrics, predictive analytics, reporting and registries for care management, and utilization management

Clinical Integration: The proposed IT infrastructure will support clinical integration through the wide-spread achievement of data exchange and interoperability.

Financial Sustainability: Capability to monitor and track PPS partner performance metrics will depend on the financial sustainability of the PPS overall, in order to provide the needed centralized infrastructure for performance reporting.

Funds Flow: The availability of DSRIP funds to support the centralized infrastructure that will be necessary in order to support all DSRIP projects and the ability to achieve metrics and milestones.

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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
Provision of centralized IT services to fulfill 2.a.i and other project core IT requirements	Kumar Chatani, CIO, Mount Sinai Health System and IT Committee: Greg Fortin, Isabella Nursing Home; Richard Pineda, Amsterdam Nursing Home; Warria Esmond, Settlement Health; Kate Nixon, Visiting Nurse Service of New York; Mitze Amoroso, ArchCare; Miguel Mendez, Housing Works; Daniel Lowy, Argus Community, Inc.; Bill Moran, The Brooklyn Hospital Center; Richard Clarkson, Callen-Lorde Community Health Center; Ricardo Santiago, Village Center for Care d/b/a VillageCare; Vivek Sawhney, YAI; Kathy Cresswell, Institute of Family Health; Patricia Marthone, 1199 SEIU UHWE; Michael Buckner, Bailey House; Barbara Hood, William F. Ryan Community Health Network; Crystal Jordan, Harlem United; Deborah Witham, VIP Community Services; Edwin Young, MD, Mount Sinai; Kash Patel, Sr. Director of Innovation & Analytics, Mount Sinai	Design, plan and implementation of IT infrastructure to achieve: bidirectional data sharing, HIE connectivity, alerts, messaging, care coordination, PCMH level III and adoption of MU II eligible EHRs
Inform clinical requirements and data needs for UM, performance management and RCE	Theresa Soriano, MD, MPH, Mount Sinai, Matthew Weissman, MD, MBA, FAAP, Community Health Network, and CMO Edwidge Thomas, Clinical Director of DSRIP PMO, Mount Sinai	Coordinate with IT committee to ensure clinical data needs for reporting, RCE, UM and quality management are understood and included within IT strategy and proposed solutions; including RHIO data capture. Inform workflow needs and how data integration will impact care delivery and coordination.
Ensure alignment of strategy with long-term vision, business priorities and DSRIP objectives	Jill Huck, Director and Edwidge Thomas, Clinical Director of Mount Sinai DSRIP PMO and the MS PPS Board of Managers : Art Gianelli*, MS Health System; Arthur Klein, MS Health System; Brad Beckstrom, MS Health System; Brian Mcindoe, William Ryan Center; Caryn Scwab, MS Health System;	Strategic oversight and alignment across workstreams, PPS and DSRIP projects Arbitrate priorities for strategic success and resource allocations (in coordination with recommendations and guidance of CFO and Finance committee)

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
	Don Scanlon, MS Health System; Donna Colonna, CBC and SUS/Palladia; Ed Lucy, MS Health System; Frank Cino, MS Health System; Gary Burke, MS Health System; Hany Abdelaal, VNS of New York; James Ferris, NYSNA; Jane Maksoud, MS Health System; Jay Gormley, Metropolitan Jewish Health System; Jim Davis, Amsterdam House ; Joan Clark-Carney, Brooklyn Hospital Center; Kelly Cassano, MS Health System; Kumar Chatani, MS; Mali Trilla*, Settlement Health; Neil Calman, IFH; Peter Scaminaci, Phoenix House New York; Richard Park, City MD; Rizwan Hameed, All Medical IPA; Roy Cohen, MS; Sabina Lim, MS Health System; Saily Cabral, SEIU 1199; Scott La Rue, Arch Care; Sharen Duke, AIDS Service Center; Theresa Soriano, MS	
Provision of IT and data governance for PPS partners, RHIOs and coordination with State entities and MCOs for data exchange, analytics, reporting, etc.	CIO Kumar Chatani, CIO, Mount Sinai Health System and IT Committee (see names above)	Data governance model and data use agreement(s) by provider type Minimum Data Set requirements by provider type HIPAA and IS compliance policies, training and infrastructure Data and user access management & audits Vendor selection and management
Provide feedback on overall IT strategy in its ability to meet DSRIP and PPS requirements for data sharing and project requirement.	IT Committee (see names above)	Feedback on IT strategy from partner organizations to ensure that the strategy takes all partner, DSRIP, and PPS needs into consideration to ensure that requirements and milestones can be met in a timely manner. Partners will also provide feedback throughout the implementation phase to ensure all issues and challenges are addressed to minimize risks/impact.
Provide consistent, impartial and balanced leadership for PPS IT strategy and infrastructure needs	Kumar Chatani, CIO, Mount Sinai Health System and IT Committee (see names above)	IT leadership on behalf of MS PPS partners to ensure IT strategy, investments and services/ infrastructure meet the needs of the PPS, address critical gaps and enable ongoing rapid cycle evaluation and performance management

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Operational leadership and Performance management oversight	MS PPS, LLC: Board of Directors; CIO (TBD)	Development of performance management and reporting tools Development of dashboards as needed by PPS leadership, committees and providers IT implementation plan management; daily oversight of project teams and vendors Lead development of technical assistance and resources with vendors, project teams, etc.

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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		
Barbara Hood, CIO, William F. Ryan Community Health Network & Kumar Chatani, CIO, Mount Sinai Health System	Responsible for representation of PPS partner interests/needs	Ongoing coordination and strategy alignment across PPS to ensure data sharing and care coordination for significant proportion of PPS members; Responsible for development of implementation plan with in put from committee members
MS PPS Committees and workgroups	PPS partner representation and project managers/ leads	Coordination with IT committee and representation of PPS partners to inform IT needs for projects and network performance; ensure IT strategy reflects and address the collective partner needs and will enable improve care delivery to address CNA
External Stakeholders		
MS PPS IT Committee members: Greg Fortin, Isabella Nursing Home; Richard Pineda, Amsterdam Nursing Home; Warria Esmond, Settlement Health; Kate Nixon, VNS of New York; Mitze Amoroso, ArchCare; Miguel Mendez, Housing Works; Daniel Lowy, Argus Community, Inc.; Bill Moran, The Brooklyn Hospital Center; Richard Clarkson, Callen-Lorde Community Health Center; Ricardo Santiago, Village Center for Care d/b/a VillageCare; Vivek Sawhney, YAI; Kathy Cresswell, Institute of Family Health; et al.	Representation of PPS provider types	Represent various partner types for 2ai and PPS to ensure diversity of partner needs, roles and capabilities are represented in planning, governance and implementation
Local RHIOs Leadership: Tom Check and Jason Thaw of Healthix; additionally, Interboro RHIO and Bronx RHIO.	RHIO leadership within region	Responsible for coordination with MS PPS IT leadership for deployment of IT strategy; delivery of HIE connectivity, and select functionality (e.g. DIRECT messaging); ensuring cross-RHIO/PPS connectivity via SHIN-NY; provision of consent management and integration with statewide MPI and data sharing initiatives
PPS Parnters: (In first wave) Greg Fortin, Isabella	Performing partners and coordinating providers	Responsible for informing IT needs of PPS, being responsive to

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Nursing Home; Warria Esmond, Settlement Health; Mitze Amoroso, ArchCare;Bill Moran, The Brooklyn Hospital Center; Kathy Cresswell, Institute of Family Health; Barbara Hood, William F. Ryan Community Health Network		assessment and planning requests, investing in basic IT infrastructure per DSRIP project and IT strategy requirements; adopting standards and protocols defined by PPS leadership; ongoing engagement in reporting and process improvement activities

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IPQR Module 5.7 - Progress Reporting

Instructions :

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

The IT work stream leadership will develop a comprehensive implementation plan, supplemented by GANTT chart outlining quarterly milestones based on performance requirements (DSRIP) and implementation milestones for the PPS IT strategy. The implementation plan will provide a measurable guide for progress that will be regularly shared with Leadership and collaborating committees to ensure provision of deliverables, services and functionality in line with PPS scale and speed, and overall PPS IT requirements. The IT team will also work to identify a set of internal metrics that will define success beyond meeting the milestones required by the state to ensure high quality of service that meets the PPSs DSRIP needs. In addition to IT implementation progress tracking and management, the committee will engage in PPS partner feedback requests through surveys and discussion forums to ensure solutions and services continually meet partner needs, expectations and deliver value.

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	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 2. Develop Interim reporting solutions to begin reporting on requirements and milestones, including those in Speed and Scale, identified for DY1.	Completed	We are currently finalizing the interim reporting strategy for DY1 reporting needs.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3. Define metrics to track and report on processes and outcomes in collaboration with local stakeholders and NYSDOH, including any PPS metrics beyond NYSDOH requirements.	In Progress	Step 3. Define metrics to track and report on processes and outcomes in collaboration with local stakeholders and NYSDOH, including any PPS metrics beyond NYSDOH requirements.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4. Define dashboard technologies that will be used by staff and participants to monitor outcomes and guide targeted quality improvement interventions, taking into account functionality elements provided by NYSDOH via the MAPP.	In Progress	Step 4. Define dashboard technologies that will be used by staff and participants to monitor outcomes and guide targeted quality improvement interventions, taking into account functionality elements provided by NYSDOH via the MAPP.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5. Establish framework for facilitating rapid cycle improvement informed by continuous	In Progress	Step 5. Establish framework for facilitating rapid cycle improvement informed by continuous outcomes monitoring.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
outcomes monitoring.									
Task Step 6. Establish a committee with project manager lead and Director of Provider Relations from the PMO, including Clinical committee leads and IT committee leads to design PPS wide performance monitoring and communication.	Completed	Step 1.: Establish a committee with project manager lead and Director of Provider Relations from the PMO, including Clinical committee leads and IT committee leads to design PPS wide performance monitoring and communication.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 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.	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1. Develop PPS-wide training program for clinical quality and performance reporting.	In Progress	Performance Reporting committee will work with provider relations team and Stakeholder engagement Cross-functional working group to design overall PPS plan.	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2. Establish draft training program for review by multidisciplinary team of partners.	In Progress	Performance reporting committee will request review by various stakeholders to comment on draft plan.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3. Finalize training program for execution.	In Progress	Step 3. Finalize training program for execution.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4. Review and approval by MS PPS leadership.	In Progress	Step 4. Review and approval by MS PPS leadership.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5: Deliver training program to PPS partners.	In Progress	Need to solicit partners for training of performance reporting and clinical quality.	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

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish reporting structure for PPS-wide performance reporting and communication.	Reporting work group established to address Steps 2 and 5. Members of the work group includes representation from IT, Clinical Director, Provider Relations, Data Analytics, and Physician Informaticist.
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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Mount Sinai PPS, LLC (PPS ID:34)

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.

Risk 1: There is currently lack of definition on the performance monitoring and reporting infrastructure that will be provided by NYSDOH via the MAPP relative to what will be provided by PPSs themselves.
Mitigation Strategy: Close collaboration and transparency with NYSDOH, including participation in DSRIP CIO forum.
Risk 2: Defining performance metrics in multi-stakeholder environments often takes significant time and effort.
Mitigation: Develop initial set of measures with input from NYSDOH and experts in the field, with stakeholder input throughout the process.
Risk 3: Some MS PPS members may not want their performance outcomes to be evaluated or compared with their competitors' performance.
Mitigation: Develop a communications strategy to address these concerns.
Risk 4: Risks resulting from the integration of a broad network of providers into a new network with contracting dollars linked to performance, including some competing provider organizations and others with no experience in collaborative care models.
Mitigation: Implement transparent governance and oversight of performance monitoring and outcomes-based payment processes. Define processes and expectations well in advance of implementing collaborative care practices and the underlying IT infrastructure.
Risk 5: Risk that technology vendors will not deliver services enabling the detailed performance and financial monitoring demanded by the PPS.
Mitigation: Engage in a thorough and standardized procurement process for IT vendors, beginning with detailed definition of requirements. Include detailed requirements in procurement documents, and provide training to proposal evaluation committees so that they fully understand requirement details to optimize their decision-making process. Apply vendor contracting and management best practices.
Risk 6: Workforce(s) inexperienced in performance management and reporting systems.
Mitigation: staff to required level at the PPS, including education and training staff; provide "high-touch" education and training to PPS participants; develop accessible resources and toolkits; elicit participant concerns early and often, listen to them in a sincere manner, and address them with respect without deviating from the overall goals of the program.
Risk 7: Operating in multiple markets within NYC exposes the PPS to several performance monitoring and reporting risks.
Mitigation: Because our attributed patient population will cut across market segments, our analytic tools will enable tracking of outcomes and performance among specific cohorts that the PPS and PPS members can define according to multiple such as geography, health condition, provider affiliation, RHIO affiliation, etc. While we will pursue broad outcome improvement initiatives across the PPS, we will utilize more granular segmentation of patients for interventions appropriate to specific market segments and populations.
Risk 8: partners who are participating in multiple PPSs
Mitigation: The PPS will collaborate with multiple PPSs to develop reporting measures, roll-out plan, and implementation to reduce risk of duplication and conflicting reporting processes
Risk 9: Partners may experience constraints on resources and conflicting reporting requirements from participation in multiple programs
Mitigation: The PPS will develop reporting structure in alignment with existing program requirements where ever possible. For instance, the PPS will develop reporting tools for MU in alignment with MU requirements to reduce duplication of reports. Additionally, the PPS will consolidate reports where ever possible to reduce resource constraints and work with other reporting distribution channels to align communications on those measures.

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Mount Sinai PPS, LLC (PPS ID:34)

IPQR Module 6.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

Performance reporting will require close coordination with other committees and leadership to ensure all key metrics and indicators are effectively tracked, captured, reported and maintained in a central data repository. Each respective committee, e.g. workforce, finance, IT, etc. will define key indicators, thresholds for performance (e.g. max and min) for performance monitoring. Monitoring and reporting will support PPS governance, rapid cycle evaluation and partner funds flow distribution in alignment with performance-based contract requirements and expectations. Careful coordination will be required with project leads and committees to determine these indicators are the best, most efficient means for standardized, consistent data collection and reporting. Additionally, the PPS will have to carefully communicate with other committees and partners to ensure performance reporting plan, requirements, and training are consistent and efficient. Successful PPS reporting will require the development of a CRM tool that will enable easy tracking of partner performance and deployment of PPS governance and provider dashboards.
In addition, the Performance reporting will coordinate with NYSDOH to ensure alignment and fulfillment of reporting requirements.

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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
Oversight and accountability for delivery of performance reporting capability.	MS PPS Leadership; CIO; IT Committee	Performance reporting infrastructure (design, planning and implementation). Coordination with NYDOH, PPS partners and other sources for data collection. Development of dashboards to enable performance management and rapid cycle evaluation. Management and oversight of performance reporting and data collection staff and project leads, including engagement of committees and governance leads to inform process.
Responsible for informing development of performance tools, monitoring performance of partners and PPS, informing process improvement and corrective action.	Leadership, Finance Committee, IT Committee, Clinical Committee	Inform identification of key indicators and operational, clinical, financial, quality and other performance metrics. Responsible for informing development of dashboards, performance thresholds, reviewing data/reports and making recommendations to Governing Board on necessary actions.
Responsible for determining appropriate actions to ensure PPS performance based on available information.	Governing Board	Responsible for reviewing dashboards and performance recommendations from leadership and committees and making decisions for PPS to ensure necessary process improvements, corrective actions, etc.

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IPQR Module 6.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
PPS Partners	Submit data and review dashboards.	Based on reports and data, adapt DSRIP performance, strategies and initiatives to achieve metrics/milestones and/or bridge gaps to goal measures; provide timely reporting and submission of data in specified manner/format.
PMO	Project Management office for the Mount Sinai PPS.	Tracks and reports performance and data throughout the PPS and to the state. Executes projects from implementation plan to ensure the success of DSRIP.
IT Committee	Design and build of performance reporting infrastructure.	Design and build infrastructure for performance reporting including the capacity to capture and store critical data, connectivity with partners and any necessary analytics support
Clinical Committee	Governance of performance reporting and partner engagement.	Develop and implement governance structure for reporting, monitoring projects from implementation plan to ensure the success of DSRIP.
MSHP	Collaborate with IT committee on performance reporting.	Will support IT in developing performance reporting platforms and dashboards.
External Stakeholders		
NYSDOH	Provision of statewide/PPS dashboards and performance data	Provide data, including claims data, consolidated reports and web-based dashboards for PPSs for performance management; provide templates for DSRIP performance reporting; provide common operational definitions for metrics and milestones and reporting requirements; provide guidance on performance improvement opportunities and evidence-based guidance and PPS benchmark data.
Patients, Advocates and Caregivers (consumers)	Member Satisfaction and loyalty	Provide direct and indirect feedback to FLPPS. Direct feedback through patient satisfaction surveys, HCAHPS, CAHPS, etc. as well as indirect feedback through utilization patterns - preferred providers will have higher demand. Planning process will include engagement of consumer input in design of services, user engagement/activation tools and marketing, outreach and education.

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
MCOs	Provision of claims data, benchmark data and support in development of population health analytic tools	Coordinate with PPS in provision of claims data and benchmark data to support performance management; potential for contract negotiation based on improved total cost management.

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Mount Sinai PPS, LLC (PPS ID:34)

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.

The MS PPS data infrastructure will enable performance monitoring and reporting in several ways: (1) Interoperability between systems including RHIO infrastructure will create a robust pool of data for analysis and reporting; (2) the MS PPS data analytics platform will enable performance tracking from the provider to the PPS level, and tracking of outcomes for specific population cohorts; (3) care management teams will proactively engage prioritized patient cohorts; and (4) reporting tools and dashboards informed by DSRIP metrics will produce reports for internal stakeholders, NYSDOH, and external stakeholders.

IPQR Module 6.8 - Progress Reporting

Instructions :

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

Success will be defined by developing a set of measures that will consider the progress in planning, design and deployment of the performance reporting processes, tools and centralized dashboard with user access. Performance reporting will likely begin as a more manual process, with increasing automation, queries, user features and data points over time. The IT Committee, in coordination with other Committees such as Clinical, PMO, Provider Relations Team and PPS leadership will define the requirements and milestones for performance reporting capabilities and timeline, in line with State provided reporting tools, data and timelines. In addition, the PMO will track the number of engaged partners in the training program for performance monitoring and clinical quality by partners. It will be critical to have a high success rate of partner participation by those who adhere to the training protocol and report improvement in their practice. The PPS will continue to develop a robust system to track the set of metrics during Rapid Cycle evaluation with our partners.

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	09/01/2015	07/31/2016	09/01/2015	07/31/2016	09/30/2016	DY2 Q2	NO
Task Step 1. Identify models of provider engagement that work best within multiple settings, and how engagement may need to vary geographically or by project participation.	In Progress	Draft provider engagement list of best practices.	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2. Assess with our partners their challenges in engaging with practitioners.	In Progress	Stakeholder engagement meeting minutes.	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3. Develop effective messages for practitioners, such as describing discrete financial gains from achieving patient care objectives as described by PPS and ensure leadership adherence to foster provider trust.	In Progress	Draft provider/stakeholder engagement print and media educational materials; meeting minutes	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4. Develop a draft physician communication and engagement plan which: 1) Reflects identified provider engagement models and best	In Progress	Draft provider/stakeholder engagement print and media educational materials; meeting minutes	09/01/2015	03/31/2016	09/01/2015	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
practices; 2) Leverages early adopters and leaders as potential PPS "champions"; 3) Reflects physician feedback to the PPS regarding information needs and preferred methods of communication and engagement; 4) Establishes channels for two-way information flow between the PPS/PMO and physicians; 5) Facilitates peer-to-peer learning for participating providers; 6) Engages the clinical committee and project committees, as appropriate.									
Task Step 5. Assess availability of key practitioner stakeholders to hold positions of leadership within the PPS.	In Progress	Stakeholder engagement meeting minutes and attendance lists	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6. Identify early adopters within the provider network.	In Progress	Stakeholder engagement meeting minutes and attendance lists	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 7. Identify potential conflicts in values and beliefs between providers in the PPS and with PPS leadership.	In Progress	Stakeholder engagement meeting minutes and attendance lists	09/01/2015	07/31/2016	09/01/2015	07/31/2016	09/30/2016	DY2 Q2	
Task Step 8. Finalize provider communication and engagement plan which reflects stakeholder input.	In Progress	Board-approved provider communication and engagement plan	09/01/2015	07/31/2016	09/01/2015	07/31/2016	09/30/2016	DY2 Q2	
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.	09/01/2015	10/31/2016	09/01/2015	10/31/2016	12/31/2016	DY2 Q3	NO
Task Step 1. Assess communication tools to be used by practitioners within the PPS.	In Progress	Stakeholder Engagment Committee meeting minutes detailing discussion of communication tools	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2. Design training/education plan for	In Progress	PPS traning/education plan	09/01/2015	03/31/2016	09/01/2015	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
practitioners that includes materials and strategies for targeting: 1) large practitioner organizations in each of the Domains; 2) smaller practitioner organizations, particularly those needing additional support around IT; and 3) different provider types and practice levels.									
Task Step 3: Develop plan to define metrics to track and measure success of trainings for each group above (Step 2)	In Progress	PPS training/education plan with metrics for success of each group	11/30/2015	09/30/2016	11/30/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4. Solicit practitioner feedback to improve and refine training, educational plans, materials, and metrics to track.	In Progress	Summary report of practitioner feedback	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5. Develop toolkit materials to educate practitioners about the DSRIP program and PPS projects, as well as outreach and education plan to reach practitioners. Materials will be targeted at types of practitioners and by DSRIP project topics. For example, educational materials on evidence-based goals for at home patient care will be distributed to non-physician dominated groups to ensure home agencies are aligned with goals of patient care.	In Progress	PPS practitioner education/training toolkit	12/01/2015	09/30/2016	12/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 6. Develop formal provider retention policies that are standardized with discrete goals, and which can be supported by the training programs.	In Progress	Board-approved practitioner retention policies	12/01/2015	09/30/2016	12/01/2015	09/30/2016	09/30/2016	DY2 Q2	

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

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop Practitioners communication and engagement plan.	
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.	

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.

Major risks include the availability of funding to carry out the major changes associated with DSRIP and the Mt. Sinai PPS. Each provider needs an assessment as to the information technology, workforce, and data reporting capabilities to ensure smaller providers are not left behind in achieving goals. This assessment should start using key early adopters, who can serve as role models and champions for the PPS, but will need expansion. The ease of use of the IT selected software package will have a large impact on the ability to aggregate data and share findings with individual groups of providers. Each domain's educational goals and performance improvement benchmarks will require identifying the large stakeholders for the initial round of education. Survey utilization can confirm the education progress and alignment of goals.

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, Clinical Integration, and Workforce will be critical for practitioner engagement. Many practitioners will need significant support from the PPS in implementing standardized IT systems to allow for communication and data flow across the PPS, as well as workforce development and deployment to support the DSRIP transformation initiatives as well as data collection. The better the PPS can clearly communicate to practitioners about all relevant aspects of PPS implementation, the more effectively practitioners can be engaged in the process.

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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
Director of PMO	Jill Huck, MS	General oversight & management
Head of Network Development	Arthur Klein, MS	Strategic oversight and input
Network Development & Strategy	Ben Kornitzer, MS	Strategic oversight and input, provider engagement
Network Development & Strategy	Brent Stackhouse	Strategic oversight and input, provider engagement
IPA Management	Ed Lucy	Strategic oversight and input, IPA engagement
Head of Population Health & MSO Development	Niyum Gandhi	Strategic oversight and input, population health and MSO support
MSO Operations	Theresa Dolan	MSO operations & support
Clinical Committee Co-chair	Theresa Soriano	Clinical operations oversight and strategy
Clinical Committee Co-chair	Matt Weissman, Community Healthcare Network	Clinical operations oversight and strategy
Behavioral Health Expert, Leadership Committee	Sabina Lim	Behavioral health specific strategy
PMO Medical Director	Edwidge Thomas	Clinical operations oversight and strategy
Community Affiars Director	Brad Beckstrom	Community Affairs

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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		
Network Practitioners	Target of engagement activities	Attend training sessions; report to relevant Practitioner Champions
Workforce Committee Members	Oversight of all training strategies, including practitioner education / training described above	Input into practitioner education / training plan
Clinical Committee Members	Governance committee on which practitioner Champions sit	Monitor levels of practitioner engagement; forum for decision making about any changes to the practitioner engagement plan
IT Committee Members	Oversight of IT/data sharing strategies	Oversight and protocals related to HIE & data sharing to support population health
MSO Leadership	Provide supportive services	Supportive services as needed based on site specific needs
External Stakeholders		
PPS partner organizations Settlement Health - Warria Esmond, CMO Community Healthcare Network - Matthew Weissman, CMO William F. Ryan Center - Jonathan Swartz, CMO Brooklyn Hospital Center - Joshua Rosenberg	Provide expertise and guidance with their successful engagement training program	Input into practitioner education / training plan
Payers	Provide expertise and guidance with their successful engagement training program	Input into practitioner education / training plan

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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.

The proposed deployment of a shared IT infrastructure will support PPS Practitioner Engagement, particularly through implementation of the MS PPS User Portal. This tool is a web-based portal that will allow access to the MS PPS data warehouse, including analytic functionality, dashboards, care management tools, Learning Management System modules and DSRIP performance reporting support. The goal of the portal is to improve communication between providers and patients and allow for timely access to health information to support chronic disease self-management and population health management while minimally impacting existing provider workflows by ideally provisioning a single point of access.

In addition, the MS PPS proposed IT infrastructure will deliver efficiency, interoperability and high value solutions to participating providers, facilitating practitioner engagement through provision of tools that support better time management and overall provider satisfaction.

IPQR Module 7.8 - Progress Reporting

Instructions :

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

Practitioners will be given multiple opportunities to contribute to the leadership structure of the PPS. The continuation of town halls combined with smaller meetings at provider locations will ensure practitioner concerns are taken seriously by PPS leadership and that communication can flow both to and from practitioners. Formal roles should be created to ensure providers have an opportunity to grow within the PPS as their contributions increase. The PPS will create dashboards enabling comparison between both similar geographic locations and sized organizations in the PPS. Quality control surveys will help assess the quality of education, define success of education and training plan, and inform any changes needed in how the PPS is interacting with practitioners.

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.	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1. PMO will be established to support and report progress on the development of clinical programming, network provider and patient engagement, financial and risk management, and IT infrastructure to support an IDS.	Completed	PMO table of organization and meetings	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2. PMO, with MSHP support, will use data from CNA, attribution list, available payer claims, and internal PPS data to identify PPS patient population, characterizing subgroups of need by region, practice, preventable utilization, and/or service needs.	In Progress	Results of data analysis of patient population	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3. From results of data analyses in Step 2, the Clinical Committee and PMO will determine highest-priority diagnoses, practice sites, and geographic areas in PPS to prioritize selection and timing of applicable projects for	In Progress	Results of prioritization and process on milestones and health outcomes	09/01/2015	12/31/2015	09/01/2015	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
implementation, provide feedback to projects on progress of milestones and strategies with positive impact on health outcomes.									
Task Step 4: Define priority target populations by using community needs assessment and available data to develop disease specific profiles that identifies co-morbidities and social determinants of health.	In Progress	.	10/30/2015	03/31/2016	10/30/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5: Working with clinical committee and project work groups, define plans for addressing target population health disparities.	In Progress	.	10/30/2015	03/31/2016	10/30/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6. Acquire, aggregate and leverage data for analysis in support of population health management of identified target populations.	In Progress	.	10/30/2015	06/30/2016	10/30/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 7: Engage stakeholders including patients, partners/providers and CBOs to create a collaborative partnership to develop population health road map.	In Progress	.	10/30/2015	06/30/2016	10/30/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 8: Present to leadership for approval of population health road map.	In Progress	.	10/30/2015	09/30/2016	10/30/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 9: Work with IT to identify the necessary IT infrastructure to support a population health approach.	In Progress	.	10/30/2015	03/31/2017	10/30/2015	03/31/2017	03/31/2017	DY2 Q4	
Task Step 10: IT Committee, with MSHP support, will leverage state and existing PPS partner resources to plan phased adoption of a common IT platform for secure clinical data and care plan sharing within and between PPSs (Milestone 6).	In Progress	Preliminary report of IT infrastructure and platform, includes plan for phased adoption; Resource assessment that includes existing resources and identified gaps; Quarterly report of progress towards adoption of common IT platform	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 11: PMO, with MSHP support and	In Progress	Board approved PCMH practice assessment plan for PPS; Quarterly report on progress towards PCMH level 3	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
experienced PPS partners will develop plan for assessing practices and begin providing technical assistance for 2014 PCMH Level 3 certification (Milestone 5). This includes identifying PCMH Level 3 requirements by provider type and developing a strategy on how the PPS works with those providers to meet these requirements.		certification							
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.	06/01/2015	03/31/2017	06/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1. Establish Bed Complement and Utilization Workgroup. This workgroup will consist of partners/stakeholders who are impacted by bed reduction . The group will be responsible for creating a model and methodology for determining the number of beds that can be reduced. Additionally, this group will oversee monitoring and reporting on reductions in avoidable hospital use, as well as modeling the impact of all DSRIP projects on bed utilization.	In Progress	1. Identify workgroup members, meeting schedule, concrete goals with more refined timelines of completion of goals	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2. Assessment Phase: 1. Inventory number of beds by type, location and occupancy rate to develop both site-based and overall PPS bed count and occupancy rates by bed type 2. Obtain patient days and LOS data by MSDRGs for baseline bed occupancy type by diagnosis, to determine both site-based and overall PPS occupancy rates by MSDRG 3. Determine the baseline/starting point for where all partners who are affected.	In Progress	1. Complete report of all described data elements for each site for entire PPS 2. High level summary report of data collection and reporting requirements across the PPS 3. Preliminary report of data analysis	06/01/2015	03/31/2016	06/01/2015	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
4. Determine data collection and reporting requirements necessary across the PPS to be able to analyze and review on defined frequency bed utilization data 5. Review Community Needs Assessment and other community health related data for any geographic variability in health conditions that may impact bed utilization									
Task Step 3. Preliminary Data Analysis Phase 1. Analyze data from assessment phase and identify any additional data needs and/or planning steps to consider in formulating bed plan	In Progress	1. Complete report of all described data elements for each site for entire PPS 2. High level summary report of data collection and reporting requirements across the PPS 3. Preliminary report of data analysis	06/01/2015	03/31/2016	06/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4. Forecasting Phase: Develop a model and methodology to forecast impacts of all DSRIP projects on avoidable hospital use and utilization based on targeted reduction of avoidable hospitalizations by DSRIP years. Model/Methodology may include contributing variables such as: 1. DRGs most impacted by DSRIP projects; 2. Bed types most likely affected by DSRIP projects; 3. Conditions driving potentially preventable hospitalizations and re-admissions; 4. Specific community health needs/conditions that may affect bed complement and bed utilization both related to and independent of DSRIP projects 5. Contingency planning for unexpected mass health crises	In Progress	Draft written model and methodology	06/01/2015	03/31/2016	06/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5. Workforce Impact: Assess employees impacted by bed reduction with workforce and type of training that will need to occur	In Progress	Report of workforce impact	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task	In Progress	Preliminary report of IT infrastructure and platform	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 6. Data Collection and Analysis IT Platform-Phase 1: Identify IT tools, data collection, and data reporting framework to obtain regular and accurate service utilization data across the PPS									
Task Step 7. Vetting of Draft Model and Methodolologies: Share model and methodologies with partners via PPS Governance Structure regarding approach to bed reduction for feedback, revision, to further inform forecasting	In Progress	Governance Structure Minutes	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 8. Establish high-level forecasts of the following (this forecast capacity model will be updated on a regular basis throughout the 5 years) a. Reduced avoidable hospital use over time by bed type (and diagnoses if possible) b. Changes in inpatient capacity, by bed type c. Resulting changes in required community / outpatient capacity	In Progress	Draft forecasts with data elements as described	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 9. Draft Bed Capacity Change Plan: 1. Providers impacted by forecast capacity change to determine their own 'first draft' capacity change plan, to be consolidate into a PPS-wde capacity change plan. 2. Bed Complement and Utilization Workgroup to develop first draft capacity change plans and vet through PPS Governance Structure.	In Progress	Draft written Bed Capacity Change Plan	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 10. Data Collection and Analysis IT Platform--Phase 2: Finalize IT tools and infrastructure necessary for seamless updates and reporting of forecasts	In Progress	Final summary re: IT platform	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 11. Final Bed Capacity Plan: Finalize and publish final capacity change / bed reduction	In Progress	Final written plan	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
plan, establish and schedule of annual updates on capacity changes across the network									

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop population health management roadmap.	Narrative for completion of Step 1 (Oct. 2015): Committees/workgroups supported by the PMO have been established to address these areas. The development of clinical programming is being addressed by the project workgroups, clinical executive co-lead team, and Clinical committee. Network provider and patient engagement is addressed by the stakeholder engagement cross functional group, which will support the patient advisory committee. The Finance, Compliance, and IT committees are in place to support and report on financial and risk management, and IT infrastructure for the IDS, respectively.
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.

Risk 1: Inadequate patient and community engagement.
Mitigation: MSPPS will hold introductory and recurring community-based forums starting early in DY1 to educate and gather feedback from stakeholders about local DSRIP project implementation and the goal of an IDS. The PPS PMO will create a patient advisory board which will meet regularly to inform PPS governance of reactions and response to project and IDS implementation.

Risk 2: Inadequate PPS Provider engagement may result in continued disjointed care.
Mitigation: Our PPS will create regional "hubs" to tailor and implement PPS projects relevant to specific communities' and populations' clinical and social service needs, engaging local providers and service organizations to provide core project services. We are implementing a PPS Stakeholder Engagement Committee to proactively gather feedback on operational planning and future decisions across PPS domains. Workforce and Clinical technical committees are collaborating on a centralized training program for all provider types to deliver culturally sensitive and competent service that promote health literacy and address social determinants of health specific to our projects' target populations. Through MSHP, we will provide support for performance tracking and management, IT implementation, PCMH certification, and care management training or staff recruitment so partners with less infrastructure can achieve required DSRIP goals while also meeting other internal priorities.

Risk 3: Challenges in workforce recruitment, training, and collaboration with labor groups to adequately meet demand.
Mitigation: We will leverage and establish relationships with labor groups (e.g. SEIU, NYSNA) and training/advocacy organizations (e.g. PHI) to communicate DSRIP project plans, identify training needs and develop re/training programs that optimize workforce knowledge and skills in the successful delivery of DSRIP program services. We will work with recruitment agencies, health worker training programs and professional schools of social work, nursing, behavioral and health sciences to educate trainees about career opportunities in an integrated delivery system, and hold regular recruitment events.

Risk 4: Inability to secure adequate resources to support population health infrastructure for all partners.
Mitigation: We will leverage existing IT, clinical and care management resources, including PPS partners and Mount Sinai's population health infrastructure, MSHP, to provide the IDS's foundation. The IT, Clinical and Finance committees are meeting to ensure responsible decision-making regarding (1) adequate flow of funds to carry out initiatives at every site; (2) selection of the appropriate applications for a common IT platform that can accommodate existing HIE, EMRs and other application; (3) planning for ultimate financial sustainability of individual projects; and (4) engaging with MCOs to gradually but aggressively shift contracts from fee for service to fully risk-based as groups within the PPS are able.

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.)

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The success of the clinical projects relies on the ability to establish a shared IT platform to communicate and share clinical and care management data across PPS providers, and between PPSs. Likewise, engagement, training, performance feedback and incentivization of workforce to operate as a clinically integrated system will be integral to the effective implementation of clinical projects. Ongoing, timely analysis of patient-level data will facilitate identification of subgroups that require intervention, in order to achieve the goal of optimizing population health management and reducing disparities. Transparent and adequate financial models that support the IDS as well as the PPS projects, and successful development of relationships that result in risk-based contracts with payers, will determine long-term sustainability of the IDS and its providers.

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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
PMO Director	Jill Huck	Administrative oversight of PPS
PMO Medical Director	Edwidge Thomas	Clinical oversight of PPS projects
PMO Associate Directors	Nina Bastian	Assist PMO Director in oversight of PPS activities
Leadership Committee	PPS members	Provide guidance and feedback on population health management system implementation
Clinical Committee	PPS members	Develop, implement and modify PPS clinical projects
Finance Committee	PPS members	Oversee and manage PPS financial operations; guiding processes towards value-based payer contracts and provider compensation models
Workforce Committee	PPS members	Lead PPS workforce assessment and needs for each project; design and implementation of training programs for PPS; collaborate on value-based compensation and benefits model
IT Committee	PPS members	Lead PPS IT systems assessment, design and implementation
Mount Sinai Health Partners (Population Health Managed Services Organization)	N/A	Provide data, IT, clinical integration, care management, and contracting support for PPS and/or partners

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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		
Mount Sinai Health System	Lead applicant	Lead all PPS partners in clinical integration efforts to adequately deliver population-based health services
Mount Sinai Health Partners (Population Health MSO)	Support role as above	Provide data, IT, clinical integration, care management, and contracting support for PPS and/or partners
External Stakeholders		
PPS partners	Service providers	Collaborate within PPS to implement clinical projects and redesign organizations to deliver care as an IDS
FQHC partners	Service providers	Collaborate within PPS to implement clinical projects and redesign organizations to deliver care as an IDS
Hospital partners	Service providers	Collaborate within PPS to implement clinical projects and redesign organizations to deliver care as an IDS
LTC/SNF partners	Service providers	Collaborate within PPS to implement clinical projects and redesign organizations to deliver care as an IDS
CHHA partners	Service providers	Collaborate within PPS to implement clinical projects and redesign organizations to deliver care as an IDS
Other PPSs	Serving overlapping populations/geograpies	Collaborate with each other in learning sessions; align clinical projects and/or infrastructural processes
NYCDOHMH	Local collaborator	Convene HIV providers in common clinical project (4.c.ii)
Managed Care Organizations	Long-term sustainability of PPSs as provider entities	Work with PPSs to engage in value-based contracts which incorporate both clinical and non-clinical services

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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.

There are a number of population health management solutions implemented by The Mount Sinai Health System (MSHS) that will be leveraged for the MS PPS, under DSRIP, including a robust care management program for individuals living with HIV, an advanced multidisciplinary adolescent health program and a home-based primary and palliative care program, all of which rely on an existing IT infrastructure.

MS PPS will leverage and grow these capabilities through the deployment of a centralized data warehouse and associated analytic platforms that will include critical functions, such as clinical decision support, population health metrics, predictive analytics, reporting and registries for care management, and utilization management. Together with the HIE for all providers and programs, these tools will be used to measure population health status and to prioritize the deployment of high value interventions to improve outcomes.

IPQR Module 8.8 - Progress Reporting

Instructions :

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

The PMO will be responsible for overseeing and tracking progress of the various Committees' responsibilities and deliverables towards development of a Population Health Management infrastructure. The PMO will track and report process and clinical outcomes on a monthly basis for high-priority projects, and meet at least monthly to update and receive updates from Clinical, IT, Finance, Workforce and Leadership Committees to ensure specific goals are being met within the proper timeline.

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	06/01/2015	03/31/2016	06/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task STEP 1: Develop/Draft a plan for how we will conduct a clinical integration needs assessment including components not limited to: carrying out, measuring and reporting common evidence-based protocols and quality metrics, communication between providers across care settings, facilitation of care coordination by employing information technology solutions, and implementation of high-quality clinical programs for targeted populations.	In Progress	Draft written work plan detailing action items for development of clinical integration needs assessment	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task STEP 2: Develop/Draft process metrics to track progress and success of plan.	In Progress	Documentation of process metrics and process of tracking success	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task STEP 3: Have draft reviewed by appropriate committees for input and submit to Leadership	In Progress	Documentation of review, meeting review minutes	06/01/2015	12/31/2015	06/01/2015	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
for approval									
Task STEP 4: Map the providers in the MSPPS network and their requirements for clinical integration	In Progress	Completed needs assessment document, including documentation of potential barriers/challenges and mitigation steps; Provider directory, task lists detailing provider requirements	06/01/2015	09/30/2015	06/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task STEP 5: Perform assessment of partner facilities, such as patient centered medical homes	In Progress	Completed facility review instrurment	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task STEP 6: Identify key data points for shared access and identify challenges partners might face in accessing data sharing platform	In Progress	Meeting Minutes, list of shared key data points, list of anticipated challenges in accessing data sharing platform	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task "STEP 7: Identify key activities that are necessary for clinical integration between providers such as development of shared evidence-based clinical pathways, including care transitions protocols, common IT platforms for care coordination and data reporting. "	In Progress	Meeting minutes, list of key interfaces that will impact clinical integration during care transitions and management	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task STEP 8: Finalize needs assessment of provider, establish uniform evidenced based practice guidelinesand establish current process for communicatiton. Present to Clinical and other appropriate committees for approval	In Progress	Final and board-approved needs assessment document and plan; record of ongoing needs assessment analysis methodology, committee meeting minutes	06/01/2015	03/31/2016	06/01/2015	03/31/2016	03/31/2016	DY1 Q4	
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	06/01/2015	06/30/2016	06/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		communication tools							
Task STEP 1: Develop a strategy for clinical and other info sharing	Completed	STEP 1: Develop a strategy for clinical and other info sharing	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task STEP 2: Develop and conduct a risk assessment of the attributed lives within the MSPPS	In Progress	STEP 2: Develop and conduct a risk assessment of the attributed lives within the MSPPS	06/01/2015	09/30/2015	06/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task STEP 3: Task clinical committee with creating a specific transitions strategy. Also design an optimized admission and discharge process across the MSPPS with some flexibility for tailoring to local and borough specific needs, with approval from the MSPPS	In Progress	STEP 3: Task clinical committee with creating a specific transitions strategy. Also design an optimized admission and discharge process across the MSPPS with some flexibility for tailoring to local and borough specific needs, with approval from the MSPPS	06/01/2015	09/30/2015	06/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task STEP 4: Develop a strategy with IT and Clinical regarding data sharing and interoperability	In Progress	STEP 4: Develop a strategy with IT and Clinical regarding data sharing and interoperability	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task STEP 5: Ensure that the specific transitions strategy include a consistent measurement strategy to determine risk levels of patients within the PPS and communicate that strategy across the MSPPS. Present to Leadership for adoption.	In Progress	STEP 5: Ensure that the specific transitions strategy include a consistent measurement strategy to determine risk levels of patients within the PPS and communicate that strategy across the MSPPS. Present to Leadership for adoption.	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task STEP 6: Develop and conduct an assessment of what tools providers currently have and will need in the future for coordinated communication	In Progress	STEP 6: Develop and conduct an assessment of what tools providers currently have and will need in the future for coordinated communication	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task STEP 7: Develop a training strategy for providers across all settings within the MSPPS regarding clinical integration, tools and communication for coordination	In Progress	STEP 7: Develop a training strategy for providers across all settings within the MSPPS regarding clinical integration, tools and communication for coordination	06/01/2015	03/31/2016	06/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task STEP 8: Working with the workforce committee, create a training protocol for providers and their operations staff regarding coordination tools	In Progress	STEP 8: Working with the workforce committee, create a training protocol for providers and their operations staff regarding coordination tools	06/01/2015	06/30/2016	06/01/2015	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 SYEP 9: Finalize and deploy PPS-wide clinical integration strategy	In Progress	SYEP 9: Finalize and deploy PPS-wide clinical integration strategy	06/01/2015	06/30/2016	06/01/2015	06/30/2016	06/30/2016	DY2 Q1	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform a clinical integration 'needs assessment'.	Oct. 2015 - Narrative for Change of End Date for Step 4: PPS is currently assessing standards of care within the partner organizations and reviewing best practices. Standards need to be determined and applied across the PPS
Develop a Clinical Integration strategy.	Oct. 2015 - Narrative for Completion of Step 1: HIE adoption strategy is in place with 5 phases/waves. Waves 1 and 2 includes piloting with partners who are early adopters. Early adopters are those with advanced technological capacity for info sharing. Oct. 2015 - Narrative for Change of End Date of Step 2: PPS is developing payment/reporting metrics requiring partners to provide baseline data of their patient population, particularly the population at risk. Oct. 2015 - Narrative for Change of End Date of Step 3: The care coordination cross functional workgroup is tasked with creating a unified care plan that will be accessed by the patient's care providers and will be a critical component of the optimal admission/discharge processes. Approval of processes and protocols will be made by the Clinical Committee voting members.

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.

Risk 1: PPS partners not fully comprehending the IT requirements
Mitigation Strategy: Engage in comprehensive community-based partner education through workshops, web-based learning tools and 1:1 interaction at partner sites; development of education materials by provider type to clearly state expectations and requirements.
Risk 2: Partners inability to achieve meaningful adoption of IT capabilities to connect to centralized IT services and engage in data sharing
Mitigation Strategy: PPS has planned for provision of technical assistance with relation to EHR adoption and PCMH certification. PPS will establish incremental IT adoption milestones and site visits to ensure progress towards defined requirements and performance objectives. Financial incentives will be put into place to encourage IT adoption by partners with DSRIP dollars.
Risk 3: Breadth of EHRs and electronic platforms currently in use may pose significant barrier and/or cost for development of interfaces by vendors for HIE connectivity
Mitigation Strategy: PPS IT committee will conduct a deeper assessment to better understand vendors within PPS, work to negotiate interfaces for top volume platforms first; as well as work with partners without IT platforms to adopt software from a select set of vendors.
Risk 4: Consent process may inhibit ability to access and share pertinent patient data
Mitigation Strategy: Continue to coordinate with GNYHA, other PPSs, RHIOs and stakeholders to drive policy change and consent education for patients through providers to continually improve level of consent and mitigate policy barriers.
Risk 5: As with any collaborative, stakeholders may not reach consensus on strategic, business or governance decisions in a timely manner
Mitigation Strategy: Implementation plan will carefully map out deliverable/decision points and risks of indecision will be raised immediately to PPS leadership for arbitration; PPS will leverage State guidance on key business and technical decisions where appropriate.
Risk 6: Funding challenge to attain resources to help realize IT strategy and investments
Mitigation Strategy: MS PPS has already submitted a capital request to help fund the IT needs for the PPS. Partners have also been encouraged to apply for a capital request, which many have done. Additionally, the PPS is providing information for alternative funding sources, such as PCIP, for partners to connect with.
Risk 7: Partners fail to respond to the needs assessment
Mitigation Strategy: MSPPS will reach out to each provider individually to ensure a response
Risk 8: Partners do not commit to the new trainings for clinical integration and coordination.
Mitigation Strategy: MSPPS will conduct extensive outreach to all partners to determine if the universal MSPPS training process is application or if modifications would serve the partner and community better.

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.)

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Clinical integration will require regular collaboration between all committees within the PPS as well as the other work groups created to address implementation planning. IT systems will need to collaborate with Clinical to ensure that universal consent is recognized through the PPS, provider engagement will be critical to ensure that all providers are able to communicate seamlessly when integrating health care delivery. Cultural competency will need to work with Workforce as well as Clinical to ensure that the right training are being provided by and provided to the right individuals.

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IPQR Module 9.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Clinical Committee Co-Chair	Dr. Theresa Soriano	Clinical Committee Co-Chair
Leadership Committee	Ed Lucy	Leadership Committee
MSO	Theresa Dolan	MSO
IT Committee Co-Chair	Kumar Chatani	IT Committee Co-Chair
Workforce Committee Co-Chair	Jane Maksoud	Workforce Committee Co-Chair
Clinical Director of PMO	Edwidge Thomas	Clinical Director of PMO

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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		
Clinical Committee Members	Data providers and assessments	Provide feedback for the needs assessment and implement strategy
Finance Committee	Data providers and assessments	Provide feedback for the needs assessment and implement strategy
IT Committee	Data providers and assessments	Provide feedback for the needs assessment and implement strategy
External Stakeholders		
PAYERS Healthfirst - Dr. Susan Beane, Medical Director	Partner in creating an integrated health care delivery system	Provide feedback for the needs assessment and implement strategy
CBO's ArchCare - Mitze Amoroso, CIO Housing Works - Miguel Mendez, CTO VIP Community Services - Deborah With, Chief Program Officer	Partner in creating an integrated health care delivery system	Responsible for participating in the needs assessment and implementing the clinical implementation strategy
Clinics Settlement Health - Warria Esmond, CMO Institute of Family Health - Kathy Cresswell, CIO William F. Ryan Community Health Center - Barbara Hood, CIO Community Healthcare Network - Jason Pomaski, CIO Callen-Lorde Community Health Center - Richard Clarkson, CIO	Partner in creating an integrated health care delivery system	Seeing MSPPS attributed lives before they are admitted through the ER
RHIOS	Facilitating data connectivity	facilitating data connectivity
Patient Advocates	Representation of patients	Participate in the needs assessment of providers and potential training protocols
IT Departments are represented by the CIO/CTOs from our partnering organizations	Support the assessment and strategy	actually implement the needs assessment and strategy, conduct surveys
Clinical and Non Clinical Providers Isabella Nursing Home - Greg Fortin, CIO	Treat patients	implement the strategy

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
City Health Works - Aaron Baum, Director of Technology		

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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.

Clinical integration is the ultimate goal of the MS PPS IT infrastructure, particularly through the widespread achievement of data exchange and interoperability. The PPS Health Information Exchange (HIE), as defined under the proposed architectural model, will build upon the PPS's robust network of Electronic Health Records systems and allow for the bidirectional sharing of information of clinical, behavioral and social determinants of health data across systems, providers and partners. This information will facilitate widespread integration, including data-supported care management and transitions of care. In addition, the MS PPS will deploy specific interfaces and enhancements that support clinical integration including: (1) RHIO interfaces that that allows partners to access a longitudinal patient record through RHIO-supported "subscription" services and to engage in direct messaging across systems; (2) CBO data conversion tools that allow community-based partners to exchange data and track outcomes as well as to produce standardized health data elements; and (3) Closed-loop referral management and tracking tools which will better enable consultation between PCP and Specialty providers. Interfaces to the PPS' RHIO partners will additionally allow for data contained and collected within the PPS, such as data from CBOs, to be accessible to the RHIOs, expanding their role as community clinical integrators.

IPQR Module 9.8 - Progress Reporting

Instructions :

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

Initially, the Clinical Committee will develop the metrics that define success of clinical integration specific to this PPS. Then, progress reporting will be a collaborative process between IT and Clinical committee. Both committees will work together to develop a work plan and a set of metrics to define success. The PPS will accurately and timely submit quarterly reports which will detail the progress the MS PPS has accomplished over each time period. Once the state issues initial benchmarks, the MS PPS will ensure that the needs assessment and the clinical integration strategy are tailored to measure those benchmarks moving forward. To that end, IT will provide a measurement tool to track patient outcomes and present in a dashboard. The IT work stream leadership will develop a comprehensive implementation plan, supplemented by GANTT chart outlining quarterly milestones based on performance requirements (DSRIP) and implementation milestones for the PPS IT strategy. The implementation plan will provide a measurable guide for progress that will be regularly shared with Leadership and collaborating committees to ensure provision of deliverables, services and functionality in line with PPS scale and speed, and overall PPS IT requirements. In addition to IT implementation progress tracking and management, the committee will engage in PPS partner feedback requests through surveys and discussion forums to ensure solutions and services continually meet partner needs, expectations and deliver value.

IPQR Module 9.9 - IA Monitoring:

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Instructions :

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Section 10 – General Project Reporting

IPQR Module 10.1 - Overall approach to implementation

Instructions :

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

MSPPS approach to implementation of its ten DSRIP projects is a delegated governance structure forming an LLC. All partners have a responsibility to the PPS. The PPS lead will facilitate decision making in conjunction with all partners. Also, establishment up of MSPPS Project Management Office will be critical to completing the milestones/metrics of DSRIP.

The PPS will have a strong focus on meaningful education, training of best practices and communication throughout the process. As expected of the clinical quality committee, standardization of clinical and operating processes and methodology will be a goal of the overall PPS with MS PMO support.

Using a delegated model, transitioning from Leadership committee to the Board of Managers of
Mount Sinai PPS, LLC, 29 voting members have been selected reflective of the continuum of care and are geographically representative of the PPS. To ensure the Mount Sinai PPS provider network becomes increasingly integrated, it will be necessary for providers and clinicians to be educated on: (a) what these DSRIP-driven changes mean for their practice and how they will be affected at each step of implementation; and (b) what their role, expectations, and obligations are. Education and provider inclusion will be one of the key roles of our Clinical Quality Committee and its sub-committees for each project. Provider education is also a two-way process and MSPPS intends to work with the State to be involved in both the project breakthrough series and the annual learning collaborative conferences to maximize the impact of our DSRIP.

MSPPS invested in training, education and consistent bidirectional communication that is transparent across the PPS. Mount Sinai has been strong in its' stakeholder engagement and community outreach. The approach taken has been inclusive of all partners using weekly meetings, newsletters, webinars, strong notifications and communications to partners, town halls and ongoing opportunities for collaboration from our partners. PPS wide deliverables such as bed reductions have pulled in stakeholders who will be affected by the decrease in the number of staffed bed units. In planning for the bed reduction we included partners from the Brooklyn Hospital Center, Mount Sinai hospitals, SNFs and Board of Managers in helping with the overall plan of the bed reduction deliverable.

Mount Sinai PPS is also working towards adapting project plans, evaluating and improving the plan through a continuous quality improvement cycle. This approach was meant to ensure the PMO is constantly tracking the best practices and methodologies that will work in keeping partners accountable. In addition, the MSPPS is working to develop a CRM inclusive of its' network partners contacts and information for feasible and easy to reach of partners within a centralized area. The process of standardizing clinical and operational protocols is likely to be the most difficult task facing the Mount Sinai PMO. It is not just about aligning systems, but also achieving a common language between providers, a common method of performance measurement for the PPS, and a common culture focused on patient outcomes – all of which will underpin the transition to VBP. The following initiatives are central to our drive for increasing standardization across our network:
– Development of shared IT infrastructure and data sharing, ensuring that patient information is seamlessly and securely transferred.

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– Care transitions strategy and the buy-in to this strategy from practitioners throughout the network.
– The sharing of best practice and performance information, through the network of project clinical committees
– Hiring, training, and redeployment of staff that will happen as part of our workforce transition strategy

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.

The Mount Sinai PPS is one of the largest PPS provider network in the DSRIP program. With 10 Projects, interdependencies between projects and between cross-cutting PPS-development initiatives will be inevitable requiring synergy between all projects. Because partners may be in multiple projects, implementation of the 10 DSRIP projects will require surveying to compliment the deliverables that are overlapping and interdependent of each other. Development of current and future state gap analysis, use of tools to find overlapping milestones and metrics, in addition development of a metrics manual to understand the similarities and differences of each project will be imperative in our approach of complementary projects. Additionally, for different projects with similar goals and project requirements, a framework will be developed to capture the overlap of the providers. This framework will entail geomapping and a network analysis of our partners to determine which providers share which projects, their locations and their levels of overlap.

For example, managing transitions of care more effectively will be a central part of multiple projects and without a proactive approach to our Care Transitions Strategy there is a risk that different protocols will be developed at different sites or in different projects. Many projects also share same or similar project requirements. Taking that into account, we have taken a robust approach to predicting, planning for, and managing the overlap between project requirements. For those project requirements that are most pervasive, we have set up cross-functional work groups tasked with driving consistent, coordinated implementation. For example, achieving PCMH 2014 Level 3 certification will be a priority for many providers and will be an important success factor in many projects. We have therefore set up a dedicated PCMH Certification Team that will be responsible for all relevant providers meeting this project requirement according to the timetable set out in our project speed of implementation forecasts. We will set up task teams for the following most overlapping requirements to track:
- Use of EHRs to track all patients engaged in projects;
- Ensure that all PPS safety net providers are actively sharing EHR systems with local HIE/RHIO/SHIN-NY and sharing health information among clinical partners 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 by the end of DY 3; and
- Establish agreements with the Medicaid MCOs serving the affected population to provide coverage for the service array under a specific project.

We believe this is a starting point for identifying the clinical, financial, administrative, or technological initiatives that will be most important for the successful delivery of our DSRIP projects. Most likely our approach will change accordingly as we determine what works best for our network and how to assess it accordingly. All projects will be managed and directed by the Mount Sinai PPS PMO.

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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
MS PPS PMO	Overarching project management office	- PMO will be responsible for delivering quarterly reports to DOH - Project leadership teams will report into PMO - PMO will manage any major risks that are escalated from Project leadership teams - PMO will be responsible for driving the implementation of those projects requirements identified as the most pervasive - PMO will monitor the implementation of cross-PPS organizational development initiatives, such as IT infrastructure development and workforce transformation - PMO will be the link between the Project leadership teams and the Mount Sinai Finance Committee, the Mount Sinai Workforce Committee, the Mount Sinai IT Committee and the Mount Sinai Compliance Committee
Project working groups	Project Management	- Day-to-Day management of progress against Project requirements - Reporting on progress against Project requirements to Forestland PPS PMO - Managing clinical integration at A Project level and Compliance with PPS initiatives such as Care Transitions Strategy - Implementation of Project-specific workforce initiatives – i.e. the retraining, hiring, redeployment required by each specific Project
Mount Sinai PPS Clinical Quality Committee	Oversight of the clinical quality committees for individual projects and project work groups	"MS Clinical Quality committee will ensure project-specific clinical quality committees are effectively driving improvements in clinical outcomes and improved clinical integration; Project-specific clinical quality committees will escalate any major quality issues / risks to the MS PPS MS Clinical Quality committee will ensure any overlap between project-specific clinical quality committees is managed (for example, where there is considerable overlap between two of our projects, we may consider merging the two clinical quality committees)

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		MS Clinical quality committee will oversee and sign off the performance metrics for each of the DSRIP projects MS Clinical quality commitee will be educatiing and sharing with network providers on the details of project implementations "

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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		
Mount Sinai Health Partners (Population Health MSO)	Population Health MSO	Provide data, IT, clinical integration, care management, and contracting support for PPS and partners
MS PPS PMO	Overarching project management office	PMO will be responsible for delivering quarterly reports to DOH project leadership teams will report into PMO PMO will manage any major risks that are escalated from Project leadership teams PMO will be responsible for driving the implementation of those projects requirements identified as the most pervasive PMO will monitor the implementation of cross-PPS organizational development initiatives, such as IT infrastructure development and workforce transformation PMO will be the link between the Project leadership teams and the Mount Sinai Finance Committee, the Mount Sinai Workforce Committee, the Mount Sinai IT Committee and the Mount Sinai Compliance Committee"
Mount Sinai PPS Clinical Quality Committee	Oversight of the clinical quality committees for individual projects and project work groups	"MS Clinical Quality committee will ensure project-specific clinical quality committees are effectively driving improvements in clinical outcomes and improved clinical integration; Project-specific clinical quality committees will escalate any major quality issues / risks to the MS PPS MS Clinical Quality committee will ensure any overlap between project-specific clinical quality committees is managed (for example, where there is considerable overlap between two of our projects, we may consider merging the two clinical quality committees) MS Clinical quality committee will oversee and sign off the performance metrics for each of the DSRIP projects MS Clinical quality committee will be educating and sharing with network providers on the details of project implementations
External Stakeholders		

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
PPS partners	Participants in clinical projects	Implement integration initiatives and clinical project(s) at respective sites
SEIU/1199	Union representation for certain workforce	Participate in determining training needs, hiring and recruitment processing, outcomes-based compensation plans for workforce
NYSNA	Union representation for certain workforce	Participate in determining training needs, hiring and recruitment processing, outcomes-based compensation plans for workforce
Managed Care Organizations	Payers	Engage in meaningful relationships with PPS to provide and share data, develop value-based contracts with PPS entity, and/or eventual contracting body
Other PPSs	Potential collaborators on projects	Align common projects and/or clinical integration processes to optimize project and provider reach and effectiveness, and patient experience

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IPQR Module 10.5 - IT Requirements

Instructions :

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

Two central themes that carry through the MS PPS DSRIP project selection are improved transitions of care between settings and improved disease management. The proposed IT infrastructure will support these objectives in a number of ways. First, a central component of the MS PPS IT infrastructure is the significant expansion of the organizations HIE capabilities. Once fully realized, HIE will allow for the real-time sharing of information on clinical, behavioral and social determinants of health across all participating providers and CBOs -- ensuring that all relevant information is available at the site of care, and that data follows care transitions. A second feature of the MS PPS IT infrastructure that will be imperative for successful project implementation is the development of a data warehouse. This and the associated analytic platforms will drive PPS capabilities to leverage clinical and claims data to drive projects associated with population health improvement as well as care coordination and management activities. Additional tools that will be centrally implemented to specifically target improved care coordination and management will allow for the deployment of disease management platforms, patient monitoring techniques, care alerts, automated data transmission triggers, sharing of and collaboration around patient care plans, referral management and tracking, and development of robust and dynamic patient registries. Additional key IT infrastructure improvements that will be important to overall project success include implementation of a flat file/CBO data conversion process, which more fully links community-based interventions to the PPS, to be integrated, monitored and evaluated by the health system, and a Learning Management System (LMS) which will support the widespread deployment of project-related protocols and procedures.

To meet the requirements for population health analytics and sophisticated care management in an integrated network, MS PPS will develop a data warehouse populated with data from the RHIO, PPS partners and other relevant sources. Population health, risk monitoring, and care management applications deployed as a part of the central MS PPS infrastructure will utilize the data in this warehouse. These services will be accessed through a user portal in one consolidated location to minimize disruption for PPS partners in their workflows as they work to enhance care coordination, and actively participate and realize value from these central PPS components. Finally, in order to monitor overall program performance, MS PPSwill develop business intelligence tools including a participant data management system, performance dashboards and measures tracking, and a robust DSRIP reporting system, which include a centralized customer relationship management (CRM) service to track partners' progress and drive partner engagement.

IPQR Module 10.6 - Performance Monitoring

Instructions :

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

The Mount Sinai PPS will be using the outcome measures and actively engaged patient definitions provided by the state as a benchmark of achievement to meet the quality performance that it has set each DSRIP Quarter. A system will be created to monitor the quality performance of each project by partner to meet metrics within the committed time frame and total set number of patients. This system will require a robust Health

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informations exchange technology that pulls the data from all of our partners and RHIOs. Additionally, ongoing data reports will be provided to the MS PPS to get an idea of where the PPS is regarding the specific projects and any outstanding deliverables that need to be met. We will also ensure to track our patient population's improved health and review how this effects hospitalizations with regards to where this will fit. The PPS will also work on incentivizing to partners when meeting the milestones and metrics through bonus payments. Performance reporting and monitoring will be expected by all partners to complete and be successful. With the MS PPS PMO, each project manager as asssigned from the MS PPS Project Management Office will oversee the projects and the deliverables where they will maintain the relationship with our partners to ensure quality measurements and maintenance of an ongoing reporting system. System informatics and data analytic tools will be used by the DSRIP MS PMO office to secure seamless information transfer. Additonally, a stakeholder engagement group will assist in securing partner buy in for projects and understanding the reporting of information to the PMO office.

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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.

For CBOs in our PPS, we will be entering into the same partner agreement as our other partners and we will evaluate if we need additional CBO engagement throughout DSRIP. We will make a concerted effort to reach out to CBOs, making sure to engage a diverse array of CBOs including Legal Services and God's Love We Deliver. As DSRIP rolls along, we will continue to engage the CBOs in our PPS network by providing opporutnities to participate in the governance structure, and to build upon the services they provide to ensure our PPS meets all milestones and metrics. Additionally, as part of our Stakeholder engagement cross functional workgroup, we will be working on engaging the CBOs more by having a partner CBO lead these efforts. Our Project Advisory Committee will also consist of community board members and some Medicaid beneficiaries to guide the DSRIP projects and contribute to the success.

The risks we see associated with our aforementioned approach is how we will get buy-in from our CBOs and community board. We also are concerned in the level of understanding each partner CBO and community board will have regarding DSRIP. We anticipate a significant amount of partner engagement and stakeholder engagement will be needed to make this successful.

IPQR Module 10.8 - IA Monitoring

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 :

In order to meet the Compensation and Benefit Milestone #4, the PPS has gone through a rigorous RFP process and has narrowed down its options in the vendor selection process. We are currently in the contracting phase, and anticipate signing with a vendor by the end of DY1 Q3. The PPS has standardized when it will give surveys to partners to ensure consistency, and the benefits and compensation analysis survey is scheduled to be completed in February 2016. The vendor will then analyze the results of the survey and prepare a report for the Workforce Committee's review.

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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	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1. Formalize and redefine the scope of the Workforce Committee (with representation from diverse PPS partners and other stakeholders, as needed to ensure appropriate expertise) to execute the research and analysis activities laid out in the Implementation Plan. Additional sub-committees and cross-functional groups will be created on an as needed basis to acomodate the need for more global collaboration.	Completed	Formalize and redefine the scope of the Workforce Committee (with representation from diverse PPS partners and other stakeholders, as needed to ensure appropriate expertise) to execute the research and analysis activities laid out in the Implementation Plan. Additional sub-committees and cross-functional groups will be created on an as needed basis to acomodate the need for more global collaboration.			07/01/2015	07/01/2015	09/30/2015	DY1 Q2	
Task Step 2. Develop and customize assessment tools to conduct an Organizational and Partner Needs Impact Assessment.	In Progress	Develop and customize assessment tools to conduct an Organizational and Partner Needs Impact Assessment.			07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3. Conduct Organizational and Partner Needs Impact Assessment. i. Work with Clinical Committee and clinical project teams to build an overarching staffing framework for clinical delivery. Together, identify/reassess/confirm key workforce impacts, including: - New and redesigned jobs/roles and associated qualifications (i.e., education, licensure, competencies, skills, experience)	In Progress	Conduct Organizational and Partner Needs Impact Assessment. i. Work with Clinical Committee and clinical project teams to build an overarching staffing framework for clinical delivery. Together, identify/reassess/confirm key workforce impacts, including: - New and redesigned jobs/roles and associated qualifications (i.e., education, licensure, competencies, skills, experience) - Associated training, recruitment, redeployment, and workforce support needs ii. Collaboration will be undertaken by having clinical			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
- Associated training, recruitment, redeployment, and workforce support needs ii. Collaboration will be undertaken by having clinical representation attend Workforce Committee meetings, having the Clinical Committee present to the Workforce Committee, and holding joint targeted committee meetings or focus groups to discuss issues. - Clinical and Workforce Committee leadership will determine if a vendor facilitated process is needed to acomplish this goal, and if so, will follow Mount Sinai's established formal RFP process. - Any formal assessment of partners realted to financial or compensation data will be reviewed by Finance, Legal, and Governance leadership to ensure proper measures are taken to maintain confidentiality.		representation attend Workforce Committee meetings, having the Clinical Committee present to the Workforce Committee, and holding joint targeted committee meetings or focus groups to discuss issues. - Clinical and Workforce Committee leadership will determine if a vendor facilitated process is needed to acomplish this goal, and if so, will follow Mount Sinai's established formal RFP process. - Any formal assessment of partners realted to financial or compensation data will be reviewed by Finance, Legal, and Governance leadership to ensure proper measures are taken to maintain confidentiality.						
Task Step 4. Define target workforce state (e.g. what roles will be significantly impacted, what changes to the workforce will be needed).	In Progress	Define target workforce state (e.g. what roles will be significantly impacted, what changes to the workforce will be needed).			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5. Review and sign off on target workforce state by Workforce Committee, and Clinical Committee leadership.	In Progress	Review and sign off on target workforce state by Workforce Committee, and Clinical Committee leadership.			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	In Progress	Completed workforce transition roadmap, signed off by PPS workforce governance body.			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1. Formalize Workforce Committee governance model in acordance with PPS-wide governance model	Completed	Step 1. Formalize Workforce Committee governance model in acordance with PPS-wide governance model			07/01/2015	07/01/2015	09/30/2015	DY1 Q2	
Task Step 2. Based on the gap analysis detailed in Milestone 3, create a consolidated roadmap of actions, processes, and timelines needed to accomplish MSPPS workforce goals. This will	In Progress	Step 2. Based on the gap analysis detailed in Milestone 3, create a consolidated roadmap of actions, processes, and timelines needed to accomplish MSPPS workforce goals. This will include issues of recruitment, retraining, redeployment, and potential reduction.			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
include issues of recruitment, retraining, redeployment, and potential reduction.									
Task Step 3. Review and sign off on workforce transition roadmap by Workforce Committee.	In Progress	Step 3. Review and sign off on workforce transition roadmap by Workforce Committee.			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	In Progress	Current state assessment report & gap analysis, signed off by PPS workforce governance body.			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1. Identify tools available for a Current State Assessment. Evaluate reliable and validity of tools; customize and further develop them, as needed; and ensure that any modifications do not negate their validity.	In Progress	Step 1. Identify tools available for a Current State Assessment. Evaluate reliable and validity of tools; customize and further develop them, as needed; and ensure that any modifications do not negate their validity.			07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2. Conduct a current state assessment of the MSPPS workforce based on the delivery framework and impacted jobs identified in Step 3 of Milestone 1. i. Assess competencies, qualifications, and certifications in current MSPPS workforce. ii. Assess current market conditions for impacted roles, and expected trends.	In Progress	Step 2. Conduct a current state assessment of the MSPPS workforce based on the delivery framework and impacted jobs identified in Step 3 of Milestone 1. i. Assess competencies, qualifications, and certifications in current MSPPS workforce. ii. Assess current market conditions for impacted roles, and expected trends.			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3. Combine current and future state assessments with workforce transition numbers in Milestone 4 step 1 to develop a complete gap analysis of workforce needs.	In Progress	Step 3. Combine current and future state assessments with workforce transition numbers in Milestone 4 step 1 to develop a complete gap analysis of workforce needs.			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4. Refine workforce budget needs given outcomes from the gap analysis.	In Progress	Step 4. Refine workforce budget needs given outcomes from the gap analysis.			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5. Review and sign off on gap analysis and workforce budget by Workforce Committee, as well as Clinical and Finance Committee leadership.	In Progress	Step 5. Review and sign off on gap analysis and workforce budget by Workforce Committee, as well as Clinical and Finance Committee leadership.			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #4	Not Started	Compensation and benefit analysis report, signed off by PPS			04/01/2016	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
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.		workforce governance body.							
Task Step 1. Determine expected volume of new hires, retrained, and redeployed staff by job type.	Not Started	Step 1. Determine expected volume of new hires, retrained, and redeployed staff by job type.			04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 2. Confirm, develop, and/or modify job descriptions of needed jobs.	Not Started	Step 2. Confirm, develop, and/or modify job descriptions of needed jobs.			04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3. Research market data for needed jobs.	Not Started	Step 3. Research market data for needed jobs.			04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4. Survey MSPPS to determine varying compensation and benefits structure across partners for needed jobs.	Not Started	Step 4. Survey MSPPS to determine varying compensation and benefits structure across partners for needed jobs.			04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5. Complete compensation and benefits analysis.	Not Started	Step 5. Complete compensation and benefits analysis.			04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6. Review and sign off on compensation and benefits analysis by Workforce Committee.	Not Started	Step 6. Review and sign off on compensation and benefits analysis by Workforce Committee.			04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Milestone #5 Develop training strategy.	In Progress	Finalized training strategy, signed off by PPS workforce governance body.			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1. Identify key learning and training needs (e.g. for new hires, expanded responsibilities of existing staff, redeployed existing staff)	In Progress	Step 1. Identify key learning and training needs (e.g. for new hires, expanded responsibilities of existing staff, redeployed existing staff)			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2. Identify the modality needed of certain trainings to ensure success, as well as who will be responsible for delivering that training.	In Progress	Step 2. Identify the modality needed of certain trainings to ensure success, as well as who will be responsible for delivering that training.			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3. Determine how success will be defined for each training initiative.	In Progress	Step 3. Determine how success will be defined for each training initiative.			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4. Assess the need for strategies and	In Progress	Step 4. Assess the need for strategies and methodologies for sustained learning.			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
methodologies for sustained learning.									
Task Step 5. Determine the timelines for rolling out each training initiative.	In Progress	Step 5. Determine the timelines for rolling out each training initiative.			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6. Identify key stakeholders for training.	In Progress	Step 6. Identify key stakeholders for training.			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 7. Analyze budgetary needs for training initiatives.	In Progress	Step 7. Analyze budgetary needs for training initiatives.			07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 8. Review and sign off on training strategy by Workforce Committee.	In Progress	Step 8. Review and sign off on training strategy by Workforce Committee.			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

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.	
Perform detailed gap analysis between current state assessment of workforce and projected future state.	
Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	In order to meet the Compensation and Benefit Milestone #4, the PPS has gone through a rigorous RFP process and has narrowed down its options in the vendor selection process. We are currently in the contracting phase, and anticipate signing with a vendor by the end of DY1 Q3. The PPS has standardized when it will give surveys to partners to ensure consistency, and the benefits and compensation analysis survey is scheduled to be completed in February 2016.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	The vendor will then analyze the results of the survey and prepare a report for the Workforce Committee's review.
Develop training strategy.	

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.

• There is a strong co-dependency between the Clinical Committee and the Workforce Committee. The work task that the Clinical Committee creates must dictate the work structure the Workforce Committee supports in order for implementation to be successful. It is a potential risk, that with such a large undertaking, the work may become siloed within functional groups. To mitigate this risk, the MSPPS will coordinate cross-functional workgroups to ensure collaboration. This will also serve to make estimates more realistic, as workforce will not examine each clinical project in isolation, but rather as part of a larger system change.
• The future state analysis of the workforce is similarly dependent on the outcomes of the Clinical Committee work. Workforce and Clinical leadership will work together to ensure necessary information is provided to the committees in order to achieve milestones.
• The MSPPS anticipates significant competition for talent in certain roles with other PPSs as the DSRIP initiative moves forward. The MSPPS plans on collaborating with other PPSs as well as key stakeholders and educational institutions to reduce potential difficulties.
• An additional concern is that the MSPPS clinical work will need to scale faster than the training initiatives can support. Once training needs have been identified, curriculum may need to be developed, and the training itself may take time to be done effectively. The MSPPS will work with training providers to ensure we can scale appropriately, as well as collaborate internally to address clinical needs with the resources available.
• Each partner and employees at each partner will join the PPS at differing levels of education, experience, and baseline knowledge. The training strategy will take into account these different levels in designing training initiatives and timelines.

• Preliminary discussions with some of our community-based providers suggest that there may be regulatory issues impact staffing, roles, and capacity of their workforces. The PPS will work with its partners and NYS to identify and implement solutions to such issues.
• The MSPPS may also face a risk of exposing confidential information as a result of sharing data across the various partners. There will be strict controls put in place as part of the assessment steps of implementation plan so as to minimize this risk.

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 success of the MSPPS Workforce Committee hinges on several key interdependencies. The analysis and actualization of the changes in workforce due to DSRIP depend heavily on the work of the Clinical Committee. The transformation of the delivery system and the work tasks that will be done must determine the structure of the workforce deployed in order to ensure success. Similarly, this delivery system change will require financial resources to adequately staff the transformational effort, and support recruitment, redeploying, and retraining costs. The Workforce Committee will also contribute information to inform the decisions of that transformation, and jointly the two committees will inform budgetary

decisions made at the Finance and Leadership Committee levels. The Workforce Committee is also dependent on the IT Committee and IT initiatives to support the deployment of assessment and training tools, which is further described in the IT Expectations section below.

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IPQR Module 11.6 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Workforce Committee Co-Chair	Jane Maksoud, Mount Sinai Health System	Approve policies and procedures; lead and maintain oversight of committee activities and projects
Workforce Committee Co-Chair	Linda Reid, VNSNY	Approve policies and procedures; lead and maintain oversight of committee activities and projects
Workforce Committee	PPS Members, including partner and union representation	Complete implementation plan steps; Assess and define the current and future states of the workforce; conduct a gap and benefits/compensation analysis; create a transition roadmap and training strategy
Workforce Project Management	Daniel Liss, Mount Sinai Health System; MSPPS PMO Members	Drive completion of Implementation Plan deliverables; manage community and stakeholder engagement.
Consultants	Undetermined	Help prepare workforce and training analyses and materials.

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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		
Mount Sinai Health System	Lead Applicant	Leadership; operation of centralized functions
Clinical, Finance, and IT Committees	Key partners in developing workforce goals	Collaborate with Workforce Committee to determine needs, funding, and reporting mechanisms
External Stakeholders		
VNSNY	Workforce Committee Co-chair Partner	Leadership
Other MSPPS Partners	Partners in PPS	Participate in Workforce Committee
1199 SEIU	Partners in PPS	Participate in Workforce Committee; will play prominent role in the coordination of training and other workforce efforts
NYSNA	Partners in PPS	Participate in Workforce Committee
Other, non-MSPPS, organizations and PPSs	External Stakeholder	Potentially collaborate with Workforce Committee and MSPPS on joint activities

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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.

The IT infrastructure proposed by MS PPS will be an important tool as the PPS drives workforce transformation. First and foremost, included within the MS PPS IT infrastructure is a Learning Management System (LMS) which will allow the PPS to deploy and track workforce training initiatives, including PPS-developed project-driven protocols. As key priority of the MS PPS, this system will be used to support the advancement of front line staff and team-based care. Furthermore, under the auspice of Rapid Cycle Evaluation, the LMS will allow the PPS to facilitate the learning of processes and competencies in a consistent and standardized manner, particularly as performance improvement opportunities are identified.

An additional piece of the IT infrastructure that will support workforce transformation is the MS PPS User Portal. This web-based tool will provide a one-stop-shop for all PPS-related health information and analytic support, including a PPS level performance management and monitoring function, which will be linked to a Customer Relationship Management (CRM) database for provider and performance queries. This tool will support PPS workforce transformation by ensuring high levels of transparency and relevant benchmarking to analyze the impact of workforce-related interventions and guide provider and partner improvement, all accessible in a consolidated fashion in order to improve efficiency and reduce workflow impacts.

IPQR Module 11.9 - Progress Reporting

Instructions :

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

The Workforce Committee and Workforce Project Group, as a governance structure, will drive to the completion of each step listed above to ensure the successful completion of each Workforce Milestone. As a general overview, the committee will first develop its structure and assess the tools it will use during DY1, Q1. The committee will then deploy those tools, aggregate results, and report back on the completion of each milestone in DY1, Q1 and Q2. In addition to the individual milestones, the outcome of the DY1 effort will include basline workforce transition process measures and numerical commitments. There will be a Project Management function that will be responsible for coordinating milestone outcomes, pulling together supporting documentation, and submitting them back to the state for review.

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.

Risk 1: Inadequate patient and community engagement about DSRIP and IDS
Mitigation: MSPPS will hold recurring community-based forums to educate and gather feedback from stakeholders about DSRIP project implementation and the IDS. The PPS PMO will create a "patient/community advisory board" which will meet regularly to inform PPS governance of reactions and response to project and IDS implementation. For high-priority communities, staff will be engaged to ensure open and tailored communication and engagement with patients and the community.

Risk 2: Inadequate PPS Provider engagement in development of IDS. Mitigation: The PPS will create regional "hubs" to outreach, tailor and implement projects relevant to specific communities' clinical and social service needs, supporting local providers and CBOs to provide services. We are implementing a PPS Stakeholder Committee to gather feedback on operational planning and future decisions across PPS domains. Workforce and Clinical committees are collaborating on a centralized training program to deliver culturally sensitive and competent services that promote health literacy and address social determinants of health specific to the target populations.

Risk 3: Difficulty establishing constructive partnerships with MCOs that may hinder timely value-based contracts . Mitigation: We will establish regular meetings between MCOs and PPS leadership, leveraging existing MCO relationships with Mount Sinai and other PPS partners (including affiliated lead Health Homes), to discuss performance metrics and move towards value-based programs among select PPS partners. To educate and engage PPS partners, we will plan training modules in collaboration with payers to understand and operationalize value-based reimbursement.

Risk 4 Challenges in workforce recruitment, training, and collaboration with labor groups to successfully implement IDS projects. Mitigation: We will leverage and create collaborative relationships with labor groups (e.g. SEIU, NYSNA) and training/advocacy organizations (e.g. PHI) to communicate DSRIP project plans, identify training needs and develop re/training programs that optimize workforce knowledge and skills in the successful delivery of DSRIP program services. We will work with recruitment agencies, health worker training programs and professional schools of social work, nursing, behavioral and health sciences to educate trainees about career opportunities and hold regular recruitment events.

Risk 5: Inability to secure adequate resources to support IDS infrastructure development . Mitigation: We will leverage existing IT, clinical and care management resources, including PPS partners and Mount Sinai's population health infrastructure, MSHP, to provide the IDS's foundation. The IT, Clinical and Finance committees are meeting to ensure responsible decision-making regarding (1) adequate flow of funds to carry out initiatives at every site; (2) selection of the appropriate applications for a common IT platform that can accommodate existing HIE, EMRs and other application; (3) planning for ultimate financial sustainability of individual projects; and (4) engaging with MCOs to gradually but aggressively shift contracts from fee for service to fully risk-based as groups within the PPS are able.

Risk 6: Inability to achieve successful collaboration and coordination with other PPSs . Mitigation: We have begun to establish relationships with other PPSs (e.g. Bronx Lebanon Hospital Center, Bronx Partners PPS) and plan outreach to other PPSs with overlapping service areas (e.g. HHC) to share best practices, and collaborate on interoperability plans. We will participate in regional and state-wide learning collaborative, using lessons learned from these activities to modify and improve our PPS.

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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	04/01/2015	09/30/2018	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.	Project		In Progress	04/01/2016	09/30/2018	04/01/2016	09/30/2018	09/30/2018	DY4 Q2
Task Step 1. Create PPS operational infrastructure (PMO) that includes central and regional Stakeholder Engagement teams to promote partner education and engagement in IDSD	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Inventory all providers and social service agencies in PPS by provider type, services delivered, geography served and distribute across regional teams to identify and address gaps	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Identify all managed Medicaid payers in PPS footprint, and establish regular working meetings and learning forums between MCOs and PPS partners	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4. Set up regular sessions to convene regional providers, social service agencies and payers for PPS update and feedback Town Halls and Networking events	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 5. Establish regular reporting and updating of partner participation, supporting current partners and/or onboarding of	Project		In Progress	10/01/2015	06/30/2017	10/01/2015	06/30/2017	06/30/2017	DY3 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
new partners as deemed necessary by PPS governance or project needs.									
Task Step 6: PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.	Project		Not Started			04/02/2016	09/30/2018	09/30/2018	DY4 Q2
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	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS produces a list of participating HHs and ACOs.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	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	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Engage Mount Sinai Health Partners (MSHP) to provide IT, clinical, care management, and MCO contracting support to establish foundational IDS	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. PPS PMO will inventory active population health IT, clinical and care management initiatives throughout PPS	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3. Through the inventory, PPS partners will convene to establish baseline core competencies, identify gaps, and achieve initial best practice guidelines for implementation of IDS.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. PPS will identify specific providers and CBO's in which to pilot best practices relating to IT, clinical and care management initiatives.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5. PPS workgroup will monitor best practice implementation, modify practices as needed, identify successful initiatives to be implemented across the PPS and those best implemented in selected sites.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task	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
Step 6. PMO will conduct a staged implementation of a common IT platform for communication of PHI within and between PPSs, leveraging existing EMR, HIE resources as much as possible									
Task Step 7. PMO will develop common PPS clinical and care management training modules for all provider types, a universal patient assessment, and universal care plan	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 8. PPS produces a list of participating HHs and ACOs.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 9. Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.	Project		Not Started			04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 10. Set up a schedule to regularly convene all Health Homes participating in PPS to share best practices and modify operations, providing support as necessary, to align HH activities with IDS priorities	Project		Not Started			04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 11. Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.	Project		Not Started			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	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 PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS trains staff on IDS protocols and processes.	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)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 1. Create geographic/community teams for PPS project implementation which will be comprised of local medical, behavioral health, acute, post-acute, long-term care, public health and social service providers	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Leverage MSHP (MSO) and partner data analytics to identify baseline performance gaps for key clinical process and outcome measures across PPS, prioritizing clinical and care management support to areas of highest need	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3. Establish universal patient assessment and care plan across PPS for standardized assessment of and goal-setting for medical, behavioral, public health and community support needs	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Establish specific clinical protocols and outcome benchmarks for each PPS project and determine workforce/care team member(s) responsible for carrying out each measure	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5. For each PPS project, educate all clinical and care management providers across PPS re: provision of services using standardized clinical protocols and care pathways	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6. Set up a schedule to track and report on a quarterly basis clinical performance metrics at each project site, including patient satisfaction and fulfillment of care plan, providing support and remediation to low-performing practices and spreading best practices from high-achieving sites	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 7: Clinically Interoperable System is in place for all participating providers.	Project		On Hold			04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 8: PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.	Project		On Hold			04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 9: PPS trains staff on IDS protocols and processes.	Project		On Hold			04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 10: PPS has process for tracking care outside of hospitals	Project		On Hold			04/01/2015	03/31/2020	03/31/2020	DY5 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
to ensure that all critical follow-up services and appointment reminders are followed.									
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.	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 connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	01/01/2016	03/31/2018	01/01/2016	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	01/01/2016	03/31/2018	01/01/2016	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	01/01/2016	03/31/2018	01/01/2016	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	01/01/2016	03/31/2018	01/01/2016	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	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Assess partner EMRs and identify bi-directional data interface capability / gaps to EHRs and other data source systems	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Develop and agree on the future state and a plan to close any gaps identified in step 1	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. Provision MSPPS HIE eMPI for use with PPS data interfaces	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4. Develop, implement, and deploy CBO data entry portal and associated flat-file data collection and normalization process	Project		In Progress	01/01/2016	06/30/2017	01/01/2016	06/30/2017	06/30/2017	DY3 Q1

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DSRIP Implementation Plan Project

Mount Sinai PPS, LLC (PPS ID:34)

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 Step 5. Implement interfaces from EHRs and other data sources topartnering RHIOs, or directly to MS PPS system	Project		In Progress	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task Step 6. Develop, implement, and deploy Direct messaging and referrals management tools	Project		In Progress	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	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	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	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Identify baseline and gaps in adoption of ONC-certified EHR technology among PPS participants as part of the current state assessment and gap-analysis process	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Develop plan, detail around technical assistance services, and timeline for implementation of technical assistance program	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Provide technical assistance, including purchasing decision support, dissemination of EHR implementation best practices via the PPS Learning Management System (LMS), and other modes of implementation support to be determined through the current state assessment and gap-analysis processes to providers that need to adopt a new EHR or upgrade their existing EHR - in time for achievement of PCMH III and adoption of MU eligible EHRs in DY3	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	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	In Progress	07/01/2015	09/30/2018	07/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task PPS identifies targeted patients through patient registries and is	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
able to track actively engaged patients for project milestone reporting.									
Task Step 1. Develop plan for population health analytics and care management platform	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Define target populations to develop patient cohorts/registries	Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Develop plan for population health interventions for specific patient cohorts	Project		In Progress	04/01/2016	09/30/2017	04/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 4. Implement population health analytics platform	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5. Implement care management / care coordination platform	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6. Develop reports for outcome tracking and audit process to ensure accuracy	Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7. Implement population health interventions for specific patient cohorts	Project		In Progress	10/01/2017	09/30/2018	10/01/2017	09/30/2018	09/30/2018	DY4 Q2
Task Step 8. Incorporate appropriate risk stratified population Health Metrics benchmarks for MS PPS partners from NY DOH (MY2 metrics) and set up quarterly assessment schedule	Project		In Progress	04/01/2017	09/30/2018	04/01/2017	09/30/2018	09/30/2018	DY4 Q2
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	07/01/2015	03/31/2018	07/01/2015	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	07/01/2015	03/31/2018	07/01/2015	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	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note:	Project		In Progress	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
any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)									
Task Step 1. Develop methodology for tracking PCMH and MU status of all participating PCPs	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2. Begin tracking PCMH and MU status of all participating PCPs	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3.Develop initial reporting mechanism for participating PCPs that meet L3 PCMH and MU	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Develop technical assistance (TA) program to support participating PCPs, to include EHR system purchasing decision support, dissemination of EHR implementation best practices via the PPS Learning Management System, and specific PCMH training programs and resources to be disseminated via the PPS Learning Management System (LMS).	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5. Implement technical assistance (TA) program to support participating PCPs	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 6. Final report on participating PCPs that meet L4 PCMH and MU	Project		In Progress	01/01/2018	03/31/2018	01/01/2018	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	07/01/2015	09/30/2018	07/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Medicaid Managed Care contract(s) are in place that include value-based payments.	Project		In Progress	07/01/2015	09/30/2018	07/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 1. Identify all Managed Medicaid payers and other payers within the geographic footprint of the PPS	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2. Establish Communication and training models (Town Halls, Webinars, Face to Face meetings) with Payers and PPS providers to understand and operationalize value based reimbursement.	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
Task Step 3. Begin executing managed care risk contracts for select projects which have exhibited strong performance over previous performance year(s) . PPS leadership will initially identify participants from the PPS with strong performance as well as risk contract experience to serve as first participants in risk arrangements with payers, ultimately involving all PPS providers as the PPS providers collectively transition to more complex value based reimbursement arrangements. "	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 4. Develop a value based performance pilot model with select payers and with select PPS partners who represent the broad spectrum of the PPS. The select payers for the pilot would be Managed Medicaid payers with significant assigned populations assigned to MSPPS, and decided upon by the finance committee. The select PPS providers would be identified by these payers, with whom the payer has a strong and existing successful risk based relationship. The Finance committee would also approve the PPS provider selection.	Project		In Progress	04/01/2017	03/31/2018	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task Step 5. Finalize value based contracts between Managed Medicaid Organization payers and select PPS providers	Project		In Progress	04/01/2018	09/30/2018	04/01/2018	09/30/2018	09/30/2018	DY4 Q2
Task Step 6. Transition PPS providers into separate contracting entity (akin to an IPA) with Managed MCD plans for risk-based arrangements	Project		In Progress	04/01/2018	09/30/2018	04/01/2018	09/30/2018	09/30/2018	DY4 Q2
Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Identify Managed Medicaid payers and schedule monthly meetings to discuss dashboard items such as utilization trends, performance/outcome issues, associated costs and resulting	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
overall efficiencies and improvements in care delivery, including the provision of services within the IDS by non-traditional organizations (e.g. social services, CBOs)									
Task Step 2. Share performance data amongst entire PPS and establish more granular PPS provider report card. Compare performance data with other PPS's	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. Establish monthly reporting to PPS leadership and the State	Project		In Progress	07/02/2015	03/31/2017	07/02/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4. Identify PPS partners who show strong performance based outcomes and elicit their educational assistance with those PPS providers whose performance and outcomes are not as strong	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5. Utilize established PPS learning collaborative to meet collectively with the MCO plan to optimize rates, measures and processes and avoid redundancy or inconsistencies among plans and/or PPSs	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6. Utilize strong PPS partners for participation in pilot value-based contracts with payers	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7. Transition PPS providers into separate contracting entity (akin to an IPA) with Managed MCD plans for risk-based arrangements	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	07/01/2015	09/30/2018	07/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation	Project		In Progress	01/01/2018	09/30/2018	01/01/2018	09/30/2018	09/30/2018	DY4 Q2
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.	Project		In Progress	01/01/2018	09/30/2018	01/01/2018	09/30/2018	09/30/2018	DY4 Q2
Task Step 1. Explore methods and models of payment by identifying partners experienced in performance-based reimbursement, develop payment reform models with the payers	Project		In Progress	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 Step 2. PPS governance will inventory any established value-based compensation models among PPS providers (e.g. Mount Sinai Primary Care Institute) to develop benchmark metrics and pilot compensation models for each type of workforce	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Through the collaboration of managed care payers and the finance committee, establish concrete definitions and whenever possible, standardization of value based outcomes for payment purposes, for all disciplines of PPS providers.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Finance committee along with the IT committee, and in collaboration with payers, will define performance measures and outcomes and then equate dollar values to those defined outcomes and performance measures. The outcomes especially would need to be precisely qualified and measurable. This will result in pilot compensation models for the PPS	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Engage and train PPS providers on definitions and agree to standardizations across PPS providers.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 6. Pilot and evaluate performance-based compensation models among select providers/organizations, representing all provider types in PPS	Project		In Progress	01/01/2017	12/31/2017	01/01/2017	12/31/2017	12/31/2017	DY3 Q3
Task Step 7. Finalize adoption of compensation models that incentivizes and compensates each type of PPS provider based on performance and outcomes	Project		In Progress	01/01/2018	09/30/2018	01/01/2018	09/30/2018	09/30/2018	DY4 Q2
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	04/01/2015	09/30/2018	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.	Project		In Progress	04/01/2016	09/30/2018	04/01/2016	09/30/2018	09/30/2018	DY4 Q2
Task Step 1.Hold introductory and recurring PPS-led patient-engagement and educational events in which PPS leadership	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
and local clinical and service providers educate community about the PPS programs, population health and DSRIP goals to develop an IDS. During and following these events, the PPS will gather baseline and follow-up attendance, attendee knowledge about current patient/community understanding of clinical integration, participation in projects.									
Task Step 2. Establish patient advisory board whose role in PPS governance will be to monitor and advise on outreach, navigation activities and the progress that the PPS makes in engaging patients in IDS.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Launch online and/or print resources for patients to educate about DSRIP as well as specific clinical and care management programs, including the local organizations which will be providing services. Track utilization of online site, as well as incoming telephone or written correspondence from patients.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4. Leverage and train local peers, CHWs, and CBOs to provide culturally sensitive education, outreach and care management to immediate patient community, tying in efforts to larger goals of DSRIP and IDS	Project		In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 5. PPS clinical quality committee will utilize established and PPS-specific patient satisfaction assessments to assess monthly outcomes, continually modifying and tailoring programs and communications to meet patients' needs.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6. With input from patient advisory board, and PPS IT support, PMO will establish a protocol to promotes use of patient portal for self-management and communication of patients with their providers, including ongoing tracking of portal use and communication.	Project		In Progress	04/01/2016	06/30/2018	04/01/2016	06/30/2018	06/30/2018	DY4 Q1
Task Step 7. Monitoring of integrated delivery system tracked by number of activities, number of participating community health workers, peers and culturally competent community based organizations.	Project		In Progress	07/01/2015	06/30/2018	07/01/2015	06/30/2018	06/30/2018	DY4 Q1

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Task Step 8. Stakeholder Engagement cross functional work group will participate and serve as a clearing house of sharing best practices for provider types including CBOs to engage patients in the IDS.	Project		In Progress	07/01/2015	06/30/2018	07/01/2015	06/30/2018	06/30/2018	DY4 Q1

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 Step 1. Create PPS operational infrastructure (PMO) that includes central and regional Stakeholder Engagement teams to promote partner education and engagement in IDSD										
Task Step 2. Inventory all providers and social service agencies in PPS by provider type, services delivered, geography served and distribute across regional teams to identify and address gaps										
Task Step 3. Identify all managed Medicaid payers in PPS footprint, and establish regular working meetings and learning forums between MCOs and PPS partners										
Task Step 4. Set up regular sessions to convene regional providers, social service agencies and payers for PPS update and feedback Town Halls and Networking events										
Task Step 5. Establish regular reporting and updating of partner participation, supporting current partners and/or onboarding of new partners as deemed necessary by PPS governance or project needs.										
Task Step 6: PPS includes continuum of providers in IDS, including										

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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
medical, behavioral health, post-acute, long-term care, and community-based providers.										
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 Step 1. Engage Mount Sinai Health Partners (MSHP) to provide IT, clinical, care management, and MCO contracting support to establish foundational IDS										
Task Step 2. PPS PMO will inventory active population health IT, clinical and care management initiatives throughout PPS										
Task Step 3. Through the inventory, PPS partners will convene to establish baseline core competencies, identify gaps, and achieve initial best practice guidelines for implementation of IDS.										
Task Step 4. PPS will identify specific providers and CBO's in which to pilot best practices relating to IT, clinical and care management initiatives.										
Task Step 5. PPS workgroup will monitor best practice implementation, modify practices as needed, identify successful initiatives to be implemented across the PPS and those best implemented in selected sites.										
Task Step 6. PMO will conduct a staged implementation of a common IT platform for communication of PHI within and between PPSs, leveraging existing EMR, HIE resources as much as possible										
Task Step 7. PMO will develop common PPS clinical and care management training modules for all provider types, a universal patient assessment, and universal care plan										
Task Step 8: PPS produces a list of participating HHs and ACOs.										

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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 Step 9. Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.										
Task Step 10. Set up a schedule to regularly convene all Health Homes participating in PPS to share best practices and modify operations, providing support as necessary, to align HH activities with IDS priorities										
Task Step 11. Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.										
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 Step 1. Create geographic/community teams for PPS project implementation which will be comprised of local medical, behavioral health, acute, post-acute, long-term care, public health and social service providers										
Task Step 2. Leverage MSHP (MSO) and partner data analytics to identify baseline performance gaps for key clinical process and outcome measures across PPS, prioritizing clinical and care management support to areas of highest need										
Task Step 3. Establish universal patient assessment and care plan across PPS for standardized assessment of and goal-setting for medical, behavioral, public health and community support needs										

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Task Step 4. Establish specific clinical protocols and outcome benchmarks for each PPS project and determine workforce/care team member(s) responsible for carrying out each measure										
Task Step 5. For each PPS project, educate all clinical and care management providers across PPS re: provision of services using standardized clinical protocols and care pathways										
Task Step 6. Set up a schedule to track and report on a quarterly basis clinical performance metrics at each project site, including patient satisfaction and fulfillment of care plan, providing support and remediation to low-performing practices and spreading best practices from high-achieving sites										
Task Step 7: Clinically Interoperable System is in place for all participating providers.										
Task Step 8: PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.										
Task Step 9: PPS trains staff on IDS protocols and processes.										
Task Step 10: PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.										
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.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	530	811	949	978	978	978
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	1,601	2,414	2,817	2,850	2,912	2,912
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	6	6	6	6	12	12
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	102	145	167	175	175	175

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

DSRIP Implementation Plan Project

Mount Sinai PPS, LLC (PPS ID:34)

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 EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	20	26	32	35	39	39
Task PPS uses alerts and secure messaging functionality.										
Task Step 1. Assess partner EMRs and identify bi-directional data interface capability / gaps to EHRs and other data source systems										
Task Step 2. Develop and agree on the future state and a plan to close any gaps identified in step 1										
Task Step 3. Provision MSPPS HIE eMPI for use with PPS data interfaces										
Task Step 4. Develop, implement, and deploy CBO data entry portal and associated flat-file data collection and normalization process										
Task Step 5. Implement interfaces from EHRs and other data sources topartnering RHIOs, or directly to MS PPS system										
Task Step 6. Develop, implement, and deploy Direct messaging and referrals management tools										
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	0	0	0	50	100	200	300	400	600
Task Step 1. Identify baseline and gaps in adoption of ONC-certified EHR technology among PPS participants as part of the current state assessment and gap-analysis process										
Task Step 2. Develop plan, detail around technical assistance services, and timeline for implementation of technical assistance program										
Task Step 3. Provide technical assistance, including purchasing										

Mount Sinai PPS, LLC (PPS ID:34)

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
decision support, dissemination of EHR implementation best practices via the PPS Learning Management System (LMS), and other modes of implementation support to be determined through the current state assessment and gap-analysis processes to providers that need to adopt a new EHR or upgrade their existing EHR - in time for achievement of PCMH III and adoption of MU eligible EHRs in DY3										
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 Step 1. Develop plan for population health analytics and care management platform										
Task Step 2. Define target populations to develop patient cohorts/registries										
Task Step 3. Develop plan for population health interventions for specific patient cohorts										
Task Step 4. Implement population health analytics platform										
Task Step 5. Implement care management / care coordination platform										
Task Step 6. Develop reports for outcome tracking and audit process to ensure accuracy										
Task Step 7. Implement population health interventions for specific patient cohorts										
Task Step 8. Incorporate appropriate risk stratified population Health Metrics benchmarks for MS PPS partners from NY DOH (MY2 metrics) and set up quarterly assessment schedule										
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.										

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

DSRIP Implementation Plan Project

Mount Sinai PPS, LLC (PPS ID:34)

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 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	50	100	300	500	700	1,000
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 Step 1. Develop methodology for tracking PCMH and MU status of all participating PCPs										
Task Step 2. Begin tracking PCMH and MU status of all participating PCPs										
Task Step 3.Develop initial reporting mechanism for participating PCPs that meet L3 PCMH and MU										
Task Step 4. Develop technical assistance (TA) program to support participating PCPs, to include EHR system purchasing decision support, dissemination of EHR implementation best practices via the PPS Learning Management System, and specific PCMH training programs and resources to be disseminated via the PPS Learning Management System (LMS).										
Task Step 5. Implement technical assistance (TA) program to support participating PCPs										
Task Step 6. Final report on participating PCPs that meet L4 PCMH and MU										
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 value-based payments.										
Task Step 1. Identify all Managed Medicaid payers and other payers within the geographic footprint of the PPS										
Task Step 2. Establish Communication and training models (Town Halls, Webinars, Face to Face meetings) with Payers and PPS										

Mount Sinai PPS, LLC (PPS ID:34)

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
providers to understand and operationalize value based reimbursement.										
Task Step 3. Begin executing managed care risk contracts for select projects which have exhibited strong performance over previous performance year(s) . PPS leadership will initially identify participants from the PPS with strong performance as well as risk contract experience to serve as first participants in risk arrangements with payers, ultimately involving all PPS providers as the PPS providers collectively transition to more complex value based reimbursement arrangements. "										
Task Step 4. Develop a value based performance pilot model with select payers and with select PPS partners who represent the broad spectrum of the PPS. The select payers for the pilot would be Managed Medicaid payers with significant assigned populations assigned to MSPPS, and decided upon by the finance committee. The select PPS providers would be identified by these payers, with whom the payer has a strong and existing successful risk based relationship. The Finance committee would also approve the PPS provider selection.										
Task Step 5. Finalize value based contracts between Managed Medicaid Organization payers and select PPS providers										
Task Step 6. Transition PPS providers into separate contracting entity (akin to an IPA) with Managed MCD plans for risk-based arrangements										
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 Step 1. Identify Managed Medicaid payers and schedule monthly meetings to discuss dashboard items such as utilization trends, performance/outcome issues, associated costs and resulting overall efficiencies and improvements in care delivery, including the provision of services within the IDS by non-traditional organizations (e.g. social services, CBOs)										
Task Step 2. Share performance data amongst entire PPS and										

Mount Sinai PPS, LLC (PPS ID:34)

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
establish more granular PPS provider report card. Compare performance data with other PPS's										
Task Step 3. Establish monthly reporting to PPS leadership and the State										
Task Step 4. Identify PPS partners who show strong performance based outcomes and elicit their educational assistance with those PPS providers whose performance and outcomes are not as strong										
Task Step 5. Utilize established PPS learning collaborative to meet collectively with the MCO plan to optimize rates, measures and processes and avoid redundancy or inconsistencies among plans and/or PPSs										
Task Step 6. Utilize strong PPS partners for participation in pilot value-based contracts with payers										
Task Step 7. Transition PPS providers into separate contracting entity (akin to an IPA) with Managed MCD plans for risk-based arrangements										
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 Step 1. Explore methods and models of payment by identifying partners experienced in performance-based reimbursement, develop payment reform models with the payers										
Task Step 2. PPS governance will inventory any established value-based compensation models among PPS providers (e.g. Mount Sinai Primary Care Institute) to develop benchmark metrics and pilot compensation models for each type of workforce										
Task Step 3. Through the collaboration of managed care payers and the finance committee, establish concrete definitions and whenever possible, standardization of value based outcomes for payment purposes, for all disciplines of PPS providers.										

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DSRIP Implementation Plan Project

Mount Sinai PPS, LLC (PPS ID:34)

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 Step 4. Finance committee along with the IT committee, and in collaboration with payers, will define performance measures and outcomes and then equate dollar values to those defined outcomes and performance measures. The outcomes especially would need to be precisely qualified and measurable. This will result in pilot compensation models for the PPS										
Task Step 5. Engage and train PPS providers on definitions and agree to standardizations across PPS providers.										
Task Step 6. Pilot and evaluate performance-based compensation models among select providers/organizations, representing all provider types in PPS										
Task Step 7. Finalize adoption of compensation models that incentivizes and compensates each type of PPS provider based on performance and outcomes										
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 Step 1.Hold introductory and recurring PPS-led patient-engagement and educational events in which PPS leadership and local clinical and service providers educate community about the PPS programs, population health and DSRIP goals to develop an IDS. During and following these events, the PPS will gather baseline and follow-up attendance, attendee knowledge about current patient/community understanding of clinical integration, participation in projects.										
Task Step 2. Establish patient advisory board whose role in PPS governance will be to monitor and advise on outreach, navigation activities and the progress that the PPS makes in engaging patients in IDS.										
Task Step 3. Launch online and/or print resources for patients to educate about DSRIP as well as specific clinical and care management programs, including the local organizations which will be providing services. Track utilization of online site, as well										

Mount Sinai PPS, LLC (PPS ID:34)

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
as incoming telephone or written correspondence from patients.										
Task Step 4. Leverage and train local peers, CHWs, and CBOs to provide culturally sensitive education, outreach and care management to immediate patient community, tying in efforts to larger goals of DSRIP and IDS										
Task Step 5. PPS clinical quality committee will utilize established and PPS-specific patient satisfaction assessments to assess monthly outcomes, continually modifying and tailoring programs and communications to meet patients' needs.										
Task Step 6. With input from patient advisory board, and PPS IT support, PMO will establish a protocol to promotes use of patient portal for self-management and communication of patients with their providers, including ongoing tracking of portal use and communication.										
Task Step 7. Monitoring of integrated delivery system tracked by number of activities, number of participating community health workers, peers and culturally competent community based organizations.										
Task Step 8. Stakeholder Engagement cross functional work group will participate and serve as a clearing house of sharing best practices for provider types including CBOs to engage patients in the IDS.										

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 Step 1. Create PPS operational infrastructure (PMO) that includes central and regional Stakeholder Engagement teams to										

Mount Sinai PPS, LLC (PPS ID:34)

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
promote partner education and engagement in IDSD										
Task Step 2. Inventory all providers and social service agencies in PPS by provider type, services delivered, geography served and distribute across regional teams to identify and address gaps										
Task Step 3. Identify all managed Medicaid payers in PPS footprint, and establish regular working meetings and learning forums between MCOs and PPS partners										
Task Step 4. Set up regular sessions to convene regional providers, social service agencies and payers for PPS update and feedback Town Halls and Networking events										
Task Step 5. Establish regular reporting and updating of partner participation, supporting current partners and/or onboarding of new partners as deemed necessary by PPS governance or project needs.										
Task Step 6: PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.										
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 Step 1. Engage Mount Sinai Health Partners (MSHP) to provide IT, clinical, care management, and MCO contracting support to establish foundational IDS										
Task Step 2. PPS PMO will inventory active population health IT, clinical and care management initiatives throughout PPS										
Task Step 3. Through the inventory, PPS partners will convene to										

Mount Sinai PPS, LLC (PPS ID:34)

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
establish baseline core competencies, identify gaps, and achieve initial best practice guidelines for implementation of IDS.										
Task Step 4. PPS will identify specific providers and CBO's in which to pilot best practices relating to IT, clinical and care management initiatives.										
Task Step 5. PPS workgroup will monitor best practice implementation, modify practices as needed, identify successful initiatives to be implemented across the PPS and those best implemented in selected sites.										
Task Step 6. PMO will conduct a staged implementation of a common IT platform for communication of PHI within and between PPSs, leveraging existing EMR, HIE resources as much as possible										
Task Step 7. PMO will develop common PPS clinical and care management training modules for all provider types, a universal patient assessment, and universal care plan										
Task Step 8: PPS produces a list of participating HHs and ACOs.										
Task Step 9. Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.										
Task Step 10. Set up a schedule to regularly convene all Health Homes participating in PPS to share best practices and modify operations, providing support as necessary, to align HH activities with IDS priorities										
Task Step 11. Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.										
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.										

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Mount Sinai PPS, LLC (PPS ID:34)

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 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 Step 1. Create geographic/community teams for PPS project implementation which will be comprised of local medical, behavioral health, acute, post-acute, long-term care, public health and social service providers										
Task Step 2. Leverage MSHP (MSO) and partner data analytics to identify baseline performance gaps for key clinical process and outcome measures across PPS, prioritizing clinical and care management support to areas of highest need										
Task Step 3. Establish universal patient assessment and care plan across PPS for standardized assessment of and goal-setting for medical, behavioral, public health and community support needs										
Task Step 4. Establish specific clinical protocols and outcome benchmarks for each PPS project and determine workforce/care team member(s) responsible for carrying out each measure										
Task Step 5. For each PPS project, educate all clinical and care management providers across PPS re: provision of services using standardized clinical protocols and care pathways										
Task Step 6. Set up a schedule to track and report on a quarterly basis clinical performance metrics at each project site, including patient satisfaction and fulfillment of care plan, providing support and remediation to low-performing practices and spreading best practices from high-achieving sites										
Task Step 7: Clinically Interoperable System is in place for all participating providers.										
Task Step 8: PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.										
Task Step 9: PPS trains staff on IDS protocols and processes.										
Task Step 10: PPS has process for tracking care outside of hospitals										

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Mount Sinai PPS, LLC (PPS ID:34)

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
to ensure that all critical follow-up services and appointment reminders are followed.										
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.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	978	978	978	978	978	978	978	978	978	978
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	2,912	2,912	2,912	2,912	2,912	2,912	2,912	2,912	2,912	2,912
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	12	12	12	12	12	12	12	12	12	12
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	175	175	175	175	175	175	175	175	175	175
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	39	39	39	39	39	39	39	39	39	39
Task PPS uses alerts and secure messaging functionality.										
Task Step 1. Assess partner EMRs and identify bi-directional data interface capability / gaps to EHRs and other data source systems										
Task Step 2. Develop and agree on the future state and a plan to close any gaps identified in step 1										
Task Step 3. Provision MSPPS HIE eMPI for use with PPS data interfaces										
Task Step 4. Develop, implement, and deploy CBO data entry portal and associated flat-file data collection and normalization process										
Task Step 5. Implement interfaces from EHRs and other data sources topartnering RHIOs, or directly to MS PPS system										
Task Step 6. Develop, implement, and deploy Direct messaging and referrals management tools										

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Mount Sinai PPS, LLC (PPS ID:34)

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 #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.	800	978	978	978	978	978	978	978	978	978
Task Step 1. Identify baseline and gaps in adoption of ONC-certified EHR technology among PPS participants as part of the current state assessment and gap-analysis process										
Task Step 2. Develop plan, detail around technical assistance services, and timeline for implementation of technical assistance program										
Task Step 3. Provide technical assistance, including purchasing decision support, dissemination of EHR implementation best practices via the PPS Learning Management System (LMS), and other modes of implementation support to be determined through the current state assessment and gap-analysis processes to providers that need to adopt a new EHR or upgrade their existing EHR - in time for achievement of PCMH III and adoption of MU eligible EHRs in DY3										
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 Step 1. Develop plan for population health analytics and care management platform										
Task Step 2. Define target populations to develop patient cohorts/registries										
Task Step 3. Develop plan for population health interventions for specific patient cohorts										

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Mount Sinai PPS, LLC (PPS ID:34)

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 Step 4. Implement population health analytics platform										
Task Step 5. Implement care management / care coordination platform										
Task Step 6. Develop reports for outcome tracking and audit process to ensure accuracy										
Task Step 7. Implement population health interventions for specific patient cohorts										
Task Step 8. Incorporate appropriate risk stratified population Health Metrics benchmarks for MS PPS partners from NY DOH (MY2 metrics) and set up quarterly assessment schedule										
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.	1,300	1,540	1,540	1,540	1,540	1,540	1,540	1,540	1,540	1,540
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 Step 1. Develop methodology for tracking PCMH and MU status of all participating PCPs										
Task Step 2. Begin tracking PCMH and MU status of all participating PCPs										
Task Step 3.Develop initial reporting mechanism for participating PCPs that meet L3 PCMH and MU										
Task Step 4. Develop technical assistance (TA) program to support participating PCPs, to include EHR system purchasing decision support, dissemination of EHR implementation best practices via the PPS Learning Management System, and specific PCMH										

Mount Sinai PPS, LLC (PPS ID:34)

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
training programs and resources to be disseminated via the PPS Learning Management System (LMS).										
Task Step 5. Implement technical assistance (TA) program to support participating PCPs										
Task Step 6. Final report on participating PCPs that meet L4 PCMH and MU										
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 value-based payments.										
Task Step 1. Identify all Managed Medicaid payers and other payers within the geographic footprint of the PPS										
Task Step 2. Establish Communication and training models (Town Halls, Webinars, Face to Face meetings) with Payers and PPS providers to understand and operationalize value based reimbursement.										
Task Step 3. Begin executing managed care risk contracts for select projects which have exhibited strong performance over previous performance year(s) . PPS leadership will initially identify participants from the PPS with strong performance as well as risk contract experience to serve as first participants in risk arrangements with payers, ultimately involving all PPS providers as the PPS providers collectively transition to more complex value based reimbursement arrangements. "										
Task Step 4. Develop a value based performance pilot model with select payers and with select PPS partners who represent the broad spectrum of the PPS. The select payers for the pilot would be Managed Medicaid payers with significant assigned populations assigned to MSPPS, and decided upon by the finance committee. The select PPS providers would be identified by these payers, with whom the payer has a strong and existing successful risk based relationship. The Finance committee would also approve the PPS provider selection.										
Task Step 5. Finalize value based contracts between Managed										

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Mount Sinai PPS, LLC (PPS ID:34)

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
Medicaid Organization payers and select PPS providers										
Task Step 6. Transition PPS providers into separate contracting entity (akin to an IPA) with Managed MCD plans for risk-based arrangements										
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 Step 1. Identify Managed Medicaid payers and schedule monthly meetings to discuss dashboard items such as utilization trends, performance/outcome issues, associated costs and resulting overall efficiencies and improvements in care delivery, including the provision of services within the IDS by non-traditional organizations (e.g. social services, CBOs)										
Task Step 2. Share performance data amongst entire PPS and establish more granular PPS provider report card. Compare performance data with other PPS's										
Task Step 3. Establish monthly reporting to PPS leadership and the State										
Task Step 4. Identify PPS partners who show strong performance based outcomes and elicit their educational assistance with those PPS providers whose performance and outcomes are not as strong										
Task Step 5. Utilize established PPS learning collaborative to meet collectively with the MCO plan to optimize rates, measures and processes and avoid redundancy or inconsistencies among plans and/or PPSs										
Task Step 6. Utilize strong PPS partners for participation in pilot value-based contracts with payers										
Task Step 7. Transition PPS providers into separate contracting entity (akin to an IPA) with Managed MCD plans for risk-based arrangements										
Milestone #10 Re-enforce the transition towards value-based payment reform										

Mount Sinai PPS, LLC (PPS ID:34)

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
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 Step 1. Explore methods and models of payment by identifying partners experienced in performance-based reimbursement, develop payment reform models with the payers										
Task Step 2. PPS governance will inventory any established value-based compensation models among PPS providers (e.g. Mount Sinai Primary Care Institute) to develop benchmark metrics and pilot compensation models for each type of workforce										
Task Step 3. Through the collaboration of managed care payers and the finance committee, establish concrete definitions and whenever possible, standardization of value based outcomes for payment purposes, for all disciplines of PPS providers.										
Task Step 4. Finance committee along with the IT committee, and in collaboration with payers, will define performance measures and outcomes and then equate dollar values to those defined outcomes and performance measures. The outcomes especially would need to be precisely qualified and measurable. This will result in pilot compensation models for the PPS										
Task Step 5. Engage and train PPS providers on definitions and agree to standardizations across PPS providers.										
Task Step 6. Pilot and evaluate performance-based compensation models among select providers/organizations, representing all provider types in PPS										
Task Step 7. Finalize adoption of compensation models that incentivizes and compensates each type of PPS provider based on performance and outcomes										
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.										

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Mount Sinai PPS, LLC (PPS ID:34)

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 Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.										
Task Step 1.Hold introductory and recurring PPS-led patient-engagement and educational events in which PPS leadership and local clinical and service providers educate community about the PPS programs, population health and DSRIP goals to develop an IDS. During and following these events, the PPS will gather baseline and follow-up attendance, attendee knowledge about current patient/community understanding of clinical integration, participation in projects.										
Task Step 2. Establish patient advisory board whose role in PPS governance will be to monitor and advise on outreach, navigation activities and the progress that the PPS makes in engaging patients in IDS.										
Task Step 3. Launch online and/or print resources for patients to educate about DSRIP as well as specific clinical and care management programs, including the local organizations which will be providing services. Track utilization of online site, as well as incoming telephone or written correspondence from patients.										
Task Step 4. Leverage and train local peers, CHWs, and CBOs to provide culturally sensitive education, outreach and care management to immediate patient community, tying in efforts to larger goals of DSRIP and IDS										
Task Step 5. PPS clinical quality committee will utilize established and PPS-specific patient satisfaction assessments to assess monthly outcomes, continually modifying and tailoring programs and communications to meet patients' needs.										
Task Step 6. With input from patient advisory board, and PPS IT support, PMO will establish a protocol to promotes use of patient portal for self-management and communication of patients with their providers, including ongoing tracking of portal use and communication.										
Task Step 7. Monitoring of integrated delivery system tracked by number of activities, number of participating community health workers, peers and culturally competent community based organizations.										

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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 Step 8. Stakeholder Engagement cross functional work group will participate and serve as a clearing house of sharing best practices for provider types including CBOs to engage patients in the IDS.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	

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

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

Instructions :

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

1. One risk to implementation is inappropriate identification and engagement of the target population. To mitigate risk, we will:
(a) Base patient identification off the PACT model, whose data validates using patient utilization history of 1 in 30 days or 2 in 6 months. (b) Leverage PACT model: recruit staff, train and empower them to interact with patients and their caregivers to establish trust using previously implemented curricula and role modeling (c) Update and use PACT screening tool to identify high risk populations and key causes of readmission (housing, income instability, lack of transportation), (d) Encourage FACE TO FACE interaction between patients and care coordinators, (e) Assure all patients have PCP and follow-up appointment with PCP and subspecialist (if needed), (f) Recruit staff from local neighborhoods who can be matched with patients both culturally and by language
(g) Assure that patients with behavioral health or substance abuse needs are reconnected to behavioral health providers and/or referred to the appropriate providers (h) Analyze data to predict who will be best served with these interventions and which engagement strategy may work best, (i) Inform relevant doctor at time of admission (as opposed to time of discharge) if patient is currently undergoing treatment with a PCP.
2. Patients might not accept post acute intervention if they are not approached in a sensitive, patient-focused manner to assure engagement. To mitigate risk, we will:
(a) Recruit staff from within communities, being mindful of economic, ethnic, linguistic, and cultural identities (b) Train staff on appropriate patient engagement to reduce likelihood of unintentional alienation of patients and enhance staff's capacity for implementing empathic work (c) Train staff on a suite of tools for effective clinical assessment and intervention (d) Train staff to identify social determinants of readmission (e) Use Motivational Interviewing tactics, assessment of readiness and confidence rulers as indicators and social problem solving styles to inform approach (f) Educate/Empower family/caregivers on how to assist/support patient.
3. Possible risk that we will not be able to ensure access to medical and social services appropriately for patients upon discharge. To mitigate risk, we will:
(a) Train staff to educate patients and identify challenges to achieving appropriate post-discharge follow-up (b) Establish early contact with PCP to arrange timely follow-up of post discharge needs, medication reconciliation and other clinical needs during this vulnerable time (c) Establish linkage to appropriate primary care (if without PCP), correct care coordination site and/or behavioral health/substance abuse services. (d) Establish linkage to proper social and legal services depending on patient's needs. (e) Create streamlined communication protocols between PACT SWs and outpatient providers
4. Partners involved in the project may fail to properly communicate in the time following discharge. To mitigate risk, we will:
(a) Create standardized process to communicate between organizations regarding patients engaged in the project for days/weeks following discharge. (b) Engage our partner organizations early in the development of project staff training. (c) Develop a mechanism to provide feedback to PPS regarding challenges (d) Develop an interim plan prior to IT solution/supporting infrastructure and a back-up plan for communication exchange of this interim plan (e) Develop monitoring/evaluation process for interim and long-term solutions re: standardized process
5. PPS does not properly address patient coverage issues, which are important to getting patients services necessary to avoid readmission. To mitigate risk, we will:
(a) Develop a pre-discharge assessment for any missing entitlement and include it in patient's care plan

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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**
DY4,Q4	25,000

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
6,423	7,406	296.24%	-4,906	29.62%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
tomfitz	Documentation/Certification	34_null_1_2_20151027170405_Patient Registry_MountSinai_2biv_10.23.15.xlsx	Patient Registry	10/27/2015 05:07 PM

Narrative Text :

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	07/01/2015	03/31/2017	07/01/2015	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 Step 1: Inventory assessments and identify critical elements for all assessments	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Inventory care plans and identify critical elements for all care plans	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Develop care transitions workflow	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Develop a universal patient assessment (2.a.i, Milestone 3, Step 3)	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 5: Develop a universal care plan (2.a.i, Milestone 3, Step 3)	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
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	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.	Project		In Progress	12/31/2015	09/30/2017	12/31/2015	09/30/2017	09/30/2017	DY3 Q2
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and	Project		In Progress	12/31/2015	09/30/2017	12/31/2015	09/30/2017	09/30/2017	DY3 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
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.	Project		In Progress	12/31/2015	09/30/2017	12/31/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1: Determine MCOs in PPS and engage for participation in project (2.a.i, Milestone 8, Step 1)	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Identify if MCOs provide transitional care services. If MCO does not provide transitional care services, work with MCOs to delineate their roles and responsibilities	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Leverage Care Coordination Cross Functional Workgroup's Managed Care Organizations relationships to collaborate and leverage existing resources	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Cross-map care management and disease management protocols across MCOs	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Develop patient discharge criteria in partnership with managed care organizations	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6: Review and approval of discharge criteria by PPS leadership	Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 7: Implement approved discharge criteria	Project		In Progress	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Step 8: Develop protocol for service eligibility with MCOs	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 9: Review and approval of protocol for service eligibility by PPS leadership	Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 10: Implement approved protocol for service eligibility	Project		In Progress	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Step 11: Develop patient consent protocols for referrals to health homes, MCOs and other community providers	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 12: Review and approval of consent protocols for referrals by PPS leadership	Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 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 Step 13: Implement approved consent protocols criteria	Project		In Progress	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Step 14: Create a protocol for required transitions of care steps and documentation requirements	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 15: Develop mechanism for Health Home and Managed Care Organization to access/cross reference payor and providers types in PPS	Project		In Progress	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 16: Establish communication protocols to share information with patients PCP of record.	Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 17: Develop consistent tracking and quality improvement over time	Project		In Progress	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Ensure required social services participate in the project.	Project	N/A	In Progress	07/01/2015	09/30/2017	07/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Required network social services, including medically tailored home food services, are provided in care transitions.	Project		In Progress	07/01/2015	09/30/2017	07/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Identify the various types of social services by segment a. Care Management and Care Coordination to Manage Conditions and Connect Patients to Needed Services and Resources b. Primary and Specialty Care Providers to Address Physical Health and Manage Chronic Conditions c. Supportive Housing and Community-Based Social Services to Support and Stabilize Patients	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2: Identify the PPS partners, stratify their needs, interests, strengths (work w. stakeholder engagement cross functional group) (2.a.i, Milestone 1, Step 2)	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Identify specific expectations and responsibilities of social service agencies for 2.b.iv project	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Leverage ongoing stakeholder engagement webinars and/or Town Hall meetings to educate social services in areas of involvement	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	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 Step 5: Create a platform wherein patient navigators/social workers can access information about each social service agency in order to make appropriate referrals working inconjunction with IT	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
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	10/01/2015	03/31/2017	10/01/2015	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	10/01/2015	03/31/2017	10/01/2015	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	10/01/2015	03/31/2017	10/01/2015	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	10/01/2015	03/31/2017	10/01/2015	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	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Identify hospital staff who facilitate discharges to participate in project work group to help plan with Care Coordination Work group	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Work with IT to develop protocol for community primary care provider to receive notification when patient enters the hospital	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Train hospital staff in notification protocol for patient care providers	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Conduct pre- and post-testing to monitor continuous quality improvement	Project		In Progress	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5: Assess current discharge planning protocols across Phase 1 PPS hospitals	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	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 Step 6: Collaborate with CCCFW to develop CCCFW processes, workflows, and protocols as they relate to the CCCFW Charter with regards to discharge planning and case management in the hospital. CCCFW's charter and deliverables to be found in Clinical Integration Section 09- MAPP Module 9.1	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 7: Identify provider types that will need early notification of planned discharges and patient admitted to hospital	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 8: Modify current discharge protocols and create new protocols working with IT to integrate notifications for care managers to work with providers to visit patient in hospital before discharge	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 9: Develop training tools to train hospital staff in collaboration with Workforce including care managers, identified discharge hospital staff and partners on discharge planning protocols	Project		In Progress	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 10: Develop policies/procedures that allow care managers and provider representation on-site at hospitals to meet with patients advise on care transition services	Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 11: Develop policies/procedures that allow PPS providers access to hospitals outside of the PPS to develop care plan and arrange for transitional care services.	Project		In Progress	01/01/2017	03/31/2017	01/01/2017	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	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Engage IT to identify solution/platform that will be used for documenting and sharing discharge and care plan	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	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
Step 2: Discuss with IT how care plan will be integrated into electronic medical record									
Task Step 3: Actively participate in Care Coordination Cross Functional Workgroup sessions to ensure care transition plans are incorporated into patient medical records	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #6 Ensure that a 30-day transition of care period is established.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Recruit new staff from the communities where our target patients live and work to best meet cultural and/or linguistic needs	Project		In Progress	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Have case managers setup in person and face-to-face interactions with patients to build relationships	Project		In Progress	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Establish availability of 24 hour hotline (part of call/command center)	Project		In Progress	07/01/2016	03/31/2017	07/01/2016	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	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Work with IT Committee to identify and track patients	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Create a disease specific dashboard that can be shared across client care stakeholders	Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2

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.										

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Mount Sinai PPS, LLC (PPS ID:34)

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 Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.										
Task Step 1: Inventory assessments and identify critical elements for all assessments										
Task Step 2: Inventory care plans and identify critical elements for all care plans										
Task Step 3: Develop care transitions workflow										
Task Step 4: Develop a universal patient assessment (2.a.i, Milestone 3, Step 3)										
Task Step 5: Develop a universal care plan (2.a.i, Milestone 3, Step 3)										
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 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 Step 1: Determine MCOs in PPS and engage for participation in project (2.a.i, Milestone 8, Step 1)										
Task Step 2: Identify if MCOs provide transitional care services. If MCO does not provide transitional care services, work with MCOs to delineate their roles and responsibilities										
Task Step 3: Leverage Care Coordination Cross Functional Workgroup's Managed Care Organizations relationships to collaborate and leverage existing resources										
Task Step 4: Cross-map care management and disease management protocols across MCOs										

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Mount Sinai PPS, LLC (PPS ID:34)

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 Step 5: Develop patient discharge criteria in partnership with managed care organizations										
Task Step 6: Review and approval of discharge criteria by PPS leadership										
Task Step 7: Implement approved discharge criteria										
Task Step 8: Develop protocol for service eligibility with MCOs										
Task Step 9: Review and approval of protocol for service eligibility by PPS leadership										
Task Step 10: Implement approved protocol for service eligibility										
Task Step 11: Develop patient consent protocols for referrals to health homes, MCOs and other community providers										
Task Step 12: Review and approval of consent protocols for referrals by PPS leadership										
Task Step 13: Implement approved consent protocols criteria										
Task Step 14: Create a protocol for required transitions of care steps and documentation requirements										
Task Step 15: Develop mechanism for Health Home and Managed Care Organization to access/cross reference payor and providers types in PPS										
Task Step 16: Establish communication protocols to share information with patients PCP of record.										
Task Step 17: Develop consistent tracking and quality improvement over time										
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 the various types of social services by segment a. Care Management and Care Coordination to Manage Conditions and Connect Patients to Needed Services and Resources										

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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
b. Primary and Specialty Care Providers to Address Physical Health and Manage Chronic Conditions c. Supportive Housing and Community-Based Social Services to Support and Stabilize Patients										
Task Step 2: Identify the PPS partners, stratify their needs, interests, strengths (work w. stakeholder engagement cross functional group) (2.a.i, Milestone 1, Step 2)										
Task Step 3: Identify specific expectations and responsibilities of social service agencies for 2.b.iv project										
Task Step 4: Leverage ongoing stakeholder engagement webinars and/or Town Hall meetings to educate social services in areas of involvement										
Task Step 5: Create a platform wherein patient navigators/social workers can access information about each social service agency in order to make appropriate referrals working inconjunction with IT										
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.	0	0	50	158	296	444	592	770	770	770
Task Policies and procedures are in place for early notification of planned discharges.	0	0	70	216	412	633	879	1,130	1,130	1,130
Task Policies and procedures are in place for early notification of planned discharges.	0	0	1	2	3	5	7	9	9	9
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 Step 1: Identify hospital staff who facilitate discharges to participate in project work group to help plan with Care Coordination Work group										
Task Step 2: Work with IT to develop protocol for community primary care provider to receive notification when patient enters the hospital										

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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 Step 3: Train hospital staff in notification protocol for patient care providers										
Task Step 4: Conduct pre- and post-testing to monitor continuous quality improvement										
Task Step 5: Assess current discharge planning protocols across Phase 1 PPS hospitals										
Task Step 6: Collaborate with CCCFW to develop CCCFW processes, workflows, and protocols as they relate to the CCCFW Charter with regards to discharge planning and case management in the hospital. CCCFW's charter and deliverables to be found in Clinical Integration Section 09- MAPP Module 9.1										
Task Step 7: Identify provider types that will need early notification of planned discharges and patient admitted to hospital										
Task Step 8: Modify current discharge protocols and create new protocols working with IT to integrate notifications for care managers to work with providers to visit patient in hospital before discharge										
Task Step 9: Develop training tools to train hospital staff in collaboration with Workforce including care managers, identified discharge hospital staff and partners on discharge planning protocols										
Task Step 10: Develop policies/procedures that allow care managers and provider representation on-site at hospitals to meet with patients advise on care transition services										
Task Step 11: Develop policies/procedures that allow PPS providers access to hospitals outside of the PPS to develop care plan and arrange for transitional care services.										
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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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 Step 1: Engage IT to identify solution/platform that will be used for documenting and sharing discharge and care plan										
Task Step 2: Discuss with IT how care plan will be integrated into electronic medical record										
Task Step 3: Actively participate in Care Coordination Cross Functional Workgroup sessions to ensure care transition plans are incorporated into patient medical records										
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 Step 1: Recruit new staff from the communities where our target patients live and work to best meet cultural and/or linguistic needs										
Task Step 2: Have case managers setup in person and face-to-face interactions with patients to build relationships										
Task Step 3: Establish availability of 24 hour hotline (part of call/command center)										
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 Step 1: Work with IT Committee to identify and track patients										
Task Step 2: Create a disease specific dashboard that can be shared across client care stakeholders										

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										

Mount Sinai PPS, LLC (PPS ID:34)

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
health and perform as an integrated clinical team are in place.										
Task Step 1: Inventory assessments and identify critical elements for all assessments										
Task Step 2: Inventory care plans and identify critical elements for all care plans										
Task Step 3: Develop care transitions workflow										
Task Step 4: Develop a universal patient assessment (2.a.i, Milestone 3, Step 3)										
Task Step 5: Develop a universal care plan (2.a.i, Milestone 3, Step 3)										
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 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 Step 1: Determine MCOs in PPS and engage for participation in project (2.a.i, Milestone 8, Step 1)										
Task Step 2: Identify if MCOs provide transitional care services. If MCO does not provide transitional care services, work with MCOs to delineate their roles and responsibilities										
Task Step 3: Leverage Care Coordination Cross Functional Workgroup's Managed Care Organizations relationships to collaborate and leverage existing resources										
Task Step 4: Cross-map care management and disease management protocols across MCOs										
Task Step 5: Develop patient discharge criteria in partnership with										

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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
managed care organizations										
Task Step 6: Review and approval of discharge criteria by PPS leadership										
Task Step 7: Implement approved discharge criteria										
Task Step 8: Develop protocol for service eligibility with MCOs										
Task Step 9: Review and approval of protocol for service eligibility by PPS leadership										
Task Step 10: Implement approved protocol for service eligibility										
Task Step 11: Develop patient consent protocols for referrals to health homes, MCOs and other community providers										
Task Step 12: Review and approval of consent protocols for referrals by PPS leadership										
Task Step 13: Implement approved consent protocols criteria										
Task Step 14: Create a protocol for required transitions of care steps and documentation requirements										
Task Step 15: Develop mechanism for Health Home and Managed Care Organization to access/cross reference payor and providers types in PPS										
Task Step 16: Establish communication protocols to share information with patients PCP of record.										
Task Step 17: Develop consistent tracking and quality improvement over time										
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 the various types of social services by segment a. Care Management and Care Coordination to Manage Conditions and Connect Patients to Needed Services and Resources b. Primary and Specialty Care Providers to Address Physical										

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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
Health and Manage Chronic Conditions c. Supportive Housing and Community-Based Social Services to Support and Stabilize Patients										
Task Step 2: Identify the PPS partners, stratify their needs, interests, strengths (work w. stakeholder engagement cross functional group) (2.a.i, Milestone 1, Step 2)										
Task Step 3: Identify specific expectations and responsibilities of social service agencies for 2.b.iv project										
Task Step 4: Leverage ongoing stakeholder engagement webinars and/or Town Hall meetings to educate social services in areas of involvement										
Task Step 5: Create a platform wherein patient navigators/social workers can access information about each social service agency in order to make appropriate referrals working inconjunction with IT										
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.	770	770	770	770	770	770	770	770	770	770
Task Policies and procedures are in place for early notification of planned discharges.	1,130	1,130	1,130	1,130	1,130	1,130	1,130	1,130	1,130	1,130
Task Policies and procedures are in place for early notification of planned discharges.	9	9	9	9	9	9	9	9	9	9
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 Step 1: Identify hospital staff who facilitate discharges to participate in project work group to help plan with Care Coordination Work group										
Task Step 2: Work with IT to develop protocol for community primary care provider to receive notification when patient enters the hospital										

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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 Step 3: Train hospital staff in notification protocol for patient care providers										
Task Step 4: Conduct pre- and post-testing to monitor continuous quality improvement										
Task Step 5: Assess current discharge planning protocols across Phase 1 PPS hospitals										
Task Step 6: Collaborate with CCCFW to develop CCCFW processes, workflows, and protocols as they relate to the CCCFW Charter with regards to discharge planning and case management in the hospital. CCCFW's charter and deliverables to be found in Clinical Integration Section 09- MAPP Module 9.1										
Task Step 7: Identify provider types that will need early notification of planned discharges and patient admitted to hospital										
Task Step 8: Modify current discharge protocols and create new protocols working with IT to integrate notifications for care managers to work with providers to visit patient in hospital before discharge										
Task Step 9: Develop training tools to train hospital staff in collaboration with Workforce including care managers, identified discharge hospital staff and partners on discharge planning protocols										
Task Step 10: Develop policies/procedures that allow care managers and provider representation on-site at hospitals to meet with patients advise on care transition services										
Task Step 11: Develop policies/procedures that allow PPS providers access to hospitals outside of the PPS to develop care plan and arrange for transitional care services.										
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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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 Step 1: Engage IT to identify solution/platform that will be used for documenting and sharing discharge and care plan										
Task Step 2: Discuss with IT how care plan will be integrated into electronic medical record										
Task Step 3: Actively participate in Care Coordination Cross Functional Workgroup sessions to ensure care transition plans are incorporated into patient medical records										
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 Step 1: Recruit new staff from the communities where our target patients live and work to best meet cultural and/or linguistic needs										
Task Step 2: Have case managers setup in person and face-to-face interactions with patients to build relationships										
Task Step 3: Establish availability of 24 hour hotline (part of call/command center)										
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 Step 1: Work with IT Committee to identify and track patients										
Task Step 2: Create a disease specific dashboard that can be shared across client care stakeholders										

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 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.	Oct. 2015: Narrative for Step 1 Completion: Project workgroup members develped a list of social services important to consider in the segments noted. List of social services identified for: 1)Care Mgmt/Care Coordination segment: health homes, care coordination programs, PACT clinics, home care services, community paramedicine 2)Primary/Specialty Care Provider segment: community-based primary care clinics, outpatient specialty care, mental health and substance abuse programs, harm reduction community based programs, telemonitoring for patient engagement and self-management skills 3)Supportive Housing/Community based segment: Single Point of Access housing, Medicaid Assisted Living Program, alternatives to incarceration services, disability rights services, legal aid, benefits advocacy, nutritional programs, vocational/employment programs, senior day centers, educational systems, youth/homeless youth programs
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.	

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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Mount Sinai PPS, LLC (PPS ID:34)

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

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

Instructions :

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

1. Caregiver unavailable or unidentified at the time of patient discharge. To mitigate risk, will (a) Assess level of caregiver support per patient upon admission (b) Link caregivers to supportive services (c) Employ language concordant care coordination staff and recruit staff from neighborhoods we serve to optimize community engagement.
2. Without a shared EHR system, there is risk of ineffective communication between hospital and home-care services, leading to disruption in care coordination. To mitigate this risk, will (a) Integrate HIT/EHRs to facilitate health information exchange between hospitals and SNFs/home care agencies.
3. If we do not address and document advance directives goals of care and patient/caregiver preferences at each transition, we risk fragmenting care. To mitigate risk, will
(a) Leverage existing RN home services and care coordination, primary care and/or sub-specialty care services to increase goals of care training (b) Increase home and office-based palliative care consultations for chronically ill (c) Educate staff about Medical Orders for Life Sustaining Treatment (MOLST) (d) Work to communicate these wishes throughout patients' care pathways, within and outside our PPS
4. Collaboration with multiple experts and disciplines can lead to disagreements and delay completion of evidence-based care pathways. To mitigate risk, will
(a) Establish clear protocols and evidence-based guidelines for co-morbid patients (b) Develop a learning collaborative, training guides, and opportunities for providers from various settings to meet face-to face (c) Identify and appoint a "Lead" and create an escalation process; the escalation pathways are stratified on actual/potential domains (clinical, medical, psycho-social, behavioral, finance)
5. Patients may not have strong links to health care sites, particularly when patients leave facility AMA, "early dismissal". To mitigate risk, will
(a) Trigger a process for activation of Rapid Response Team (RRT) for such conditions; targeted skill set, explore possibility of Mobile RRT in community
6. Lack of integrated health IT infrastructure, need for expanded telemedicine services, and parsimony resource allocation and sharing. To mitigate risk,
(a) Significant investments to be made in shared HIT infrastructure, functioning HIE, and telemedicine services, requiring innovative payment models (b) Early and continued engagement with MCOs and policy/regulatory changes will facilitate integration and collaboration among competitive parties (c) Stratification method will be needed based on established criteria for assigned resources up to and including diffusion of care and intervention mapping
7. Regulations impacting provider-to-provider hospital-home care. To mitigate risk, will
(a) Work with DOH to seek regulatory relief if regulatory barriers are identified
8. Patients may be faced with psycho-social strain (unstable housing, limited access to phone). To mitigate risk,
(a) Rapid Response Team (RRT) will assess patients for psycho-social strain and refer to Health Home, NORC program, Senior Center or other CBO to address these.
9. May be difficult to engage CHHAs, SNFs and patients with INTERACT-like principles. To mitigate risk, will train all providers through validated methodology (motivational interviewing, patient centered assessments, etc.) to deal with culturally diverse patients with poor health literacy. Our

PPS partners have experience with this and will share best practices to improve engagement and retention with INTERACT principles.
10. Another potential risk is some Home Care agencies might become overburdened trying to meet the requirements of this project (resulting in lower performance). To mitigate risk, we will assess staffing, financial or compliance challenges on ongoing basis and support partners to improve quality

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	20,000

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
568	5,972	238.88%	-3,472	29.86%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
tomfitz	Documentation/Certification	34_null_1_2_20151027172942_PartnerAttestation_VNSNY_MSPPS_DY1Q2.pdf	VNSNY's partner attestation to aggregate actively engaged count	10/27/2015 05:30 PM
tomfitz	Documentation/Certification	34_null_1_2_20151027172706_PartnerAttestation_Premier_MSPPS_DY1Q2.pdf	Premier Home Health's partner attestation to aggregate actively engaged count	10/27/2015 05:27 PM
tomfitz	Documentation/Certification	34_null_1_2_20151027172352_PartnerAttestation_MJHS_MSPPS_DY1Q2.pdf	MJHS's partner attestation to aggregate actively engaged count	10/27/2015 05:24 PM
tomfitz	Documentation/Certification	34_null_1_2_20151027172109_PartnerAttestation_Isabella_MSPPS_DY1Q2.pdf	Isabella Home Care's partner attestation to aggregate actively engaged count	10/27/2015 05:22 PM

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.	Project	N/A	In Progress	07/01/2015	09/30/2017	07/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for: - discharge planning - discharge facilitation - confirmation of home care services	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1: Assess any current hospitalist program(s) that involve discharge planning, facilitation, or confirmation of home services	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Identify staff roles currently involved in facilitating discharges	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 3: Engage hospitalists in project workgroup	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Identify roles required and responsibility of Rapid Response Team members	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #2 Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Staff trained on care model, specific to: - patient risks for readmission - evidence-based preventive medicine - chronic disease management	Provider	Home Care Facilities	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Evidence-based guidelines for chronic-condition management	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)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
implemented.									
Task Step 1: Standardize risk stratification across PPS and implement evidence-based guidelines for each risk level leveraging Hierarchical Conditions Category (HCC) score, and other appropriate measures	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Determine information transfer from hospital to home care to assure accurate stratifications	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Develop care models for rehospitalized patients	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Establish procedures to perform initial and continuing staff competency testing	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Establish policies/procedures to monitor patient outcomes of care and/or hospital readmissions and share with staff	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 6: Educate/Orient physicians and other care givers on evidence based practices	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Collect current evidence-based practices from partnering providers	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 8: Evaluate and determine evidence-based practices to be used PPS-wide in collaboration with disease specific project workgroups	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 9: Create implementation plan of evidence-based practices and submit to PPS (each provider completes this)	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 10: Monitor use of evidence-based practices across providers	Project		In Progress	03/01/2016	12/31/2016	03/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 11: Establish continuous evaluation of new evidence-based practices for implementation	Project		In Progress	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of	Project	N/A	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)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
potential instability and intervention to avoid hospital transfer.									
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.	Provider	Safety Net Hospital	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Collect care pathways currently used by partnering providers	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Select care pathways to be used PPS-wide	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Engage physicians and other care givers on care pathways	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Determine standardized interventions for early identified instability	Project		In Progress	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Identify obstacles for implementation	Project		In Progress	12/31/2015	12/31/2016	12/31/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 6: Monitor providers' compliance with selected care pathways	Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Implement ongoing assessment for high risk patients	Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 8: Implement integrated care team to divert hospitalization working with care coordination cross functional group	Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 9: Conduct provider training on interventions	Project		In Progress	12/31/2015	09/30/2016	12/31/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #4 Educate all staff on care pathways and INTERACT-like principles.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Training program for all home care staff established, which encompasses care pathways and INTERACT-like principles.	Provider	Home Care Facilities	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Research INTERACT-like training resources and cost	Project		In Progress	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)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 2: Identify first phase of INTERACT-like tools to implement across agencies	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Determine agencies and number of staff requiring training	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Develop on-going training schedule	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Staff attend training and track participation	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6: Establish procedures to perform staff competency testing, before and after training, for new staff and on an ongoing basis; evaluate trainee feedback and reaction to material, method, and topic to strengthen training outcomes.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Perform continuous quality improvement in light of testing and training feedback to evaluate training efficacy	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1 - Inventory existing programs/agencies using advance care planning tools, compare/contrast, standardize	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2- Identify which INTERACT Advanced Care Planning tools complement existing tools	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Identify when in home care advanced care planning is explored	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Develop way for identifying patients without advanced directives and a triage plan for identfying their needs	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Identify teaching opportunities regarding advanced care planning and potential participants	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
Task Step 6: Develop training materials and schedule training	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 7: Attend training and track participation	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone #6 Create coaching program to facilitate and support implementation.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task INTERACT-like coaching program has been established for all home care and Rapid Response Team staff.	Provider	Home Care Facilities	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Identify agency representatives participating in INTERACT-like trainings who will be designated as "INTERACT Champion"	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Establish annual continuing education program	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Establish discussion groups to share best practices	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Patients and families educated and involved in planning of care using INTERACT-like principles.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Create a hand over tool to next level of care which indicates the teaching initiated in hospital and what needs to be continued.	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Determine method for assessing patient/CG knowledge base and health literacy	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Develop a variation of teaching methods	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Create patient/CG educational & training materials that is patient-centered and includes patient's goals of care	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Decide on critical learning needs prior to discharge	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6: Detemine method for integrating Patient/CG education	Project		In Progress	03/31/2016	09/30/2016	03/31/2016	09/30/2016	09/30/2016	DY2 Q2

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into the patient health record									
Milestone #8 Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.	Project	N/A	In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task All relevant services (physical, behavioral, pharmacological) integrated into care and medication management model.	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1: Actively participate in Care Coordination Cross Functional Workgroup sessions	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 2: Leverage Care Coordination Cross Functional Workgroup's resources	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Collaborate with CCCFW to develop CCCFW processes, workflows, and protocols as they relate to the CCCFW Charter. CCCFW's charter and deliverables to be found in Clinical Integration Section 09- MAPP Module 9.1	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Implement a pharmacy review of medications including antibiotics, ensure antibiotics are used appropriately and discontinued when no longer needed	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone #9 Utilize telehealth/telemedicine to enhance hospital-home care collaborations.	Project	N/A	In Progress	07/01/2015	09/30/2017	07/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Telehealth/telemedicine program established to provide care transition services, prevent avoidable hospital use, and increase specialty expertise of PCPs and staff.	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1: Develop criteria of telehealth solutions	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Research telehealth solutions demo to project workgroup	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Demonstrate existing solutions to project workgroup	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Work with IT Committee to plan, test, implement selected solution	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task	Project		In Progress	06/01/2016	03/31/2017	06/01/2016	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
Step 5: Train family/caregivers to use selected technology									
Task Step 6: Obtain feedback for optimization	Project		In Progress	06/01/2016	06/30/2017	06/01/2016	06/30/2017	06/30/2017	DY3 Q1
Milestone #10 Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.	Project	N/A	In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Clinical Interoperability System in place for all participating providers. Usage documented by the identified care coordinators.	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1: Work with IT/partners to assess interoperability systems are in plan for implementation	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Work with IT/partners to identify specific medication error alerts/fields to monitor	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Track that care coordinators are accessing EHR to check for services provided to patients	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #11 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Project	N/A	In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Service and quality outcome measures are reported to all stakeholders.	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1: Develop champions within lead and partner organizations	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	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 Step 2: Develop monthly meeting schedule to assess root cause analyses of home-care to hospital transfers	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Work with the state/MCOs to obtain real-time data on readmissions to inform training plan and improve quality	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Schedule webinars to inform workgroup of performance measures/baseline data	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 5: Evaluate and review avoidable readmissions; discuss high cost of care patients	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 6: Engage w/ MCO or MLTC to collect HEDIS measures and identify gaps in these measures	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 7: Use HCAHPS reports to monitor patient satisfaction scores across providers and identify areas of improvement	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 8: Establish process to systematically and on a schedule share outcome measures	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 9: Develop root cause analysis reports and review monthly	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 10: Determine rapid cycle methodologies to use for quality improvement initiatives	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 11: Determine quality improvement measures	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Milestone #12 Use EHRs and other technical platforms to track all patients engaged in the project.	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 targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Generate reports that are submitted quarterly to the PPS by home care agencies including number of staff trained, patients/caregivers trained and affected by staff trainings.	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3

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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 Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.										
Task Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for: - discharge planning - discharge facilitation - confirmation of home care services										
Task Step 1: Assess any current hospitalist program(s) that involve discharge planning, facilitation, or confirmation of home services										
Task Step 2: Identify staff roles currently involved in facilitating discharges										
Task Step 3: Engage hospitalists in project workgroup										
Task Step 4: Identify roles required and responsibility of Rapid Response Team members										
Milestone #2 Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.										
Task Staff trained on care model, specific to: - patient risks for readmission - evidence-based preventive medicine - chronic disease management	0	0	1	4	9	14	19	25	25	25
Task Evidence-based guidelines for chronic-condition management implemented.										
Task Step 1: Standardize risk stratification across PPS and implement evidence-based guidelines for each risk level leveraging Hierarchical Conditions Category (HCC) score, and other appropriate measures										
Task Step 2: Determine information transfer from hospital to home care to assure accurate stratifications										
Task Step 3: Develop care models for rehospitalized patients										
Task Step 4: Establish procedures to perform initial and continuing staff competency testing										

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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 Step 5: Establish policies/procedures to monitor patient outcomes of care and/or hospital readmissions and share with staff										
Task Step 6: Educate/Orient physicians and other care givers on evidence based practices										
Task Step 7: Collect current evidence-based practices from partnering providers										
Task Step 8: Evaluate and determine evidence-based practices to be used PPS-wide in collaboration with disease specific project workgroups										
Task Step 9: Create implementation plan of evidence-based practices and submit to PPS (each provider completes this)										
Task Step 10: Monitor use of evidence-based practices across providers										
Task Step 11: Establish continuous evaluation of new evidence-based practices for implementation										
Milestone #3 Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.										
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.										
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.	0	0	1	2	3	4	6	8	8	8
Task Step 1: Collect care pathways currently used by partnering providers										
Task Step 2: Select care pathways to be used PPS-wide										
Task Step 3: Engage physicians and other care givers on care pathways										
Task Step 4: Determine standardized interventions for early identified instability										

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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 Step 5: Identify obstacles for implementation										
Task Step 6: Monitor providers' compliance with selected care pathways										
Task Step 7: Implement ongoing assessment for high risk patients										
Task Step 8: Implement integrated care team to divert hospitalization working with care coordination cross functional group										
Task Step 9: Conduct provider training on interventions										
Milestone #4 Educate all staff on care pathways and INTERACT-like principles.										
Task Training program for all home care staff established, which encompasses care pathways and INTERACT-like principles.	0	0	1	4	9	14	19	25	25	25
Task Step 1: Research INTERACT-like training resources and cost										
Task Step 2: Identify first phase of INTERACT-like tools to implement across agencies										
Task Step 3: Determine agencies and number of staff requiring training										
Task Step 4: Develop on-going training schedule										
Task Step 5: Staff attend training and track participation										
Task Step 6: Establish procedures to perform staff competency testing, before and after training, for new staff and on an ongoing basis; evaluate trainee feedback and reaction to material, method, and topic to strengthen training outcomes.										
Task Step 7: Perform continuous quality improvement in light of testing and training feedback to evaluate training efficacy										
Milestone #5 Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.										
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).										

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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 Step 1 - Inventory existing programs/agencies using advance care planning tools, compare/contrast, standardize										
Task Step 2- Identify which INTERACT Advanced Care Planning tools complement existing tools										
Task Step 3: Identify when in home care advanced care planning is explored										
Task Step 4: Develop way for identifying patients without advanced directives and a triage plan for identfying their needs										
Task Step 5: Identify teaching opportunities regarding advanced care planning and potential participants										
Task Step 6: Develop training materials and schedule training										
Task Step 7: Attend training and track participation										
Milestone #6 Create coaching program to facilitate and support implementation.										
Task INTERACT-like coaching program has been established for all home care and Rapid Response Team staff.	0	0	1	4	9	14	19	25	25	25
Task Step 1: Identify agency representatives participating in INTERACT-like trainings who will be designated as "INTERACT Champion"										
Task Step 2: Establish annual continuing education program										
Task Step 3: Establish discussion groups to share best practices										
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.										
Task Patients and families educated and involved in planning of care using INTERACT-like principles.										
Task Step 1: Create a hand over tool to next level of care which indicates the teaching initiated in hospital and what needs to be continued.										
Task Step 2: Determine method for assessing patient/CG knowledge base and health literacy										

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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 Step 3: Develop a variation of teaching methods										
Task Step 4: Create patient/CG educational & training materials that is patient-centered and includes patient's goals of care										
Task Step 5: Decide on critical learning needs prior to discharge										
Task Step 6: Detemine method for integrating Patient/CG education into the patient health record										
Milestone #8 Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.										
Task All relevant services (physical, behavioral, pharmacological) integrated into care and medication management model.										
Task Step 1: Actively participate in Care Coordination Cross Functional Workgroup sessions										
Task Step 2: Leverage Care Coordination Cross Functional Workgroup's resources										
Task Step 3: Collaborate with CCCFW to develop CCCFW processes, workflows, and protocols as they relate to the CCCFW Charter. CCCFW's charter and deliverables to be found in Clinical Integration Section 09- MAPP Module 9.1										
Task Step 4: Implement a pharmacy review of medications including antibiotics, ensure antibiotics are used appropriately and discontinued when no longer needed										
Milestone #9 Utilize telehealth/telemedicine to enhance hospital-home care collaborations.										
Task Telehealth/telemedicine program established to provide care transition services, prevent avoidable hospital use, and increase specialty expertise of PCPs and staff.										
Task Step 1: Develop criteria of telehealth solutions										
Task Step 2: Research telehealth solutions demo to project workgroup										
Task Step 3: Demonstrate existing solutions to project workgroup										

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Mount Sinai PPS, LLC (PPS ID:34)

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 Step 4: Work with IT Committee to plan, test, implement selected solution										
Task Step 5: Train family/caregivers to use selected technology										
Task Step 6: Obtain feedback for optimization										
Milestone #10 Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.										
Task Clinical Interoperability System in place for all participating providers. Usage documented by the identified care coordinators.										
Task Step 1: Work with IT/partners to assess interoperability systems are in plan for implementation										
Task Step 2: Work with IT/partners to identify specific medication error alerts/fields to monitor										
Task Step 3: Track that care coordinators are accessing EHR to check for services provided to patients										
Milestone #11 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.										
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.										
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.										
Task Service and quality outcome measures are reported to all stakeholders.										
Task Step 1: Develop champions within lead and partner organizations										
Task Step 2: Develop monthly meeting schedule to assess root cause										

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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
analyses of home-care to hospital transfers										
Task Step 3: Work with the state/MCOs to obtain real-time data on readmissions to inform training plan and improve quality										
Task Step 4: Schedule webinars to inform workgroup of performance measures/baseline data										
Task Step 5: Evaluate and review avoidable readmissions; discuss high cost of care patients										
Task Step 6: Engage w/ MCO or MLTC to collect HEDIS measures and identify gaps in these measures										
Task Step 7: Use HCAHPS reports to monitor patient satisfaction scores across providers and identify areas of improvement										
Task Step 8: Establish process to systematically and on a schedule share outcome measures										
Task Step 9: Develop root cause analysis reports and review monthly										
Task Step 10: Determine rapid cycle methodologies to use for quality improvement initiatives										
Task Step 11: Determine quality improvement measures										
Milestone #12 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1: Generate reports that are submitted quarterly to the PPS by home care agencies including number of staff trained, patients/caregivers trained and affected by staff trainings.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.										

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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 Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for: - discharge planning - discharge facilitation - confirmation of home care services										
Task Step 1: Assess any current hospitalist program(s) that involve discharge planning, facilitation, or confirmation of home services										
Task Step 2: Identify staff roles currently involved in facilitating discharges										
Task Step 3: Engage hospitalists in project workgroup										
Task Step 4: Identify roles required and responsibility of Rapid Response Team members										
Milestone #2 Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.										
Task Staff trained on care model, specific to: - patient risks for readmission - evidence-based preventive medicine - chronic disease management	25	25	25	25	25	25	25	25	25	25
Task Evidence-based guidelines for chronic-condition management implemented.										
Task Step 1: Standardize risk stratification across PPS and implement evidence-based guidelines for each risk level leveraging Hierarchical Conditions Category (HCC) score, and other appropriate measures										
Task Step 2: Determine information transfer from hospital to home care to assure accurate stratifications										
Task Step 3: Develop care models for rehospitalized patients										
Task Step 4: Establish procedures to perform initial and continuing staff competency testing										
Task Step 5: Establish policies/procedures to monitor patient outcomes of care and/or hospital readmissions and share with staff										

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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 Step 6: Educate/Orient physicians and other care givers on evidence based practices										
Task Step 7: Collect current evidence-based practices from partnering providers										
Task Step 8: Evaluate and determine evidence-based practices to be used PPS-wide in collaboration with disease specific project workgroups										
Task Step 9: Create implementation plan of evidence-based practices and submit to PPS (each provider completes this)										
Task Step 10: Monitor use of evidence-based practices across providers										
Task Step 11: Establish continuous evaluation of new evidence-based practices for implementation										
Milestone #3 Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.										
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.										
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.	8	8	8	8	8	8	8	8	8	8
Task Step 1: Collect care pathways currently used by partnering providers										
Task Step 2: Select care pathways to be used PPS-wide										
Task Step 3: Engage physicians and other care givers on care pathways										
Task Step 4: Determine standardized interventions for early identified instability										
Task Step 5: Identify obstacles for implementation										
Task Step 6: Monitor providers' compliance with selected care										

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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
pathways										
Task Step 7: Implement ongoing assessment for high risk patients										
Task Step 8: Implement integrated care team to divert hospitalization working with care coordination cross functional group										
Task Step 9: Conduct provider training on interventions										
Milestone #4 Educate all staff on care pathways and INTERACT-like principles.										
Task Training program for all home care staff established, which encompasses care pathways and INTERACT-like principles.	25	25	25	25	25	25	25	25	25	25
Task Step 1: Research INTERACT-like training resources and cost										
Task Step 2: Identify first phase of INTERACT-like tools to implement across agencies										
Task Step 3: Determine agencies and number of staff requiring training										
Task Step 4: Develop on-going training schedule										
Task Step 5: Staff attend training and track participation										
Task Step 6: Establish procedures to perform staff competency testing, before and after training, for new staff and on an ongoing basis; evaluate trainee feedback and reaction to material, method, and topic to strengthen training outcomes.										
Task Step 7: Perform continuous quality improvement in light of testing and training feedback to evaluate training efficacy										
Milestone #5 Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.										
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).										
Task Step 1 - Inventory existing programs/agencies using advance care planning tools, compare/contrast, standardize										

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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 Step 2- Identify which INTERACT Advanced Care Planning tools complement existing tools										
Task Step 3: Identify when in home care advanced care planning is explored										
Task Step 4: Develop way for identifying patients without advanced directives and a triage plan for identfying their needs										
Task Step 5: Identify teaching opportunities regarding advanced care planning and potential participants										
Task Step 6: Develop training materials and schedule training										
Task Step 7: Attend training and track participation										
Milestone #6 Create coaching program to facilitate and support implementation.										
Task INTERACT-like coaching program has been established for all home care and Rapid Response Team staff.	25	25	25	25	25	25	25	25	25	25
Task Step 1: Identify agency representatives participating in INTERACT-like trainings who will be designated as "INTERACT Champion"										
Task Step 2: Establish annual continuing education program										
Task Step 3: Establish discussion groups to share best practices										
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.										
Task Patients and families educated and involved in planning of care using INTERACT-like principles.										
Task Step 1: Create a hand over tool to next level of care which indicates the teaching initiated in hospital and what needs to be continued.										
Task Step 2: Determine method for assessing patient/CG knowledge base and health literacy										
Task Step 3: Develop a variation of teaching methods										

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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 Step 4: Create patient/CG educational & training materials that is patient-centered and includes patient's goals of care										
Task Step 5: Decide on critical learning needs prior to discharge										
Task Step 6: Detemine method for integrating Patient/CG education into the patient health record										
Milestone #8 Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.										
Task All relevant services (physical, behavioral, pharmacological) integrated into care and medication management model.										
Task Step 1: Actively participate in Care Coordination Cross Functional Workgroup sessions										
Task Step 2: Leverage Care Coordination Cross Functional Workgroup's resources										
Task Step 3: Collaborate with CCCFW to develop CCCFW processes, workflows, and protocols as they relate to the CCCFW Charter. CCCFW's charter and deliverables to be found in Clinical Integration Section 09- MAPP Module 9.1										
Task Step 4: Implement a pharmacy review of medications including antibiotics, ensure antibiotics are used appropriately and discontinued when no longer needed										
Milestone #9 Utilize telehealth/telemedicine to enhance hospital-home care collaborations.										
Task Telehealth/telemedicine program established to provide care transition services, prevent avoidable hospital use, and increase specialty expertise of PCPs and staff.										
Task Step 1: Develop criteria of telehealth solutions										
Task Step 2: Research telehealth solutions demo to project workgroup										
Task Step 3: Demonstrate existing solutions to project workgroup										
Task Step 4: Work with IT Committee to plan, test, implement selected solution										

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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 Step 5: Train family/caregivers to use selected technology										
Task Step 6: Obtain feedback for optimization										
Milestone #10 Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.										
Task Clinical Interoperability System in place for all participating providers. Usage documented by the identified care coordinators.										
Task Step 1: Work with IT/partners to assess interoperability systems are in plan for implementation										
Task Step 2: Work with IT/partners to identify specific medication error alerts/fields to monitor										
Task Step 3: Track that care coordinators are accessing EHR to check for services provided to patients										
Milestone #11 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.										
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.										
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.										
Task Service and quality outcome measures are reported to all stakeholders.										
Task Step 1: Develop champions within lead and partner organizations										
Task Step 2: Develop monthly meeting schedule to assess root cause analyses of home-care to hospital transfers										
Task Step 3: Work with the state/MCOs to obtain real-time data on										

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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
readmissions to inform training plan and improve quality										
Task Step 4: Schedule webinars to inform workgroup of performance measures/baseline data										
Task Step 5: Evaluate and review avoidable readmissions; discuss high cost of care patients										
Task Step 6: Engage w/ MCO or MLTC to collect HEDIS measures and identify gaps in these measures										
Task Step 7: Use HCAHPS reports to monitor patient satisfaction scores across providers and identify areas of improvement										
Task Step 8: Establish process to systematically and on a schedule share outcome measures										
Task Step 9: Develop root cause analysis reports and review monthly										
Task Step 10: Determine rapid cycle methodologies to use for quality improvement initiatives										
Task Step 11: Determine quality improvement measures										
Milestone #12 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1: Generate reports that are submitted quarterly to the PPS by home care agencies including number of staff trained, patients/caregivers trained and affected by staff trainings.										

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
Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.	Oct. 2015 Narrative for Step 1 Completion: Project workgroup members identified the staff roles currently involved in the discharge process through a series of patient case reviews; the identified roles are Physician (Hospitalist or specialist), Social Worker/PACT worker, Physical Therapy. Before optimizing the discharge planning processes, we're understanding the current state.
Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.	
Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	
Educate all staff on care pathways and INTERACT-like principles.	
Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	
Create coaching program to facilitate and support implementation.	
Educate patient and family/caretakers, to facilitate participation in planning of care.	
Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.	
Utilize telehealth/telemedicine to enhance hospital-home care collaborations.	
Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.	
Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	
Use EHRs and other technical platforms to track all patients engaged in the project.	

Milestone Review Status

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

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Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

Associated Risk: Workforce Development
Part of the diminished capacity is the difficulty in hiring staff into a program without a standardized means of timely reimbursement.

Risk Mitigation: The financial and workforce investment in this project will be clearly defined. Our path to achieving more clarity involves close collaboration with the financial and workforce development entities to understand any potential burdens that fall outside of the scope of our expectations and strategize avenues for successfully managing those burdens.

Associated Risk: Minimal supervisory structure

Risk Mitigation: Through this project, part of the staff will include licensed clinical SWs and RNs to provide support in a standardized manner to the community navigation staff. The hub of resources will also be helpful for consultations.

Associated Risk: Lack of IT infrastructure

Risk Mitigation: Use of the MAPP portal will allow for some of the tracking mentioned. Partners in this project will need to be well versed in MAPP through various roll out phases. Additionally, infrastructure will be created through collaboration with IT development entities for the project and current HH dashboards and partner care coordination platforms will be leveraged.

Associated Risk: Potential duplication of services

Risk Mitigation: Policies and best practices will be developed to facilitate warm handoffs to various members of a patient's care team. These policies and and best practices will be created through collaboration with other DSRIP projects and current programs (i.e. Health Homes, transitional care).

Associated Risk: Low Patient Compliance

Risk Mitigation: Investment in collaboration with workforce development to ensure that patient navigators are adequately trained and equipped to ameliorate patient ambivalence and compliance barriers.

Associated Risk: Inadequate Supply of Resources, i.e. Housing and Transportation

Risk Mitigation: The PPS will employ experts in each area of need to assist patients in navigating and accessing the resources. The resource hub and resource guide will include details re: wait times, languages spoken, and services provided to help patients better access appropriate resources that are not limited.

Associated Risk: Difficulty determining the need for longitudinal vs. short-term services, caseload sizes, and patient graduation

Risk Mitigation: Needs assessments, clinical pathways, and associated policies and workflows for patients will be created so that the patient is matched with the right level of care needed.

Associated Risk: The assumptions for community navigators number
"Table #1 - This number reflects the individual community-based navigators that we have committed to this project. This number reflects community-based navigators specific to this particular project only..."

Risk Mitigation: The initial assumption is not accurate. We're also sharing resources with lead HHs and community based organizations providing HH services. We will integrate Care coordination models to include community navigators as a shared resource and will be able to include those who provide services in other projects ie 2ai etc. This will enable us to reach the 250 goal by DY4.

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "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	62,500

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
7,240	9,091	145.46%	-2,841	14.55%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
tomfitz	Documentation/Certification	34_null_1_2_20151028183626_Patient Registry_MountSinai_2ci_10.28.15.xlsx	Patient registry for actively engaged patients in 2.c.i	10/28/2015 06:37 PM
tomfitz	Documentation/Certification	34_null_1_2_20151028183506_PartnerAttestation_QueensCoordinatedCarePartners_MSPPS_DY1Q2.pdf	Queens Coordinated Care Partners' attestation to aggregated actively engaged patient report	10/28/2015 06:35 PM

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Community-based health navigation services established.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Finalize a plan to hire additional staff to assist in execution.	Project		In Progress	07/31/2015	03/31/2016	07/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Identify key elements of community-based health navigation	Project		In Progress	06/12/2015	12/31/2015	06/12/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3. Outline/ Diagram PPS care coordination. Actively participate in Care Coordination Cross Functional Workgroup sessions	Project		In Progress	06/12/2015	03/31/2018	06/12/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 4. Leverage Care Coordination Cross Functional Workgroup's resources	Project		In Progress	06/12/2015	03/31/2018	06/12/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 5. Collaborate with CCCFW to develop CCCFW processes, workflows, and protocols as they relate to the CCCFW Charter (Care Coordination documents have been uploaded to the Clinical Integration Section 09-> MAPP Module 9.1 • Prescribed Milestones #2-" Develop a Clinical Integration strategy." ; In order to achieve milestones for this project project 2ci will collaborate and has been involved in CCCFW. Page 2 of CCCFW charter, deliverables 1-9 will help project team to meet this milestone)	Project		In Progress	06/12/2015	03/31/2018	06/12/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 6. Identify services needed using CNA	Project		In Progress	06/12/2015	03/31/2018	06/12/2015	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 Step 7. Identify sites and agencies and Health Homes already doing community-based health navigation	Project		In Progress	06/30/2015	03/31/2018	06/30/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 8. Create Patient Work Flow chart	Project		In Progress	06/12/2015	03/31/2018	06/12/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 9. Create subgroups to work on developing community based services (data, workforce, patient engagement)	Project		Completed	06/30/2015	03/31/2018	06/30/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 10. Determine how community based health navigation services will collaborate with other clinical call centers to ease access and connect patients to resources and further community navigation services.	Project		In Progress	06/12/2015	03/31/2017	06/12/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.	Project	N/A	In Progress	06/12/2015	03/31/2017	06/12/2015	03/31/2017	03/31/2017	DY2 Q4
Task Resource guide completed, detailing medical/behavioral/social community resources and care protocols developed by program oversight committee.	Project		In Progress	06/12/2015	03/31/2017	06/12/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1.Finalize a staffing plan to execute project (do research, create written content, compile materials)	Project		In Progress	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2.Develop a collaborating program oversight group of med/beh health, community nursing, and social support services providers	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3.Identify key contributors within the workgroup and resources from within partner organizations.	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4.Identify and compile contents of resource guide	Project		In Progress	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5.Collaborate with other PPS projects to ensure that the content of guide will support their needs	Project		In Progress	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6.Identify / finalize resource guide mediums - web and	Project		In Progress	09/01/2015	06/30/2016	09/01/2015	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
phone-based									
Task Step 7. Determine workflow to effectively use the resource guide, and how it can be leveraged for other clinical call centers.	Project		In Progress	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 8. Distribute and track use of written resource guide,employing marketing resources through PMO and through each PPS partner agency	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #3 Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.	Project	N/A	In Progress	09/30/2015	03/31/2017	09/30/2015	03/31/2017	03/31/2017	DY2 Q4
Task Navigators recruited by residents in the targeted area, where possible.	Project		In Progress	09/30/2015	12/31/2016	09/30/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 1.Compile current job descriptions in collaboration with Workforce Committee	Project		In Progress	09/30/2015	12/31/2016	09/30/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 2. With workforce guidance, standardize job titles (external to PPS), job descriptions, qualifications / credentials, and salary ranges	Project		In Progress	09/30/2015	12/31/2016	09/30/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 3. Identify new hiring needs jointly with the Workforce Committee	Project		In Progress	09/30/2015	12/31/2016	09/30/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4. Work with Workforce to identify local recruitment resources (community job training, community newspapers / websites, libraries, job fairs)	Project		In Progress	09/30/2015	12/31/2016	09/30/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 5.Communicate needs to PPS Workforce Committee	Project		In Progress	09/30/2015	12/31/2016	09/30/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 6.Schedule and track community navigation recruitment activities (collaboration with Workforce and IT)	Project		In Progress	09/30/2015	12/31/2016	09/30/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 7. Track all community navigation hires (collaboration with Workforce and IT)	Project		In Progress	09/30/2015	12/31/2016	09/30/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 8.Assess need for temp agencies specializing in Health Care to assist in recruiting. (collaboration with Workforce)	Project		In Progress	09/30/2015	12/31/2016	09/30/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone #4	Project	N/A	In Progress	06/12/2015	03/31/2018	06/12/2015	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
Resource appropriately for the community navigators, evaluating placement and service type.									
Task Navigator placement implemented based upon opportunity assessment.	Project		In Progress	08/15/2016	03/31/2018	08/15/2016	03/31/2018	03/31/2018	DY3 Q4
Task Telephonic and web-based health navigator services implemented by type.	Project		In Progress	08/15/2016	03/31/2018	08/15/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 1.Review community needs assessment document to identify geographies of need	Project		In Progress	08/15/2016	09/30/2016	08/15/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2.Identify CBOs and HC organizations in those areas	Project		In Progress	08/15/2016	09/30/2016	08/15/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 3.Identify opportunities for co-location with other projects and generally across PPS areas of need (EDs, clinics, shelters, public housing units). (2biv , 2bviii collaboration)	Project		In Progress	06/12/2015	12/31/2017	06/12/2015	12/31/2017	12/31/2017	DY3 Q3
Task Step 4.Create co-location protocols and partnerships with other projects and generally across PPS areas of need (EDs, clinics, shelters, public housing units). (2biv, 2bviii collaboration)	Project		In Progress	08/15/2016	12/31/2017	08/15/2016	12/31/2017	12/31/2017	DY3 Q3
Task Step 5.Identify a strategic plan template or best practices for expansion	Project		In Progress	08/15/2016	12/31/2017	08/15/2016	12/31/2017	12/31/2017	DY3 Q3
Task Step 6.Draft strategic plan, get partner feedback and sign off	Project		In Progress	08/15/2016	03/31/2018	08/15/2016	03/31/2018	03/31/2018	DY3 Q4
Task With 2ai, plan phased implementation of telephonic and web-accessible Command Center / Resource Hub , leveraging existing resources within PPS lead and participating partner infrastructure	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Plan for telephonic and web-based health navigation services within "Phase 1" contact center	Project		In Progress	07/31/2015	03/31/2018	07/31/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #5 Provide community navigators with access to non-clinical resources, such as transportation and housing services.	Project	N/A	In Progress	08/15/2015	03/31/2018	08/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task Navigators have partnerships with transportation, housing, and other social services benefitting target population.	Project		In Progress	08/15/2015	03/31/2018	08/15/2015	03/31/2018	03/31/2018	DY3 Q4

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Task Step 1.Identify non-clinical partners within PPS	Project		In Progress	08/15/2015	12/31/2017	08/15/2015	12/31/2017	12/31/2017	DY3 Q3
Task Step 2.Partner with non-clinical constituents to deliver on resources required to meet milestone #5	Project		In Progress	08/15/2015	12/31/2017	08/15/2015	12/31/2017	12/31/2017	DY3 Q3
Task Step 3.Create a list of partnerships for community navigators	Project		In Progress	08/15/2015	12/31/2017	08/15/2015	12/31/2017	12/31/2017	DY3 Q3
Task Step 4. Develop and implement referral workflows and tracking protocols via telephonic and web-based navigation services.	Project		In Progress	08/15/2015	12/31/2017	08/15/2015	12/31/2017	12/31/2017	DY3 Q3
Milestone #6 Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.	Project	N/A	In Progress	08/15/2015	03/31/2017	08/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task Case loads and discharge processes established for health navigators following patients longitudinally.	Project		In Progress	08/15/2015	03/31/2017	08/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Actively participate in Care Coordination Cross Functional Workgroup sessions	Project		In Progress	08/15/2015	12/31/2016	08/15/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 2. Leverage Care Coordination Cross Functional Workgroup's resources	Project		In Progress	08/15/2015	12/31/2016	08/15/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 3. Refer to CCFW's processes, workflows, and protocols	Project		In Progress	08/15/2015	12/31/2016	08/15/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4. Collect current case load size/mix and discharge processes from partners	Project		In Progress	08/15/2015	12/31/2016	08/15/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 5.Synthesize for key elements	Project		In Progress	08/15/2015	12/31/2016	08/15/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 6.Create PPS case load and discharge process	Project		In Progress	08/15/2015	03/31/2017	08/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7.Ensure that partners all have key elements of caseload and discharge process in agency specific protocols	Project		In Progress	08/15/2015	03/31/2017	08/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 8.Develop PPS materials for partner agency use, and ensure that training is completed for all staff dedicated to the community navigation project.	Project		In Progress	08/15/2015	03/31/2017	08/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task	Project		In Progress	08/15/2015	03/31/2017	08/15/2015	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
Step 9.Establish a quality assurance plan for the determined PPS protocol.									
Milestone #7 Market the availability of community-based navigation services.	Project	N/A	In Progress	08/15/2016	03/31/2017	08/15/2016	03/31/2017	03/31/2017	DY2 Q4
Task Health navigator personnel and services marketed within designated communities.	Project		In Progress	08/15/2016	03/31/2017	08/15/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Create materials for resource guide, market and advertise resource hub, and market resources through PPS leads at each agency.	Project		In Progress	08/15/2016	03/31/2017	08/15/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 2.Define Target Audience	Project		In Progress	08/15/2016	03/31/2017	08/15/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Collaborate with Workforce to finalize a marketing plan and workflow	Project		In Progress	08/15/2016	03/31/2017	08/15/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 4. Share availability of community-based navigation services with PPS providers.	Project		In Progress	08/15/2016	03/31/2017	08/15/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	09/30/2015	03/31/2017	09/30/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	09/30/2015	03/31/2017	09/30/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1.In collaboration with PMO and IT Committee, Identify patients who would benefit from receipt of community navigation services via 2ci using fields within current EHRs and other platforms.	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2.Identify key components of quarterly report template	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3.Identify patients receiving navigation services via specific programs	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4.Develop a system to collect required data for the tracking system	Project		In Progress	08/15/2016	09/30/2016	08/15/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5.Work with IT to create tracking and reporting system that	Project		In Progress	08/15/2016	12/31/2016	08/15/2016	12/31/2016	12/31/2016	DY2 Q3

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is accessible to community navigators in the field and in the resource hub, and determine the linkages with other systems.									
Task Step 6.Work with lead HHs to include projects in their dashboards for lead HH level reporting.	Project		In Progress	08/15/2016	12/31/2016	08/15/2016	12/31/2016	12/31/2016	DY2 Q3

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.										
Task Community-based health navigation services established.										
Task Step 1. Finalize a plan to hire additional staff to assist in execution.										
Task Step 2. Identify key elements of community-based health navigation										
Task Step 3. Outline/ Diagram PPS care coordination. Actively participate in Care Coordination Cross Functional Workgroup sessions										
Task Step 4. Leverage Care Coordination Cross Functional Workgroup's resources										
Task Step 5. Collaborate with CCCFW to develop CCCFW processes, workflows, and protocols as they relate to the CCCFW Charter (Care Coordination documents have been uploaded to the Clinical Integration Section 09-> MAPP Module 9.1 • Prescribed Milestones #2-" Develop a Clinical Integration strategy." ; In order to achieve milestones for this project project 2ci will collaborate and has been involved in CCCFW. Page 2 of CCCFW charter, deliverables 1-9 will help project team to meet this milestone)										
Task Step 6. Identify services needed using CNA										
Task Step 7. Identify sites and agencies and Health Homes already doing community-based health navigation										

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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 Step 8. Create Patient Work Flow chart										
Task Step 9. Create subgroups to work on developing community based services (data, workforce, patient engagement)										
Task Step 10. Determine how community based health navigation services will collaborate with other clinical call centers to ease access and connect patients to resources and further community navigation services.										
Milestone #2 Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.										
Task Resource guide completed, detailing medical/behavioral/social community resources and care protocols developed by program oversight committee.										
Task Step 1.Finalize a staffing plan to execute project (do research, create written content, compile materials)										
Task Step 2.Develop a collaborating program oversight group of med/beh health, community nursing, and social support services providers										
Task Step 3.Identify key contributors within the workgroup and resources from within partner organizations.										
Task Step 4.Identify and compile contents of resource guide										
Task Step 5.Collaborate with other PPS projects to ensure that the content of guide will support their needs										
Task Step 6.Identify / finalize resource guide mediums - web and phone-based										
Task Step 7. Determine workflow to effectively use the resource guide, and how it can be leveraged for other clinical call centers.										
Task Step 8. Distribute and track use of written resource guide,employing marketing resources through PMO and through each PPS partner agency										

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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 #3 Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.										
Task Navigators recruited by residents in the targeted area, where possible.										
Task Step 1.Compile current job descriptions in collaboration with Workforce Committee										
Task Step 2. With workforce guidance, standardize job titles (external to PPS), job descriptions, qualifications / credentials, and salary ranges										
Task Step 3. Identify new hiring needs jointly with the Workforce Committee										
Task Step 4. Work with Workforce to identify local recruitment resources (community job training, community newspapers / websites, libraries, job fairs)										
Task Step 5.Communicate needs to PPS Workforce Committee										
Task Step 6.Schedule and track community navigation recruitment activities (collaboration with Workforce and IT)										
Task Step 7. Track all community navigation hires (collaboration with Workforce and IT)										
Task Step 8.Assess need for temp agencies specializing in Health Care to assist in recruiting. (collaboration with Workforce)										
Milestone #4 Resource appropriately for the community navigators, evaluating placement and service type.										
Task Navigator placement implemented based upon opportunity assessment.										
Task Telephonic and web-based health navigator services implemented by type.										
Task Step 1.Review community needs assessment document to identify geographies of need										
Task Step 2.Identify CBOs and HC organizations in those areas										

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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 Step 3.Identify opportunities for co-location with other projects and generally across PPS areas of need (EDs, clinics, shelters, public housing units). (2biv , 2bviii collaboration)										
Task Step 4.Create co-location protocols and partnerships with other projects and generally across PPS areas of need (EDs, clinics, shelters, public housing units). (2biv, 2bviii collaboration)										
Task Step 5.Identify a strategic plan template or best practices for expansion										
Task Step 6.Draft strategic plan, get partner feedback and sign off										
Task With 2ai, plan phased implementation of telephonic and web-accessible Command Center / Resource Hub , leveraging existing resources within PPS lead and participating partner infrastructure										
Task Plan for telephonic and web-based health navigation services within "Phase 1" contact center										
Milestone #5 Provide community navigators with access to non-clinical resources, such as transportation and housing services.										
Task Navigators have partnerships with transportation, housing, and other social services benefitting target population.										
Task Step 1.Identify non-clinical partners within PPS										
Task Step 2.Partner with non-clinical constituents to deliver on resources required to meet milestone #5										
Task Step 3.Create a list of partnerships for community navigators										
Task Step 4. Develop and implement referral workflows and tracking protocols via telephonic and web-based navigation services.										
Milestone #6 Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.										
Task Case loads and discharge processes established for health navigators following patients longitudinally.										
Task Step 1. Actively participate in Care Coordination Cross										

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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
Functional Workgroup sessions										
Task Step 2. Leverage Care Coordination Cross Functional Workgroup's resources										
Task Step 3. Refer to CCFW's processes, workflows, and protocols										
Task Step 4. Collect current case load size/mix and discharge processes from partners										
Task Step 5.Synthesize for key elements										
Task Step 6.Create PPS case load and discharge process										
Task Step 7.Ensure that partners all have key elements of caseload and discharge process in agency specific protocols										
Task Step 8.Develop PPS materials for partner agency use, and ensure that training is completed for all staff dedicated to the community navigation project.										
Task Step 9.Establish a quality assurance plan for the determined PPS protocol.										
Milestone #7 Market the availability of community-based navigation services.										
Task Health navigator personnel and services marketed within designated communities.										
Task Step 1. Create materials for resource guide, market and advertise resource hub, and market resources through PPS leads at each agency.										
Task Step 2.Define Target Audience										
Task Step 3. Collaborate with Workforce to finalize a marketing plan and workflow										
Task Step 4. Share availability of community-based navigation services with PPS providers.										
Milestone #8 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively										

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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
engaged patients for project milestone reporting.										
Task Step 1.In collaboration with PMO and IT Committee, Identify patients who would benefit from receipt of community navigation services via 2ci using fields within current EHRs and other platforms.										
Task Step 2.Identify key components of quarterly report template										
Task Step 3.Identify patients receiving navigation services via specific programs										
Task Step 4.Develop a system to collect required data for the tracking system										
Task Step 5.Work with IT to create tracking and reporting system that is accessible to community navigators in the field and in the resource hub, and determine the linkages with other systems.										
Task Step 6.Work with lead HHs to include projects in their dashboards for lead HH level reporting.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.										
Task Community-based health navigation services established.										
Task Step 1. Finalize a plan to hire additional staff to assist in execution.										
Task Step 2. Identify key elements of community-based health navigation										
Task Step 3. Outline/ Diagram PPS care coordination. Actively participate in Care Coordination Cross Functional Workgroup sessions										
Task Step 4. Leverage Care Coordination Cross Functional Workgroup's resources										

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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 Step 5. Collaborate with CCCFW to develop CCCFW processes, workflows, and protocols as they relate to the CCCFW Charter (Care Coordination documents have been uploaded to the Clinical Integration Section 09-> MAPP Module 9.1 • Prescribed Milestones #2-" Develop a Clinical Integration strategy." ; In order to achieve milestones for this project project 2ci will collaborate and has been involved in CCCFW. Page 2 of CCCFW charter, deliverables 1-9 will help project team to meet this milestone)										
Task Step 6. Identify services needed using CNA										
Task Step 7. Identify sites and agencies and Health Homes already doing community-based health navigation										
Task Step 8. Create Patient Work Flow chart										
Task Step 9. Create subgroups to work on developing community based services (data, workforce, patient engagement)										
Task Step 10. Determine how community based health navigation services will collaborate with other clinical call centers to ease access and connect patients to resources and further community navigation services.										
Milestone #2 Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.										
Task Resource guide completed, detailing medical/behavioral/social community resources and care protocols developed by program oversight committee.										
Task Step 1.Finalize a staffing plan to execute project (do research, create written content, compile materials)										
Task Step 2.Develop a collaborating program oversight group of med/beh health, community nursing, and social support services providers										
Task Step 3.Identify key contributors within the workgroup and resources from within partner organizations.										

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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 Step 4.Identify and compile contents of resource guide										
Task Step 5.Collaborate with other PPS projects to ensure that the content of guide will support their needs										
Task Step 6.Identify / finalize resource guide mediums - web and phone-based										
Task Step 7. Determine workflow to effectively use the resource guide, and how it can be leveraged for other clinical call centers.										
Task Step 8. Distribute and track use of written resource guide,employing marketing resources through PMO and through each PPS partner agency										
Milestone #3 Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.										
Task Navigators recruited by residents in the targeted area, where possible.										
Task Step 1.Compile current job descriptions in collaboration with Workforce Committee										
Task Step 2. With workforce guidance, standardize job titles (external to PPS), job descriptions, qualifications / credentials, and salary ranges										
Task Step 3. Identify new hiring needs jointly with the Workforce Committee										
Task Step 4. Work with Workforce to identify local recruitment resources (community job training, community newspapers / websites, libraries, job fairs)										
Task Step 5.Communicate needs to PPS Workforce Committee										
Task Step 6.Schedule and track community navigation recruitment activities (collaboration with Workforce and IT)										
Task Step 7. Track all community navigation hires (collaboration with Workforce and IT)										
Task Step 8.Assess need for temp agencies specializing in Health Care to assist in recruiting. (collaboration with Workforce)										

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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 #4 Resource appropriately for the community navigators, evaluating placement and service type.										
Task Navigator placement implemented based upon opportunity assessment.										
Task Telephonic and web-based health navigator services implemented by type.										
Task Step 1.Review community needs assessment document to identify geographies of need										
Task Step 2.Identify CBOs and HC organizations in those areas										
Task Step 3.Identify opportunities for co-location with other projects and generally across PPS areas of need (EDs, clinics, shelters, public housing units). (2biv , 2bviii collaboration)										
Task Step 4.Create co-location protocols and partnerships with other projects and generally across PPS areas of need (EDs, clinics, shelters, public housing units). (2biv, 2bviii collaboration)										
Task Step 5.Identify a strategic plan template or best practices for expansion										
Task Step 6.Draft strategic plan, get partner feedback and sign off										
Task With 2ai, plan phased implementation of telephonic and web-accessible Command Center / Resource Hub , leveraging existing resources within PPS lead and participating partner infrastructure										
Task Plan for telephonic and web-based health navigation services within "Phase 1" contact center										
Milestone #5 Provide community navigators with access to non-clinical resources, such as transportation and housing services.										
Task Navigators have partnerships with transportation, housing, and other social services benefitting target population.										
Task Step 1.Identify non-clinical partners within PPS										
Task Step 2.Partner with non-clinical constituents to deliver on resources required to meet milestone #5										

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Mount Sinai PPS, LLC (PPS ID:34)

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 Step 3.Create a list of partnerships for community navigators										
Task Step 4. Develop and implement referral workflows and tracking protocols via telephonic and web-based navigation services.										
Milestone #6 Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.										
Task Case loads and discharge processes established for health navigators following patients longitudinally.										
Task Step 1. Actively participate in Care Coordination Cross Functional Workgroup sessions										
Task Step 2. Leverage Care Coordination Cross Functional Workgroup's resources										
Task Step 3. Refer to CCFW's processes, workflows, and protocols										
Task Step 4. Collect current case load size/mix and discharge processes from partners										
Task Step 5.Synthesize for key elements										
Task Step 6.Create PPS case load and discharge process										
Task Step 7.Ensure that partners all have key elements of caseload and discharge process in agency specific protocols										
Task Step 8.Develop PPS materials for partner agency use, and ensure that training is completed for all staff dedicated to the community navigation project.										
Task Step 9.Establish a quality assurance plan for the determined PPS protocol.										
Milestone #7 Market the availability of community-based navigation services.										
Task Health navigator personnel and services marketed within designated communities.										
Task Step 1. Create materials for resource guide, market and advertise resource hub, and market resources through PPS leads at each agency.										

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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 Step 2.Define Target Audience										
Task Step 3. Collaborate with Workforce to finalize a marketing plan and workflow										
Task Step 4. Share availability of community-based navigation services with PPS providers.										
Milestone #8 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1.In collaboration with PMO and IT Committee, Identify patients who would benefit from receipt of community navigation services via 2ci using fields within current EHRs and other platforms.										
Task Step 2.Identify key components of quarterly report template										
Task Step 3.Identify patients receiving navigation services via specific programs										
Task Step 4.Develop a system to collect required data for the tracking system										
Task Step 5.Work with IT to create tracking and reporting system that is accessible to community navigators in the field and in the resource hub, and determine the linkages with other systems.										
Task Step 6.Work with lead HHs to include projects in their dashboards for lead HH level reporting.										

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
Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.	
Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.	
Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.	
Resource appropriately for the community navigators, evaluating placement and service type.	
Provide community navigators with access to non-clinical resources, such as transportation and housing services.	
Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.	
Market the availability of community-based navigation services.	
Use EHRs and other technical platforms to track all patients engaged in the project.	

Milestone Review Status

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

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Collaborate with Care Coordination Cross Functional Workgroup to meet Prescribed Milestones in module 4 (Req #'s 1-8)	In Progress	Actively participate in Care Coordination Cross Functional Workgroup sessions	07/16/2015	03/31/2018	07/16/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone Collaborate with Care Coordination Cross Functional Workgroup to meet Prescribed Milestones in module 4 (Req #'s 1-8)	In Progress	Leverage Care Coordination Cross Functional Workgroup's resources	07/16/2015	03/31/2018	07/16/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone Collaborate with Care Coordination Cross Functional Workgroup to meet Prescribed Milestones in module 4 (Req #'s 1-8)	In Progress	Refer to CCFW's processes, workflows, and protocols	07/16/2015	03/31/2018	07/16/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone Develop resource guide training to meet State prescribed Req#2 in module 4	In Progress	Needed to develop comprehensive web based resource guide	07/02/2015	03/31/2017	07/02/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone Work with IT to create web based resource guide to meet State prescribed Req#2 in module 4	In Progress	Needed to develop comprehensive web based resource guide	08/15/2015	12/31/2016	08/15/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone Work with Clinical QA process to vet and verify resources to meet State prescribed Req#2 in module 4	In Progress	Needed to develop comprehensive web based resource guide	08/15/2015	12/31/2016	08/15/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone Obtain list of current community navigators to meet State prescribed Req#3 in module 4	In Progress	Needed to develop comprehensive community navigator resource	08/15/2015	09/30/2016	08/15/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone Create PPS database of community navigators to meet State prescribed Req#3 in module 4	In Progress	Needed to develop comprehensive community navigator resource	08/15/2015	12/31/2016	08/15/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone	In Progress	Concurrent goal with marketing efforts and comprehensive	08/15/2015	03/31/2017	08/15/2015	03/31/2017	03/31/2017	DY2 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Increase Health Home Enrollment to meet State prescribed Req#7 in module 4		marketing plan						
Milestone Identify start-up sites and roll out timelines to meet State prescribed Req#8 in module 4	In Progress	Need for process mapping of current state to develop future state	08/15/2015	12/31/2015	08/15/2015	12/31/2015	12/31/2015	DY1 Q3

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Collaborate with Care Coordination Cross Functional Workgroup to meet Prescribed Milestones in module 4 (Req #'s 1-8)	
Collaborate with Care Coordination Cross Functional Workgroup to meet Prescribed Milestones in module 4 (Req #'s 1-8)	
Collaborate with Care Coordination Cross Functional Workgroup to meet Prescribed Milestones in module 4 (Req #'s 1-8)	
Develop resource guide training to meet State prescribed Req#2 in module 4	
Work with IT to create web based resource guide to meet State prescribed Req#2 in module 4	
Work with Clinical QA process to vet and verify resources to meet State prescribed Req#2 in module 4	
Obtain list of current community navigators to meet State prescribed Req#3 in module 4	
Create PPS database of community navigators to meet State prescribed Req#3 in module 4	
Increase Health Home Enrollment to meet State prescribed Req#7 in module 4	

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Identify start-up sites and roll out timelines to meet State prescribed Req#8 in module 4	

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

Instructions :

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Mount Sinai PPS, LLC (PPS ID:34)

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.

A key challenge will be developing competent clinical workforce for this project. The primary risk is direct negative impact to patient engagement and care. We will address this by a multi-pronged approach: 1) In-depth and diverse methods of training which will draw from internal PPS expertise, external organizations, and utilizing "train the trainer" techniques. Focused curricula will include basic concepts of integrated and collaborative care; various roles in integrated care settings (i.e., collaborative supervising psychiatrist for IMPACT; Depression Care Managers); core clinical trainings (i.e., motivational interviewing; screening questionnaires); working with patients with behavioral health conditions (for Model B physical health practitioners). We will also work with the selected primary PPS workforce training vendor, local educational institutions, as well as nationally available training (i.e., the AIMS Center) to create comprehensive training modules for all disciplines in all three models. Trainings will occur via multiple venues, including formal in-services, hands-on workshops, grand rounds, staff meetings, web-based training modules, as well as individual supervision. 2) Ensure potential future workforce members receive training and clinical exposure to integrated care settings. We hope to include trainees from multiple clinical disciplines at sites across the PPS, and they will be included in trainings as appropriate. This will also help develop a pool of trained potential workforce members in later years of DSRIP, and ensure the foundations for this new clinical field of integrated care.

A second major challenge is creating standardized operational models and workflows at each site to minimize practice variation. Risks with not implementing standardized models include significant impact on outcomes, risk of inefficiencies, and lower quality of care. We are developing standardized models and protocols of care for each clinical model, with detailed clinical and administrative workflows and implementation checklists. We will also work closely with the PPS IT to maximize automation and standardization of clinical documentation, handoffs, and notifications. The standardization will be based on available evidence and best practices, as well as allow for some flexibility due to the variety of different sites and phases of operational readiness for integrated care across sites. In addition, as one of the four PPS's involved in the KPMG Target Operating Model development for 3ai, we are using this platform to further refine models and workflows for our PPS, as well as contribute to the standardization of this level of care for other PPS's.

Another related challenge is the variation in sites of not only EHR availability, but the readiness of their EHRs to incorporate both physical health and behavioral health clinical documentation. IT clinical documentation integration will be key to minimize the risks of separate or "opaque" documentation systems between physical and behavioral health, which can have significant safety and quality impact. Some CBOs have limited EHRs which may not easily be able to incorporate physical health documentation modules. We will work closely with the PPS IT to evaluate all partner IT capabilities, and implement any and all solutions with minimal workarounds.

A final challenge will be adequate and appropriate clinical space for integrated care. Inadequate space and patient care room conditions may cause long wait times for appointments and patients dissatisfied with the care setting, leading to missed appointments and disengagement from treatment. Creative scheduling, room shares, modest expansions, and other innovative solutions will be employed. Privacy and confidentiality safeguards will be in place at the patient, provider, facility, and EHR levels.

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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	100,000

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
11,715	20,826	416.52%	-15,826	20.83%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
nk434186	Documentation/Certification	34_null_1_2_20151030131749_PartnerAttestation_Institute_MSPPS_DY1Q2.pdf	Institute for Family Health's partner attestation for aggregate actively engaged patient report	10/30/2015 01:19 PM
et547873	Documentation/Certification	34_null_1_2_20151029172536_PartnerAttestation_CHN_MSPPS_DY1Q2.pdf	Community Healthcare Network's partner attestation to aggregate actively engaged patient report	10/29/2015 05:26 PM
et547873	Documentation/Certification	34_null_1_2_20151029172426_Patient Registry_MountSinai_3ai_10.26.15.xlsx	Patient Registry of actively engaged patients in project 3.a.i	10/29/2015 05:24 PM

Narrative Text :

The reported actively engaged numbers are based on the aggregate numbers in the two partner attestations plus the patient registry. The aggregate count from the Institute for Family Health for this project was reduced by 426 for accuracy after the attestation was signed. Institute for Family Health's correct aggregate number for this project is 5,827. A new attestation can be provided if required.

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)	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Behavioral health services are co-located within PCMH/APC practices and are available.		Provider	Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards Step 1: Collaborate with 2ai to begin tracking PCMH/ and or APCM status.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards Step 2: Collaborate with 2ai PCMH Technical Assistance Program to support participating PCPs.		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards Step 3: Collaborate with 2ai PCMH Technical Assistance Program to submit NCQA / APCM applications.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Behavioral health services are co-located within PCMH/APC practices and are available Step 1: Identify pilot sites and staffing models.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
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)	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
Behavioral health services are co-located within PCMH/APC practices and are available Step 2: Develop standardized models/workflows for integrated behavioral health care in primary care settings across sites										
Task Behavioral health services are co-located within PCMH/APC practices and are available Step 3: Create job descriptions and work with workforce committee to recruit and hire staff.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Behavioral health services are co-located within PCMH/APC practices and are available Step 4: Document licensure /certification and practice schedule and provide to PPS.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Behavioral health services are co-located within PCMH/APC practices and are available Step 5: Working with compliance, perform ongoing review of need for and submission of regulatory waivers and submissions of integrated service applications.		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 1	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		In Progress	04/01/2015	10/31/2015	04/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices. Step 1: Review existing evidence-based standards of care for integrated primary care/BH services, medication management, and care engagement process.		Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	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
Regularly scheduled formal meetings are held to develop collaborative care practices. Step 2: Develop basic standards and protocols for medication management and care engagement for all sites.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices. Step 3: Draft preliminary PPS-wide high level standardized models/workflows/best practices.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices. Step 4: Draft site specific collaborative care protocol and implementation plan for Model 1.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices. Step 5: Create multidisciplinary team at each site.		Project		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. Step 6: Schedule meetings to develop triage, integrated team conferences, medication management and engagement process.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices. Step 7: Ongoing consultation of PPS 3ai core committee for workflows, protocols and evidence based 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. Step 1: Finalize initial site specific protocols for workflow, patient engagement and med management.		Project		In Progress	04/01/2015	10/31/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. Step 2: Train all new clinics and staff on collaborative care protocol.		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)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. Step 3: Create policies and procedures document for review and updates to care protocol.		Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. Step 4: Pilot care protocol and implementation plan, review and update.		Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. Step 5: Review new behavioral health standards of care guidelines and revise quarterly (or as needed) with 3ai core committee.		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. Step 6: Ongoing refinement of protocols based on continuous consultation with 3ai core committee.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. Step 7: Sites to conduct quarterly QI cycles on their programs to improve practices.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Model 1	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Policies and procedures are in place to facilitate and document completion of screenings.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Screenings are documented in Electronic Health Record.		Project		In Progress	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		Project		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)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	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. Step 1: Review existing child, adolescent, and adult screening tools.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Policies and procedures are in place to facilitate and document completion of screenings. Step 2: Choose minimum set screening tools for sites (child, adolescent, and adult).		Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Policies and procedures are in place to facilitate and document completion of screenings. Step 3: Sites to develop individual screening policies and procedures based on recommendations from 3ai core committee.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Policies and procedures are in place to facilitate and document completion of screenings. Step 4: Quarterly review of screening activities, update policies and procedures as necessary.		Project		In Progress	11/01/2015	03/31/2018	11/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Screenings are documented in Electronic Health Record Step 1: Identify current partner EHRs.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Screenings are documented in Electronic Health Record Step 2: Draft guide for recommended alerts and screening templates into collaborative care protocol.		Project		In Progress	07/01/2015	10/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Screenings are documented in Electronic Health Record Step 3: Partners integrate alerts and screening templates into EHRs.		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Screenings are documented in Electronic Health Record Step 4: Provide screenshots of screening alerts to project		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

Mount Sinai PPS, LLC (PPS ID:34)

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
team.										
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) Step 1: Identify discrete screening variable in EHRs.		Project		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) Step 2: Work with site based or Sinai IT to create screening report.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 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) Step 3: Identify denominator of eligible patients (medicaid patients who receive primary care at that site) at each site and calculate screening rates.		Project		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) Step 4: Provide quarterly roster of eligible patients screened vs the total eligible to project team.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record Step1: Review existing protocols and develop "warm transfer" protocol, including documentation in EHRs (part of overall care protocol).		Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record Step 2: Train staff at sites in		Project		In Progress	11/01/2015	03/31/2018	11/01/2015	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
protocols and documentation.										
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 1	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records Step 1: Survey partners to determine current EHR use, other technical platform use, or need for implementation.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records Step 2: Provide Technical Assistance to partners to integrate BH and EHR.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records Step 3: Document that both medical and behavioral health follow-up care are available in one EHR.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	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 Step 1: Create annual alerts in EHRs to identify eligible patients for screening		Project		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 Step 2: Identify discrete screening variable in EHRs.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting Step 3: Work with site based and / or Sinai IT to create screening report.		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)	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 PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting Step 4: Sites provide quarterly roster of patients to project team.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	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 Step 5: Sites Identify patients who screen positive and are then diagnosed with depression, substance use or other mental illness.		Project		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 Step 6: Sites track referrals and follow ups of these patients.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	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)	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Mental Health	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. Step 1: Collaborate with 2ai to begin tracking PCMH/ and or APCM status.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3. Step 2: Collaborate with 2ai PCMH Technical Assistance Program to support participating PCPs.		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	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		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	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
DY3. Step 3: Collaborate with 2ai PCMH Technical Assistance Program to submit NCQA / APCM applications.										
Task Primary care services are co-located within behavioral Health practices and are available. Step 1: Identify pilot sites and staffing models.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Primary care services are co-located within behavioral Health practices and are available. Step 2: Develop standardized models/workflows for primary care in Behavioral Health settings across sites.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Primary care services are co-located within behavioral Health practices and are available. Step 3: Create job descriptions and work with workforce committee to recruit and hire staff.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care services are co-located within behavioral Health practices and are available. Step 4: Document licensure / certification and provide to PPS.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care services are co-located within behavioral Health practices and are available. Step 5: Working with compliance, perform ongoing review of need for and submission of regulatory waivers, submissions of integrated service applications, and assessment and planning for physical space renovations.		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	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	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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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 Regularly scheduled formal meetings are held to develop collaborative care practices Step 1: Review existing evidence-based standards of care for integrated primary care/BH services, medication management, and care engagement process.		Project		In Progress	04/01/2015	10/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Regularly scheduled formal meetings are held to develop collaborative care practices Step 2: Develop basic standards and protocols for medication management and care engagement for all sites.		Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Regularly scheduled formal meetings are held to develop collaborative care practices Step 3: Draft preliminary PPS-wide high level standardized models/workflows/best practices.		Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Regularly scheduled formal meetings are held to develop collaborative care practices Step 4: Draft site specific collaborative care protocol and implementation plan for Model 2.		Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices Step 5: Create multidisciplinary team at each site.		Project		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 Step 6: Schedule meetings to develop triage, integrated team conferences, medication management and engagement process.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices Step 7: Ongoing consultation of PPS 3a1 core committee for workflows, protocols and evidence based 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		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)	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
process. Step 1: Finalize initial site specific protocols for workflow, patient engagement and med management.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process. Step 2: Train all new clinics and staff on collaborative care protocol.		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. Step 3: Create policies and procedures document for review and updates to care protocol.		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process. Step 4: Pilot care protocol and implementation plan, review and update.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process. Step 5: Review new behavioral health standards of care guidelines and revise quarterly (or as needed) with 3ai core committee.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	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. Step 6: Ongoing refinement of protocols based on continuous consultation with 3ai core committee.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process. Step 7: Sites to conduct quarterly QI cycles on their programs to improve practices.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Model 2	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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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 Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Screenings are documented in Electronic Health Record.		Project		In Progress	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		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Screenings are conducted for all patients Step 1: Review existing child, adolescent, and adult screening tools and choose minimum set.		Project		In Progress	04/01/2015	10/01/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Screenings are conducted for all patients Step 2: Develop screening policies, workflows and operational procedures based on recommendations from 3ai core committee to adapt for implementation at sites.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Screenings are conducted for all patients Step 3: Quarterly review of screening activities, update policies and procedures as necessary.		Project		In Progress	11/01/2015	03/31/2018	11/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Screenings are documented in Electronic Health Record Step 1: Identify current partner EHRs.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Screenings are documented in Electronic Health Record Step 2: Draft guide for recommended alerts and screening templates into collaborative care protocol.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Screenings are documented in Electronic Health Record Step 3: Partners integrate alerts and screening templates into EHRs.		Project		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)	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 Screenings are documented in Electronic Health Record Step 4: Provide screenshots of screening alerts to project team.		Project		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 Step 1: Identify discrete screening variable in EHRs.		Project		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 Step 2: Work with site based or Sinai IT to create screening report.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task At least 90% of patients receive screenings at the established project sites Step 3: Identify denominator of eligible patients (medicaid patients who receive primary care at that site) at each site and calculate screening rates.		Project		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 Step 4: Provide quarterly roster of eligible patients screened vs the total eligible to project team.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Positive screenings result in "warm transfer" to behavioral health provider Step 1: Review existing protocols and develop "warm transfer" protocol, including documentation in EHRs (part of overall care protocol).		Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Positive screenings result in "warm transfer" to behavioral health provider Step 2: Train staff at sites in protocols and documentation.		Project		In Progress	11/01/2015	03/31/2018	11/01/2015	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 health record within individual patient records.		Project		In Progress	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS identifies targeted patients and is able to track actively		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)	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
engaged patients for project milestone reporting.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records. Step 1: Survey partners to determine current EHR use, other technical platform use, or need for implementation.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.Step 2: Provide Technical Assistance to partners to integrate BH and EHR.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.Step 3: Document that both medical and behavioral health follow-up care are available in one EHR.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	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. Step 1: Create screening questions to identify eligible patients.		Project		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. Step 2: Identify CPT codes variables in EHRs to query and track engaged patients.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. Step 3: Work with site based or Sinai IT to create screening report.		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. Step 4: Provide quarterly roster of patients to project team.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	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. Step 5: Sites track referrals and follow ups of these patients.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Implement IMPACT Model at Primary Care Sites.	Model 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)	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 PPS has implemented IMPACT Model at Primary Care Sites.		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 PPS has implemented IMPACT Model at Primary Care Sites. Step 1: Draft customizable protocol template of Best Practices for IMPACT model.		Project		In Progress	07/01/2015	10/01/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task PPS has implemented IMPACT Model at Primary Care Sites. Step 2: Identify sites with capacity to implement or currently using IMPACT.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS has implemented IMPACT Model at Primary Care Sites. Step 3: Recruit and hire staff for new sites.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has implemented IMPACT Model at Primary Care Sites. Step 4: Develop IMPACT model training.		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS has implemented IMPACT Model at Primary Care Sites. Step 5: Train Depression Care Managers, PCPs, Psychiatrists on IMPACT model.		Project		In Progress	11/01/2015	03/31/2018	11/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has implemented IMPACT Model at Primary Care Sites. Step 6: Customize patient flow and protocol at site.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	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	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	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 Coordinated evidence-based care protocols are in place		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	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
Step 1: Utilize basic protocols from 3ai workgroup to develop site specific protocols for workflow, patient engagement and med management. Pilot care protocol and implementation plan, review and update.										
Task Coordinated evidence-based care protocols are in place Step 2: Create policies and procedures document for review and updates to care protocol.		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Coordinated evidence-based care protocols are in place Step 3: Train all new clinics and staff on collaborative care protocol.		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 Step 4: Review new behavioral health standards of care guidelines and revise quarterly (or as needed) with workgroup.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place Step 5: Sites to conduct quarterly QI cycles on their programs to improve practices.		Project		In Progress	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 Step 1: Review existing evidence based policies and procedures for psychiatry consults.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures include process for consulting with Psychiatrist Step 2: Create customizable procedure for sites (which would include weekly meetings- telephonic or in person and documentation procedures).		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Policies and procedures include process for consulting with Psychiatrist Step 3: Sites customize and incorporate into collaborative care protocols.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures include process for consulting with Psychiatrist Step 4: Review quarterly and revise as necessary.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Mount Sinai PPS, LLC (PPS ID:34)

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 #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	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 PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	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 PPS identifies qualified Depression Care Manager Step 1: PPS identifies sites with exisiting DCMs and sites needing to hire DCMs.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies qualified Depression Care Manager Step 2: Develop DCM job descriptions and qualifications for new DCMs.		Project		In Progress	10/01/2015	10/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS identifies qualified Depression Care Manager Step 3: Collaborate with Workforce Committee to recruit and hire Depression Care Managers.		Project		In Progress	11/01/2015	03/31/2017	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies qualified Depression Care Manager Step 4: DCM documents patient care in EMR.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Depression care manager meets requirements of IMPACT model Step 1: Create protocol for minimum training requirements and annual updates.		Project		In Progress	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Depression care manager meets requirements of IMPACT model Step 2: Develop or identify training resources for DCM: depression care and monitoring, coaching patients in behavioral activation, consulting, and completing a relapse prevention plan.		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task		Project		In Progress	11/01/2015	03/31/2016	11/01/2015	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
Depression care manager meets requirements of IMPACT model Step 3: Develop supervision structure for training period for new DCM.										
Task Depression care manager meets requirements of IMPACT model Step 4: Create or modify existing templates for behavioral activation, Motivational interviewing, relapse prevention.		Project		In Progress	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Depression care manager meets requirements of IMPACT model Step 5: Chart audit to see if DCM had completed certain relevant templates for patients.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Depression care manager meets requirements of IMPACT model Step 6: Designate and provide ongoing consultative support in the PPS via the 3ai core committee.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	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	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task All IMPACT participants in PPS have a designated Psychiatrist.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task All IMPACT participants in PPS have a designated Psychiatrist Step 1: Develop Psychiatrist job descriptions specific to IMPACT model.		Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task All IMPACT participants in PPS have a designated Psychiatrist Step 2: Identify existing psychiatrists when possible and / or collaborate with Workforce Committee to recruit and hire psychiatrists.		Project		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 Step 3: Train pscyhiatrists in case consultation for IMPACT model.		Project		In Progress	11/01/2015	03/31/2017	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task All IMPACT participants in PPS have a designated Psychiatrist Step 4: Develop triage and referral protocols at new sites.		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)	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 All IMPACT participants in PPS have a designated Psychiatrist Step 5: Develop collaborative care case review customizable template specific to psychiatrist.		Project		In Progress	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task All IMPACT participants in PPS have a designated Psychiatrist Step 6: PCP or DCM identifies collaborating psychiatrist in IMPACT model patient EMR.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	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		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 Step 1: Identify discrete screening variable in participating site EHRs to identify patients screened and not screened.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task At least 90% of patients receive screenings at the established project sites Step 2: Identify denominator of eligible patients (medicaid patients receiving PC) at participating sites and calculate screening rates.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task At least 90% of patients receive screenings at the established project sites Step 3: Work with site based (partners', including MSH) IT departments to create screening reports to be duplicated at future sites.		Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task At least 90% of patients receive screenings at the established project sites Step 4: Provide quarterly roster of eligible patients screened vs the total eligible to project team.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task At least 90% of patients receive screenings at the established project sites Step 5: Analyze screening rates		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	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
and methods to bring overall PPS screening rates in participating projects to 90%.										
Task At least 90% of patients receive screenings at the established project sites Step 6: Collaborate with IT Committee to perform analysis of opportunities for screening needs to be met by the PPS's IT infrastucture to create or streamline screening and depression registries and outcomes, including how changes will be synchronized with the PPS's IT needs for interoperability and clinical data sharing overall.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task At least 90% of patients receive screenings at the established project sites Step 7: Collaborate with IT committee to determine how to plan for and implement any changes from above analysis.		Project		In Progress	07/01/2016	03/31/2018	07/01/2016	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		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 Step 1: Review evidence-based IMPACT care model guidelines from AIMS Center.		Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm Step 2: Create standard algorithm for treatment for depression/anxiety/substance use (and/or disorders as determined by the 3ai core committee).		Project		In Progress	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm Step 3: Individual new sites adjust standard algorithm to fit their specific site,		Project		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)	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
which must meet the basic requirements of the stepped care model										
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm Step 4: Reassess and adjust algorithm as needed after 1-2 cycles.		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	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		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health Step 1: Survey partners to determine current EHR use, other technical platform use, or need for implementation.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task EHR demonstrates integration of medical and behavioral health Step 2: Provide Technical Assistance to partners to integrate BH and EHR.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health Step 3: Document that both medical and behavioral health follow-up care are available in one EHR.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients Step 1: Create annual alerts in EHRs to identify eligible patients for screening.		Project		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 Step 2: Identify discrete engagement variable in EHRs (ex: appointment with PC kept or medical assessment).		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS identifies targeted patients and is able to track actively		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)	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
engaged patients Step 3: Work with site based or Sinai IT to create screening report.										
Task PPS identifies targeted patients and is able to track actively engaged patients Step 4: Provide quarterly roster of patients to project team.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients Step 5: Sites track referrals and follow ups of these patients.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	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 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.	0	0	0	0	34	68	102	136	170	204
Task Behavioral health services are co-located within PCMH/APC practices and are available.	0	0	0	0	2	4	7	10	13	16
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards Step 1: Collaborate with 2ai to begin tracking PCMH/ and or APCM status.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards Step 2: Collaborate with 2ai PCMH Technical Assistance Program to support participating PCPs.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards Step 3: Collaborate with 2ai PCMH Technical Assistance Program to submit NCQA / APCM applications.										
Task Behavioral health services are co-located within PCMH/APC practices and are available Step 1: Identify pilot sites and staffing models.										

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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 Behavioral health services are co-located within PCMH/APC practices and are available Step 2: Develop standardized models/workflows for integrated behavioral health care in primary care settings across sites										
Task Behavioral health services are co-located within PCMH/APC practices and are available Step 3: Create job descriptions and work with workforce committee to recruit and hire staff.										
Task Behavioral health services are co-located within PCMH/APC practices and are available Step 4: Document licensure /certification and practice schedule and provide to PPS.										
Task Behavioral health services are co-located within PCMH/APC practices and are available Step 5: Working with compliance, perform ongoing review of need for and submission of regulatory waivers and submissions of integrated service applications.										
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 Regularly scheduled formal meetings are held to develop collaborative care practices. Step 1: Review existing evidence-based standards of care for integrated primary care/BH services, medication management, and care engagement process.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices. Step 2: Develop basic standards and protocols for medication management and care engagement for all sites.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices. Step 3: Draft preliminary PPS-wide high level standardized models/workflows/best practices.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices. Step 4: Draft site specific										

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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
collaborative care protocol and implementation plan for Model 1.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices. Step 5: Create multidisciplinary team at each site.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices. Step 6: Schedule meetings to develop triage, integrated team conferences, medication management and engagement process.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices. Step 7: Ongoing consultation of PPS 3ai core committee for workflows, protocols and evidence based practices.										
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. Step 1: Finalize initial site specific protocols for workflow, patient engagement and med management.										
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. Step 2: Train all new clinics and staff on collaborative care protocol.										
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. Step 3: Create policies and procedures document for review and updates to care protocol.										
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. Step 4: Pilot care protocol and implementation plan, review and update.										
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. Step 5: Review new behavioral health standards of care guidelines and revise quarterly (or as needed) with 3ai core committee.										
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. Step 6: Ongoing refinement of protocols based on										

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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
continuous consultation with 3ai core committee.										
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. Step 7: Sites to conduct quarterly QI cycles on their programs to improve practices.										
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.										
Task Policies and procedures are in place to facilitate and document completion of screenings.										
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	0	0	0	0	34	68	102	136	170	204
Task Policies and procedures are in place to facilitate and document completion of screenings. Step 1: Review existing child, adolescent, and adult screening tools.										
Task Policies and procedures are in place to facilitate and document completion of screenings. Step 2: Choose minimum set screening tools for sites (child, adolescent, and adult).										
Task Policies and procedures are in place to facilitate and document completion of screenings. Step 3: Sites to develop individual screening policies and procedures based on recommendations from 3ai core committee.										
Task Policies and procedures are in place to facilitate and document completion of screenings. Step 4: Quarterly review of screening activities, update policies and procedures as necessary.										
Task Screenings are documented in Electronic Health Record Step 1: Identify current partner EHRs.										

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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 Screenings are documented in Electronic Health Record Step 2: Draft guide for recommended alerts and screening templates into collaborative care protocol.										
Task Screenings are documented in Electronic Health Record Step 3: Partners integrate alerts and screening templates into EHRs.										
Task Screenings are documented in Electronic Health Record Step 4: Provide screenshots of screening alerts to project team.										
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) Step 1: Identify discrete screening variable in EHRs.										
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) Step 2: Work with site based or Sinai IT to create screening report.										
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) Step 3: Identify denominator of eligible patients (medicaid patients who receive primary care at that site) at each site and calculate screening rates.										
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) Step 4: Provide quarterly roster of eligible patients screened vs the total eligible to project team.										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record Step1: Review existing protocols and develop "warm transfer" protocol, including documentation in EHRs (part of overall care protocol).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record Step 2: Train staff at sites in protocols and documentation.										

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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 #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 EHR demonstrates integration of medical and behavioral health record within individual patient records Step 1: Survey partners to determine current EHR use, other technical platform use, or need for implementation.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records Step 2: Provide Technical Assistance to partners to integrate BH and EHR.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records Step 3: Document that both medical and behavioral health follow-up care are available in one EHR.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting Step 1: Create annual alerts in EHRs to identify eligible patients for screening										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting Step 2: Identify discrete screening variable in EHRs.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting Step 3: Work with site based and / or Sinai IT to create screening report.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting Step 4: Sites provide quarterly roster of patients to project team.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting Step 5: Sites Identify patients who screen positive and are then diagnosed with depression, substance use or other mental illness.										
Task PPS identifies targeted patients and is able to track actively										

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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
engaged patients for project milestone reporting Step 6: Sites track referrals and follow ups of these patients.										
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	36	72	108	144	180	216
Task Primary care services are co-located within behavioral Health practices and are available.	0	0	0	0	36	72	108	144	180	216
Task Primary care services are co-located within behavioral Health practices and are available.	0	0	0	0	2	4	7	10	13	16
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3. Step 1: Collaborate with 2ai to begin tracking PCMH/ and or APCM status.										
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3. Step 2: Collaborate with 2ai PCMH Technical Assistance Program to support participating PCPs.										
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3. Step 3: Collaborate with 2ai PCMH Technical Assistance Program to submit NCQA / APCM applications.										
Task Primary care services are co-located within behavioral Health practices and are available. Step 1: Identify pilot sites and staffing models.										
Task Primary care services are co-located within behavioral Health practices and are available. Step 2: Develop standardized models/workflows for primary care in Behavioral Health settings across sites.										
Task Primary care services are co-located within behavioral Health practices and are available. Step 3: Create job descriptions and work with workforce committee to recruit and hire staff.										
Task Primary care services are co-located within behavioral Health practices and are available. Step 4: Document licensure / certification and provide to PPS.										

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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 Primary care services are co-located within behavioral Health practices and are available. Step 5: Working with compliance, perform ongoing review of need for and submission of regulatory waivers, submissions of integrated service applications, and assessment and planning for physical space renovations.										
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 Regularly scheduled formal meetings are held to develop collaborative care practices Step 1: Review existing evidence-based standards of care for integrated primary care/BH services, medication management, and care engagement process.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices Step 2: Develop basic standards and protocols for medication management and care engagement for all sites.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices Step 3: Draft preliminary PPS-wide high level standardized models/workflows/best practices.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices Step 4: Draft site specific collaborative care protocol and implementation plan for Model 2.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices Step 5: Create multidisciplinary team at each site.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices Step 6: Schedule meetings to develop triage, integrated team conferences, medication management and engagement process.										
Task Regularly scheduled formal meetings are held to develop										

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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
collaborative care practices Step 7: Ongoing consultation of PPS 3a1 core committee for workflows, protocols and evidence based practices.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process. Step 1: Finalize initial site specific protocols for workflow, patient engagement and med management.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process. Step 2: Train all new clinics and staff on collaborative care protocol.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process. Step 3: Create policies and procedures document for review and updates to care protocol.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process. Step 4: Pilot care protocol and implementation plan, review and update.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process. Step 5: Review new behavioral health standards of care guidelines and revise quarterly (or as needed) with 3ai core committee.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process. Step 6: Ongoing refinement of protocols based on continuous consultation with 3ai core committee.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process. Step 7: Sites to conduct quarterly QI cycles on their programs to improve practices.										
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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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
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	36	72	108	144	180	216
Task Screenings are conducted for all patients Step 1: Review existing child, adolescent, and adult screening tools and choose minimum set.										
Task Screenings are conducted for all patients Step 2: Develop screening policies, workflows and operational procedures based on recommendations from 3ai core committee to adapt for implementation at sites.										
Task Screenings are conducted for all patients Step 3: Quarterly review of screening activities, update policies and procedures as necessary.										
Task Screenings are documented in Electronic Health Record Step 1: Identify current partner EHRs.										
Task Screenings are documented in Electronic Health Record Step 2: Draft guide for recommended alerts and screening templates into collaborative care protocol.										
Task Screenings are documented in Electronic Health Record Step 3: Partners integrate alerts and screening templates into EHRs.										
Task Screenings are documented in Electronic Health Record Step 4: Provide screenshots of screening alerts to project team.										
Task At least 90% of patients receive screenings at the established project sites Step 1: Identify discrete screening variable in EHRs.										
Task At least 90% of patients receive screenings at the established project sites Step 2: Work with site based or Sinai IT to create screening report.										

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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 At least 90% of patients receive screenings at the established project sites Step 3: Identify denominator of eligible patients (medicaid patients who receive primary care at that site) at each site and calculate screening rates.										
Task At least 90% of patients receive screenings at the established project sites Step 4: Provide quarterly roster of eligible patients screened vs the total eligible to project team.										
Task Positive screenings result in "warm transfer" to behavioral health provider Step 1: Review existing protocols and develop "warm transfer" protocol, including documentation in EHRs (part of overall care protocol).										
Task Positive screenings result in "warm transfer" to behavioral health provider Step 2: Train staff at sites in protocols and documentation.										
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 EHR demonstrates integration of medical and behavioral health record within individual patient records. Step 1: Survey partners to determine current EHR use, other technical platform use, or need for implementation.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.Step 2: Provide Technical Assistance to partners to integrate BH and EHR.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.Step 3: Document that both medical and behavioral health follow-up care are available in one EHR.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. Step 1: Create screening questions to identify eligible patients.										

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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 identifies targeted patients and is able to track actively engaged patients for project milestone reporting. Step 2: Identify CPT codes variables in EHRs to query and track engaged patients.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. Step 3: Work with site based or Sinai IT to create screening report.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. Step 4: Provide quarterly roster of patients to project team.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. Step 5: Sites track referrals and follow ups of these patients.										
Milestone #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	0	0	0	0	2	4	6	8	10	12
Task PPS has implemented IMPACT Model at Primary Care Sites. Step 1: Draft customizable protocol template of Best Practices for IMPACT model.										
Task PPS has implemented IMPACT Model at Primary Care Sites. Step 2: Identify sites with capacity to implement or currently using IMPACT.										
Task PPS has implemented IMPACT Model at Primary Care Sites. Step 3: Recruit and hire staff for new sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites. Step 4: Develop IMPACT model training.										
Task PPS has implemented IMPACT Model at Primary Care Sites. Step 5: Train Depression Care Managers, PCPs, Psychiatrists on IMPACT model.										
Task PPS has implemented IMPACT Model at Primary Care Sites. Step 6: Customize patient flow and protocol at site.										
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.										

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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 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 Coordinated evidence-based care protocols are in place Step 1: Utilize basic protocols from 3ai workgroup to develop site specific protocols for workflow, patient engagement and med management. Pilot care protocol and implementation plan, review and update.										
Task Coordinated evidence-based care protocols are in place Step 2: Create policies and procedures document for review and updates to care protocol.										
Task Coordinated evidence-based care protocols are in place Step 3: Train all new clinics and staff on collaborative care protocol.										
Task Coordinated evidence-based care protocols are in place Step 4: Review new behavioral health standards of care guidelines and revise quarterly (or as needed) with workgroup.										
Task Coordinated evidence-based care protocols are in place Step 5: Sites to conduct quarterly QI cycles on their programs to improve practices.										
Task Policies and procedures include process for consulting with Psychiatrist Step 1: Review existing evidence based policies and procedures for psychiatry consults.										
Task Policies and procedures include process for consulting with Psychiatrist Step 2: Create customizable procedure for sites (which would include weekly meetings- telephonic or in person and documentation procedures).										
Task Policies and procedures include process for consulting with Psychiatrist Step 3: Sites customize and incorporate into collaborative care protocols.										
Task Policies and procedures include process for consulting with Psychiatrist Step 4: Review quarterly and revise as necessary.										

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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 PPS identifies qualified Depression Care Manager Step 1: PPS identifies sites with exisiting DCMs and sites needing to hire DCMs.										
Task PPS identifies qualified Depression Care Manager Step 2: Develop DCM job descriptions and qualifications for new DCMs.										
Task PPS identifies qualified Depression Care Manager Step 3: Collaborate with Workforce Committee to recruit and hire Depression Care Managers.										
Task PPS identifies qualified Depression Care Manager Step 4: DCM documents patient care in EMR.										
Task Depression care manager meets requirements of IMPACT model Step 1: Create protocol for minimum training requirements and annual updates.										
Task Depression care manager meets requirements of IMPACT model Step 2: Develop or identify training resources for DCM: depression care and monitoring, coaching patients in behavioral activation, consulting, and completing a relapse prevention plan.										
Task Depression care manager meets requirements of IMPACT model Step 3: Develop supervision structure for training period for new DCM.										
Task Depression care manager meets requirements of IMPACT model Step 4: Create or modify existing templates for behavioral activation, Motivational interviewing, relapse prevention.										
Task Depression care manager meets requirements of IMPACT model										

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Step 5: Chart audit to see if DCM had completed certain relevant templates for patients.										
Task Depression care manager meets requirements of IMPACT model Step 6: Designate and provide ongoing consultative support in the PPS via the 3ai core committee.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Task All IMPACT participants in PPS have a designated Psychiatrist Step 1: Develop Psychiatrist job descriptions specific to IMPACT model.										
Task All IMPACT participants in PPS have a designated Psychiatrist Step 2: Identify existing psychiatrists when possible and / or collaborate with Workforce Committee to recruit and hire psychiatrists.										
Task All IMPACT participants in PPS have a designated Psychiatrist Step 3: Train pscyhiatrists in case consultation for IMPACT model.										
Task All IMPACT participants in PPS have a designated Psychiatrist Step 4: Develop triage and referral protocols at new sites.										
Task All IMPACT participants in PPS have a designated Psychiatrist Step 5: Develop collaborative care case review customizable template specific to psychiatrist.										
Task All IMPACT participants in PPS have a designated Psychiatrist Step 6: PCP or DCM identifies collaborating psychiatrist in IMPACT model patient EMR.										
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 At least 90% of patients receive screenings at the established project sites Step 1: Identify discrete screening variable in participating site EHRs to identify patients screened and not										

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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
screened.										
Task At least 90% of patients receive screenings at the established project sites Step 2: Identify denominator of eligible patients (medicaid patients receiving PC) at participating sites and calculate screening rates.										
Task At least 90% of patients receive screenings at the established project sites Step 3: Work with site based (partners', including MSH) IT departments to create screening reports to be duplicated at future sites.										
Task At least 90% of patients receive screenings at the established project sites Step 4: Provide quarterly roster of eligible patients screened vs the total eligible to project team.										
Task At least 90% of patients receive screenings at the established project sites Step 5: Analyze screening rates and methods to bring overall PPS screening rates in participating projects to 90%.										
Task At least 90% of patients receive screenings at the established project sites Step 6: Collaborate with IT Committee to perform analysis of opportunities for screening needs to be met by the PPS's IT infrastucture to create or streamline screening and depression registries and outcomes, including how changes will be synchronized with the PPS's IT needs for interoperability and clinical data sharing overall.										
Task At least 90% of patients receive screenings at the established project sites Step 7: Collaborate with IT committee to determine how to plan for and implement any changes from above analysis.										
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 In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm Step 1: Review evidence-based IMPACT care model guidelines from AIMS Center.										
Task In alignment with the IMPACT model, treatment is adjusted										

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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
based on evidence-based algorithm Step 2: Create standard algorithm for treatment for depression/anxiety/substance use (and/or disorders as determined by the 3ai core committee).										
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm Step 3: Individual new sites adjust standard algorithm to fit their specific site, which must meet the basic requirements of the stepped care model										
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm Step 4: Reassess and adjust algorithm as needed after 1-2 cycles.										
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 EHR demonstrates integration of medical and behavioral health Step 1: Survey partners to determine current EHR use, other technical platform use, or need for implementation.										
Task EHR demonstrates integration of medical and behavioral health Step 2: Provide Technical Assistance to partners to integrate BH and EHR.										
Task EHR demonstrates integration of medical and behavioral health Step 3: Document that both medical and behavioral health follow-up care are available in one EHR.										
Task PPS identifies targeted patients and is able to track actively engaged patients Step 1: Create annual alerts in EHRs to identify eligible patients for screening.										
Task PPS identifies targeted patients and is able to track actively engaged patients Step 2: Identify discrete engagement variable in EHRs (ex: appointment with PC kept or medical assessment).										
Task PPS identifies targeted patients and is able to track actively engaged patients Step 3: Work with site based or Sinai IT to create screening report.										

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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 identifies targeted patients and is able to track actively engaged patients Step 4: Provide quarterly roster of patients to project team.										
Task PPS identifies targeted patients and is able to track actively engaged patients Step 5: Sites track referrals and follow ups of these patients.										

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.	238	272	272	272	272	272	272	272	272	272
Task Behavioral health services are co-located within PCMH/APC practices and are available.	20	26	26	26	26	26	26	26	26	26
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards Step 1: Collaborate with 2ai to begin tracking PCMH/ and or APCM status.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards Step 2: Collaborate with 2ai PCMH Technical Assistance Program to support participating PCPs.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards Step 3: Collaborate with 2ai PCMH Technical Assistance Program to submit NCQA / APCM applications.										
Task Behavioral health services are co-located within PCMH/APC practices and are available Step 1: Identify pilot sites and staffing models.										
Task Behavioral health services are co-located within PCMH/APC practices and are available Step 2: Develop standardized models/workflows for integrated behavioral health care in primary care settings across sites										
Task Behavioral health services are co-located within PCMH/APC										

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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
practices and are available Step 3: Create job descriptions and work with workforce committee to recruit and hire staff.										
Task Behavioral health services are co-located within PCMH/APC practices and are available Step 4: Document licensure /certification and practice schedule and provide to PPS.										
Task Behavioral health services are co-located within PCMH/APC practices and are available Step 5: Working with compliance, perform ongoing review of need for and submission of regulatory waivers and submissions of integrated service applications.										
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 Regularly scheduled formal meetings are held to develop collaborative care practices. Step 1: Review existing evidence-based standards of care for integrated primary care/BH services, medication management, and care engagement process.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices. Step 2: Develop basic standards and protocols for medication management and care engagement for all sites.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices. Step 3: Draft preliminary PPS-wide high level standardized models/workflows/best practices.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices. Step 4: Draft site specific collaborative care protocol and implementation plan for Model 1.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices. Step 5: Create multidisciplinary team at each site.										
Task Regularly scheduled formal meetings are held to develop										

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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
collaborative care practices. Step 6: Schedule meetings to develop triage, integrated team conferences, medication management and engagement process.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices. Step 7: Ongoing consultation of PPS 3ai core committee for workflows, protocols and evidence based practices.										
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. Step 1: Finalize initial site specific protocols for workflow, patient engagement and med management.										
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. Step 2: Train all new clinics and staff on collaborative care protocol.										
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. Step 3: Create policies and procedures document for review and updates to care protocol.										
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. Step 4: Pilot care protocol and implementation plan, review and update.										
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. Step 5: Review new behavioral health standards of care guidelines and revise quarterly (or as needed) with 3ai core committee.										
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. Step 6: Ongoing refinement of protocols based on continuous consultation with 3ai core committee.										
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. Step 7: Sites to conduct quarterly QI cycles on their programs to improve practices.										
Milestone #3 Conduct preventive care screenings, including behavioral health										

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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
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.	238	272	272	272	272	272	272	272	272	272
Task Policies and procedures are in place to facilitate and document completion of screenings. Step 1: Review existing child, adolescent, and adult screening tools.										
Task Policies and procedures are in place to facilitate and document completion of screenings. Step 2: Choose minimum set screening tools for sites (child, adolescent, and adult).										
Task Policies and procedures are in place to facilitate and document completion of screenings. Step 3: Sites to develop individual screening policies and procedures based on recommendations from 3ai core committee.										
Task Policies and procedures are in place to facilitate and document completion of screenings. Step 4: Quarterly review of screening activities, update policies and procedures as necessary.										
Task Screenings are documented in Electronic Health Record Step 1: Identify current partner EHRs.										
Task Screenings are documented in Electronic Health Record Step 2: Draft guide for recommended alerts and screening templates into collaborative care protocol.										
Task Screenings are documented in Electronic Health Record Step 3: Partners integrate alerts and screening templates into EHRs.										
Task Screenings are documented in Electronic Health Record Step 4: Provide screenshots of screening alerts to project team.										

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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 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) Step 1: Identify discrete screening variable in EHRs.										
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) Step 2: Work with site based or Sinai IT to create screening report.										
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) Step 3: Identify denominator of eligible patients (medicaid patients who receive primary care at that site) at each site and calculate screening rates.										
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) Step 4: Provide quarterly roster of eligible patients screened vs the total eligible to project team.										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record Step1: Review existing protocols and develop "warm transfer" protocol, including documentation in EHRs (part of overall care protocol).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record Step 2: Train staff at sites in protocols and documentation.										
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 EHR demonstrates integration of medical and behavioral health										

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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
record within individual patient records Step 1: Survey partners to determine current EHR use, other technical platform use, or need for implementation.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records Step 2: Provide Technical Assistance to partners to integrate BH and EHR.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records Step 3: Document that both medical and behavioral health follow-up care are available in one EHR.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting Step 1: Create annual alerts in EHRs to identify eligible patients for screening										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting Step 2: Identify discrete screening variable in EHRs.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting Step 3: Work with site based and / or Sinai IT to create screening report.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting Step 4: Sites provide quarterly roster of patients to project team.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting Step 5: Sites Identify patients who screen positive and are then diagnosed with depression, substance use or other mental illness.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting Step 6: Sites track referrals and follow ups of these patients.										
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.	252	288	288	288	288	288	288	288	288	288
Task Primary care services are co-located within behavioral Health practices and are available.	252	288	288	288	288	288	288	288	288	288

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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 Primary care services are co-located within behavioral Health practices and are available.	20	26	26	26	26	26	26	26	26	26
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3. Step 1: Collaborate with 2ai to begin tracking PCMH/ and or APCM status.										
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3. Step 2: Collaborate with 2ai PCMH Technical Assistance Program to support participating PCPs.										
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3. Step 3: Collaborate with 2ai PCMH Technical Assistance Program to submit NCQA / APCM applications.										
Task Primary care services are co-located within behavioral Health practices and are available. Step 1: Identify pilot sites and staffing models.										
Task Primary care services are co-located within behavioral Health practices and are available. Step 2: Develop standardized models/workflows for primary care in Behavioral Health settings across sites.										
Task Primary care services are co-located within behavioral Health practices and are available. Step 3: Create job descriptions and work with workforce committee to recruit and hire staff.										
Task Primary care services are co-located within behavioral Health practices and are available. Step 4: Document licensure / certification and provide to PPS.										
Task Primary care services are co-located within behavioral Health practices and are available. Step 5: Working with compliance, perform ongoing review of need for and submission of regulatory waivers, submissions of integrated service applications, and assessment and planning for physical space renovations.										
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement 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
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 Regularly scheduled formal meetings are held to develop collaborative care practices Step 1: Review existing evidence-based standards of care for integrated primary care/BH services, medication management, and care engagement process.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices Step 2: Develop basic standards and protocols for medication management and care engagement for all sites.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices Step 3: Draft preliminary PPS-wide high level standardized models/workflows/best practices.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices Step 4: Draft site specific collaborative care protocol and implementation plan for Model 2.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices Step 5: Create multidisciplinary team at each site.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices Step 6: Schedule meetings to develop triage, integrated team conferences, medication management and engagement process.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices Step 7: Ongoing consultation of PPS 3a1 core committee for workflows, protocols and evidence based practices.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process. Step 1: Finalize initial site specific protocols for workflow, patient engagement and med management.										
Task Coordinated evidence-based care protocols are in place,										

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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
including a medication management and care engagement process. Step 2: Train all new clinics and staff on collaborative care protocol.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process. Step 3: Create policies and procedures document for review and updates to care protocol.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process. Step 4: Pilot care protocol and implementation plan, review and update.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process. Step 5: Review new behavioral health standards of care guidelines and revise quarterly (or as needed) with 3ai core committee.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process. Step 6: Ongoing refinement of protocols based on continuous consultation with 3ai core committee.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process. Step 7: Sites to conduct quarterly QI cycles on their programs to improve practices.										
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	252	288	288	288	288	288	288	288	288	288

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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
provider as measured by documentation in Electronic Health Record.										
Task Screenings are conducted for all patients Step 1: Review existing child, adolescent, and adult screening tools and choose minimum set.										
Task Screenings are conducted for all patients Step 2: Develop screening policies, workflows and operational procedures based on recommendations from 3ai core committee to adapt for implementation at sites.										
Task Screenings are conducted for all patients Step 3: Quarterly review of screening activities, update policies and procedures as necessary.										
Task Screenings are documented in Electronic Health Record Step 1: Identify current partner EHRs.										
Task Screenings are documented in Electronic Health Record Step 2: Draft guide for recommended alerts and screening templates into collaborative care protocol.										
Task Screenings are documented in Electronic Health Record Step 3: Partners integrate alerts and screening templates into EHRs.										
Task Screenings are documented in Electronic Health Record Step 4: Provide screenshots of screening alerts to project team.										
Task At least 90% of patients receive screenings at the established project sites Step 1: Identify discrete screening variable in EHRs.										
Task At least 90% of patients receive screenings at the established project sites Step 2: Work with site based or Sinai IT to create screening report.										
Task At least 90% of patients receive screenings at the established project sites Step 3: Identify denominator of eligible patients (medicaid patients who receive primary care at that site) at each site and calculate screening rates.										
Task At least 90% of patients receive screenings at the established project sites Step 4: Provide quarterly roster of eligible patients screened vs the total eligible to project team.										
Task Positive screenings result in "warm transfer" to behavioral health										

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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
provider Step 1: Review existing protocols and develop "warm transfer" protocol, including documentation in EHRs (part of overall care protocol).										
Task Positive screenings result in "warm transfer" to behavioral health provider Step 2: Train staff at sites in protocols and documentation.										
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 EHR demonstrates integration of medical and behavioral health record within individual patient records. Step 1: Survey partners to determine current EHR use, other technical platform use, or need for implementation.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.Step 2: Provide Technical Assistance to partners to integrate BH and EHR.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.Step 3: Document that both medical and behavioral health follow-up care are available in one EHR.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. Step 1: Create screening questions to identify eligible patients.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. Step 2: Identify CPT codes variables in EHRs to query and track engaged patients.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. Step 3: Work with site based or Sinai IT to create screening report.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. Step 4: Provide										

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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
quarterly roster of patients to project team.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. Step 5: Sites track referrals and follow ups of these patients.										
Milestone #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	14	16	16	16	16	16	16	16	16	16
Task PPS has implemented IMPACT Model at Primary Care Sites. Step 1: Draft customizable protocol template of Best Practices for IMPACT model.										
Task PPS has implemented IMPACT Model at Primary Care Sites. Step 2: Identify sites with capacity to implement or currently using IMPACT.										
Task PPS has implemented IMPACT Model at Primary Care Sites. Step 3: Recruit and hire staff for new sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites. Step 4: Develop IMPACT model training.										
Task PPS has implemented IMPACT Model at Primary Care Sites. Step 5: Train Depression Care Managers, PCPs, Psychiatrists on IMPACT model.										
Task PPS has implemented IMPACT Model at Primary Care Sites. Step 6: Customize patient flow and protocol at site.										
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 Coordinated evidence-based care protocols are in place Step 1: Utilize basic protocols from 3ai workgroup to develop site specific										

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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
protocols for workflow, patient engagement and med management. Pilot care protocol and implementation plan, review and update.										
Task Coordinated evidence-based care protocols are in place Step 2: Create policies and procedures document for review and updates to care protocol.										
Task Coordinated evidence-based care protocols are in place Step 3: Train all new clinics and staff on collaborative care protocol.										
Task Coordinated evidence-based care protocols are in place Step 4: Review new behavioral health standards of care guidelines and revise quarterly (or as needed) with workgroup.										
Task Coordinated evidence-based care protocols are in place Step 5: Sites to conduct quarterly QI cycles on their programs to improve practices.										
Task Policies and procedures include process for consulting with Psychiatrist Step 1: Review existing evidence based policies and procedures for psychiatry consults.										
Task Policies and procedures include process for consulting with Psychiatrist Step 2: Create customizable procedure for sites (which would include weekly meetings- telephonic or in person and documentation procedures).										
Task Policies and procedures include process for consulting with Psychiatrist Step 3: Sites customize and incorporate into collaborative care protocols.										
Task Policies and procedures include process for consulting with Psychiatrist Step 4: Review quarterly and revise as necessary.										
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										

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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
plan.										
Task PPS identifies qualified Depression Care Manager Step 1: PPS identifies sites with exisiting DCMs and sites needing to hire DCMs.										
Task PPS identifies qualified Depression Care Manager Step 2: Develop DCM job descriptions and qualifications for new DCMs.										
Task PPS identifies qualified Depression Care Manager Step 3: Collaborate with Workforce Committee to recruit and hire Depression Care Managers.										
Task PPS identifies qualified Depression Care Manager Step 4: DCM documents patient care in EMR.										
Task Depression care manager meets requirements of IMPACT model Step 1: Create protocol for minimum training requirements and annual updates.										
Task Depression care manager meets requirements of IMPACT model Step 2: Develop or identify training resources for DCM: depression care and monitoring, coaching patients in behavioral activation, consulting, and completing a relapse prevention plan.										
Task Depression care manager meets requirements of IMPACT model Step 3: Develop supervision structure for training period for new DCM.										
Task Depression care manager meets requirements of IMPACT model Step 4: Create or modify existing templates for behavioral activation, Motivational interviewing, relapse prevention.										
Task Depression care manager meets requirements of IMPACT model Step 5: Chart audit to see if DCM had completed certain relevant templates for patients.										
Task Depression care manager meets requirements of IMPACT model Step 6: Designate and provide ongoing consultative support in the PPS via the 3ai core committee.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										

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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 All IMPACT participants in PPS have a designated Psychiatrist Step 1: Develop Psychiatrist job descriptions specific to IMPACT model.										
Task All IMPACT participants in PPS have a designated Psychiatrist Step 2: Identify existing psychiatrists when possible and / or collaborate with Workforce Committee to recruit and hire psychiatrists.										
Task All IMPACT participants in PPS have a designated Psychiatrist Step 3: Train pscyhiatrists in case consultation for IMPACT model.										
Task All IMPACT participants in PPS have a designated Psychiatrist Step 4: Develop triage and referral protocols at new sites.										
Task All IMPACT participants in PPS have a designated Psychiatrist Step 5: Develop collaborative care case review customizable template specific to psychiatrist.										
Task All IMPACT participants in PPS have a designated Psychiatrist Step 6: PCP or DCM identifies collaborating psychiatrist in IMPACT model patient EMR.										
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 At least 90% of patients receive screenings at the established project sites Step 1: Identify discrete screening variable in participating site EHRs to identify patients screened and not screened.										
Task At least 90% of patients receive screenings at the established project sites Step 2: Identify denominator of eligible patients (medicaid patients receiving PC) at participating sites and calculate screening rates.										
Task At least 90% of patients receive screenings at the established project sites Step 3: Work with site based (partners', including MSH) IT departments to create screening reports to be duplicated at future sites.										

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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 At least 90% of patients receive screenings at the established project sites Step 4: Provide quarterly roster of eligible patients screened vs the total eligible to project team.										
Task At least 90% of patients receive screenings at the established project sites Step 5: Analyze screening rates and methods to bring overall PPS screening rates in participating projects to 90%.										
Task At least 90% of patients receive screenings at the established project sites Step 6: Collaborate with IT Committee to perform analysis of opportunities for screening needs to be met by the PPS's IT infrastucture to create or streamline screening and depression registries and outcomes, including how changes will be synchronized with the PPS's IT needs for interoperability and clinical data sharing overall.										
Task At least 90% of patients receive screenings at the established project sites Step 7: Collaborate with IT committee to determine how to plan for and implement any changes from above analysis.										
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 In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm Step 1: Review evidence-based IMPACT care model guidelines from AIMS Center.										
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm Step 2: Create standard algorithm for treatment for depression/anxiety/substance use (and/or disorders as determined by the 3ai core committee).										
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm Step 3: Individual new sites adjust standard algorithm to fit their specific site, which must meet the basic requirements of the stepped care model										
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm Step 4: Reassess and adjust										

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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
algorithm as needed after 1-2 cycles.										
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 EHR demonstrates integration of medical and behavioral health Step 1: Survey partners to determine current EHR use, other technical platform use, or need for implementation.										
Task EHR demonstrates integration of medical and behavioral health Step 2: Provide Technical Assistance to partners to integrate BH and EHR.										
Task EHR demonstrates integration of medical and behavioral health Step 3: Document that both medical and behavioral health follow-up care are available in one EHR.										
Task PPS identifies targeted patients and is able to track actively engaged patients Step 1: Create annual alerts in EHRs to identify eligible patients for screening.										
Task PPS identifies targeted patients and is able to track actively engaged patients Step 2: Identify discrete engagement variable in EHRs (ex: appointment with PC kept or medical assessment).										
Task PPS identifies targeted patients and is able to track actively engaged patients Step 3: Work with site based or Sinai IT to create screening report.										
Task PPS identifies targeted patients and is able to track actively engaged patients Step 4: Provide quarterly roster of patients to project team.										
Task PPS identifies targeted patients and is able to track actively engaged patients Step 5: Sites track referrals and follow ups of these patients.										

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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
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.	
Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	
Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	
Designate a Psychiatrist meeting requirements of the IMPACT Model.	
Measure outcomes as required in the IMPACT Model.	
Provide "stepped care" as required by the IMPACT Model.	
Use EHRs or other technical platforms to track all patients engaged in this project.	

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Milestone Review Status

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

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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.a.iii – Implementation of evidence-based medication adherence programs (MAP) in community based sites for behavioral health medication compliance

IPQR Module 3.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 foremost project risk pertains to the identified vulnerabilities and needs of the target population itself. Adherence to medication treatment specifically and both behavioral and physical health treatment generally comprise final common pathway problems and primary targets for project intervention.
Challenge 1: Development of a scalable evidence-based adherence intervention targeting both behavioral health and physical health medications and related clinical encounters aligned with provider mandates. Strategy: Expand/adapt existing evidence based strategies for the behavioral health population, including both behavioral and physical health medications and related clinical engagement supported by tailored technologies, including a mobile platform to support extra-mural engagement and deployment, integrated into established workflows.
Challenge 2: Implement a scalable standardized adherence intervention across Manhattan, Brooklyn and Queens and diverse professional and non-professional staff. Strategy: Interventions and related training will be piloted with discrete staff and patient cohorts then replicated with project partners supported by standardized training protocols. Each site will develop self-sustaining autonomy and network integration.
Challenge 3: Complex impediments to the progressive engagement and activation of a culturally diverse, vulnerable population with prevalent multiple morbidities, social, financial, and housing problems, and family stressors. Engaging this population requires a highly committed culturally fluent staff familiar with population challenges. Strategy: A robust, established PPS apparatus for workforce recruitment, training and supervision, employing an assembled workforce of care coordinators, care navigators and peers will be oriented to population needs and 3aiii project interventions supported by a mobile technology platform. A major focus will be consumer education and health literacy in which peers may play an exceptional role. Education and treatment materials will be provided in multiple languages.
Challenge 4: Assuring staff competency and adherence to prescribed interventions, related reporting, including measures of intervention efficacy. Strategy: Across the PPS, each practice setting and node will report ongoing assessment of staff adherence to the prescribed interventions and discrete performance metrics and outcomes using an integrated/mobile technology platform.
Challenge 5: Other IT integration including data capture from pharmacy and other resource utilization both within and outside the PPS, including emergency services and hospitalization. Strategy: The project specific technology platform will integrate other data resources including regional and health information exchanges, and PSYCKES. Work related to the primary pilot, currently underway, is expected to produce viable scalable solutions to such integration then available to project partners.
Challenge 6: Duplication of PPS services, which could complicate and impede the delivery of organized, efficient services. Strategy: Coordination at both the PPS and project level, through use of the MRT Innovation eXchange (MIX) idea bank as well as other direct collaborative initiatives, including sharing standardized approaches and protocols, experience and data, and collaborate on project development when possible.
Challenge 7: Ensuring access to mobile technologies. Strategy: Access to mobile technologies and multiple points of access is a key project component of this project. When direct consumer access is not possible, case managers/care coordinators and peers may utilize other project funded mobile technologies (laptop/pad devices) to implement the adherence model.

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IPQR Module 3.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	45,000

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
0	982	98.20%	18	2.18%

Warning: Please note that your patients engaged to date does not meet your committed amount (1,000)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
et547873	Documentation/Certification	34_null_1_2_20151029174650_PartnerAttestation_TBHC_MSPPS_DY1Q2.pdf	The Brooklyn Hospital's partner attestation to aggregate actively engaged patients report	10/29/2015 05:47 PM
tomfitz	Documentation/Certification	34_null_1_2_20151027183005_Patient Registry_MountSinai_3aiii_10.22.15.xlsx	Patient registry of actively engaged patients for DY1 Q2	10/27/2015 06:30 PM

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 3.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 medication adherence program to improve behavioral health medication adherence through culturally-competent health literacy initiatives including methods based on the Fund for Public Health NY's Medication Adherence Project (MAP).	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 an active medication adherence program which includes initiatives reflecting the Fund for Public Health NY's MAP.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Project staff and participants receive training on PPS medication adherence program initiatives, either utilizing MAP materials or similar materials developed by the PPS.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has an active medication adherence program Step 1: Review existing literature and DOHMH MAP program best practices.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task PPS has an active medication adherence program Step 2: Develop and refine PPS self management goal intervention content and template to engage patients.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task PPS has an active medication adherence program Step 3: Develop mobile Care4Today Mental Health Solutions (C4TMHS) intervention platform.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS has an active medication adherence program Step 4: Pilot and refine interventions.	Project		In Progress	08/01/2015	07/31/2016	08/01/2015	07/31/2016	09/30/2016	DY2 Q2
Task PPS has an active medication adherence program Step 5: Create implementation protocol and module inclusive of IT integration for dissemination.	Project		In Progress	08/01/2015	07/31/2016	08/01/2015	07/31/2016	09/30/2016	DY2 Q2

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DSRIP Implementation Plan Project

Mount Sinai PPS, LLC (PPS ID:34)

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 Project staff and participants receive training on PPS medication adherence program initiatives Step 1: Review literature, including: DOHMH MAP and CDC SIMPLE Protocols, Motivational Interviewing, Health Literacy, Shared Decision Making, and Wellness Self Management principles.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Project staff and participants receive training on PPS medication adherence program initiatives Step 2: Create draft training curriculum including introduction of self-management templates.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Project staff and participants receive training on PPS medication adherence program initiatives Step 3: Pilot and refine training curriculum including use of C4TMHS.	Project		In Progress	08/01/2015	07/31/2016	08/01/2015	07/31/2016	09/30/2016	DY2 Q2
Task Project staff and participants receive training on PPS medication adherence program initiatives Step 4: Identify target training participants and initial and follow-up training schedules.	Project		In Progress	08/01/2015	07/31/2017	08/01/2015	07/31/2017	09/30/2017	DY3 Q2
Task Project staff and participants receive training on PPS medication adherence program initiatives Step 5: Maintain training rosters and submit for quarterly reports.	Project		In Progress	08/01/2015	03/31/2018	08/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Project staff and participants receive training on PPS medication adherence program initiatives Step 6: Ongoing assessment of training program and monitoring of incorporation into practice.	Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Form care teams including practitioners, care managers including Health Home care managers, social workers and pharmacists who are engaged with the behavioral health population.	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 assembled care teams focused on evidence-based medication adherence, including primary care and behavioral health practitioners as well as supporting practitioners, care managers, and others.	Project		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 and update operational protocols based on evidence-based medication adherence standards.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Mount Sinai PPS, LLC (PPS ID:34)

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 Regularly scheduled formal meetings are held to develop and update operational protocols based on evidence-based medication adherence standards.	Provider	Mental Health	In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS conducts follow-up evaluations to determine patient outcomes and progress towards therapy goals, including evaluation of appropriateness, effectiveness, safety and drug interactions, and adherence where applicable.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has assembled care teams focused on evidence-based medication adherence Step 1: Actively participate in Care Coordination Cross Functional Workgroup sessions to design a plan for engaging behavioral health population.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has assembled care teams focused on evidence-based medication adherence Step 2: Leverage Care Coordination Cross Functional Workgroup's resources.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has assembled care teams focused on evidence-based medication adherence Step 3: Collaborate with CCCFW to develop CCCFW processes, workflows, and protocols as they relate to the CCCFW Charter (uploaded in Clinical Integration, 9.1, Milestone 2).	Project		In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has assembled care teams focused on evidence-based medication adherence Step 4: Review best practices for care teams focused on medication adherence.	Project		In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has assembled care teams focused on evidence-based medication adherence Step 5: Create care teams at sites and submit site care team roster and updates to PPS project team.	Project		In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has assembled care teams focused on evidence-based medication adherence Step 6: Ongoing training of care teams and administrators in evidence based care team functions and project requirements.	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 and update operational protocols Step 1: Implement regular care	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
team meetings, sites submit meeting schedule to PPS project team.									
Task Regularly scheduled formal meetings are held to develop and update operational protocols Step 2: Project Workgroup creates customizable operational protocols for individual sites to adapt.	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Regularly scheduled formal meetings are held to develop and update operational protocols Step 3: Participating care teams review and adapt protocols.	Project		In Progress	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Regularly scheduled formal meetings are held to develop and update operational protocols Step 4: Review and update operational protocol quarterly.	Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS conducts follow-up evaluations Step 1: Determine evaluation tools, including intervention template.	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task PPS conducts follow-up evaluations Step 2: Create reports progress towards therapy goal.	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task PPS conducts follow-up evaluations Step 3: Review representative sample of charts and / or electronic reports.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS conducts follow-up evaluations Step 4: Review prescriptive practices when applicable.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS conducts follow-up evaluations Step 5: Review issues with care teams and initiate corrective action plans.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Use EHRs or other technical platforms to track all patients engaged 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 identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR for individual patients includes medication information, drug history, allergies and problems, and treatment plans with expected duration.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task	Project		In Progress	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)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
PPS identifies targeted patients and is able to track actively engaged patients Step 1: Finalize patient inclusion criteria and identification.									
Task PPS identifies targeted patients and is able to track actively engaged patients Step 2: Build discrete variables into EHR/Template to identify engaged patients.	Project		In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients Step 3: Create tracking and reporting system with IT/ Mobile Care4Today platform.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS identifies targeted patients and is able to track actively engaged patients Step 4: Maintain ongoing monitoring of staff adherence and patient engagement reporting.	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR for individual patients includes medication information, drug history, allergies and problems, and treatment plans Step 1: Build EHR checklist review tool.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task EHR for individual patients includes medication information, drug history, allergies and problems, and treatment plans Step 2: Review EHRs for all participating partners.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task EHR for individual patients includes medication information, drug history, allergies and problems, and treatment plans Step 3: Build templates into EHRs missing key elements.	Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task EHR for individual patients includes medication information, drug history, allergies and problems, and treatment plans Step 4: Document compliance with goal with EHR screenshots.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Coordinate with Medicaid Managed Care Plans to improve medication adherence.	Project	N/A	In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task PPS has engaged MCO to develop protocols for coordination of services under this project.	Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has engaged MCO Step 1: Identify key elements of service coordination.	Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task PPS has engaged MCO Step 2: Create draft protocols for coordination of services.	Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has engaged MCO Step 3: Identify MCOs and contacts.	Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has engaged MCO Step 4: Work with Finance Committee and PPS Board of Managers to negotiate service contracts.	Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Develop a medication adherence program to improve behavioral health medication adherence through culturally-competent health literacy initiatives including methods based on the Fund for Public Health NY's Medication Adherence Project (MAP).										
Task PPS has an active medication adherence program which includes initiatives reflecting the Fund for Public Health NY's MAP.										
Task Project staff and participants receive training on PPS medication adherence program initiatives, either utilizing MAP materials or similar materials developed by the PPS.										
Task PPS has an active medication adherence program Step 1: Review existing literature and DOHMH MAP program best practices.										
Task PPS has an active medication adherence program Step 2: Develop and refine PPS self management goal intervention content and template to engage patients.										
Task PPS has an active medication adherence program Step 3: Develop mobile Care4Today Mental Health Solutions (C4TMHS) intervention platform.										
Task PPS has an active medication adherence program Step 4: Pilot and refine interventions.										
Task PPS has an active medication adherence program Step 5: Create implementation protocol and module inclusive of IT integration for dissemination.										

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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 Project staff and participants receive training on PPS medication adherence program initiatives Step 1: Review literature, including: DOHMH MAP and CDC SIMPLE Protocols, Motivational Interviewing, Health Literacy, Shared Decision Making, and Wellness Self Management principles.										
Task Project staff and participants receive training on PPS medication adherence program initiatives Step 2: Create draft training curriculum including introduction of self-management templates.										
Task Project staff and participants receive training on PPS medication adherence program initiatives Step 3: Pilot and refine training curriculum including use of C4TMHS.										
Task Project staff and participants receive training on PPS medication adherence program initiatives Step 4: Identify target training participants and initial and follow-up training schedules.										
Task Project staff and participants receive training on PPS medication adherence program initiatives Step 5: Maintain training rosters and submit for quarterly reports.										
Task Project staff and participants receive training on PPS medication adherence program initiatives Step 6: Ongoing assessment of training program and monitoring of incorporation into practice.										
Milestone #2 Form care teams including practitioners, care managers including Health Home care managers, social workers and pharmacists who are engaged with the behavioral health population.										
Task PPS has assembled care teams focused on evidence-based medication adherence, including primary care and behavioral health practitioners as well as supporting practitioners, care managers, and others.										
Task Regularly scheduled formal meetings are held to develop and update operational protocols based on evidence-based medication adherence standards.	0	0	0	0	35	75	105	135	165	205
Task Regularly scheduled formal meetings are held to develop and update operational protocols based on evidence-based medication adherence standards.	0	0	1	5	11	15	20	25	26	27
Task PPS conducts follow-up evaluations to determine patient										

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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
outcomes and progress towards therapy goals, including evaluation of appropriateness, effectiveness, safety and drug interactions, and adherence where applicable.										
Task PPS has assembled care teams focused on evidence-based medication adherence Step 1: Actively participate in Care Coordination Cross Functional Workgroup sessions to design a plan for engaging behavioral health population.										
Task PPS has assembled care teams focused on evidence-based medication adherence Step 2: Leverage Care Coordination Cross Functional Workgroup's resources.										
Task PPS has assembled care teams focused on evidence-based medication adherence Step 3: Collaborate with CCCFW to develop CCCFW processes, workflows, and protocols as they relate to the CCCFW Charter (uploaded in Clinical Integration, 9.1, Milestone 2).										
Task PPS has assembled care teams focused on evidence-based medication adherence Step 4: Review best practices for care teams focused on medication adherence.										
Task PPS has assembled care teams focused on evidence-based medication adherence Step 5: Create care teams at sites and submit site care team roster and updates to PPS project team.										
Task PPS has assembled care teams focused on evidence-based medication adherence Step 6: Ongoing training of care teams and administrators in evidence based care team functions and project requirements.										
Task Regularly scheduled formal meetings are held to develop and update operational protocols Step 1: Implement regular care team meetings, sites submit meeting schedule to PPS project team.										
Task Regularly scheduled formal meetings are held to develop and update operational protocols Step 2: Project Workgroup creates customizable operational protocols for individual sites to adapt.										
Task Regularly scheduled formal meetings are held to develop and update operational protocols Step 3: Participating care teams review and adapt protocols.										
Task Regularly scheduled formal meetings are held to develop 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
update operational protocols Step 4: Review and update operational protocol quarterly.										
Task PPS conducts follow-up evaluations Step 1: Determine evaluation tools, including intervention template.										
Task PPS conducts follow-up evaluations Step 2: Create reports progress towards therapy goal.										
Task PPS conducts follow-up evaluations Step 3: Review representative sample of charts and / or electronic reports.										
Task PPS conducts follow-up evaluations Step 4: Review prescriptive practices when applicable.										
Task PPS conducts follow-up evaluations Step 5: Review issues with care teams and initiate corrective action plans.										
Milestone #3 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 EHR for individual patients includes medication information, drug history, allergies and problems, and treatment plans with expected duration.										
Task PPS identifies targeted patients and is able to track actively engaged patients Step 1: Finalize patient inclusion criteria and identification.										
Task PPS identifies targeted patients and is able to track actively engaged patients Step 2: Build discrete variables into EHR/Template to identify engaged patients.										
Task PPS identifies targeted patients and is able to track actively engaged patients Step 3: Create tracking and reporting system with IT/ Mobile Care4Today platform.										
Task PPS identifies targeted patients and is able to track actively engaged patients Step 4: Maintain ongoing monitoring of staff adherence and patient engagement reporting.										
Task EHR for individual patients includes medication information, drug history, allergies and problems, and treatment plans Step 1: Build										

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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
EHR checklist review tool.										
Task EHR for individual patients includes medication information, drug history, allergies and problems, and treatment plans Step 2: Review EHRs for all participating partners.										
Task EHR for individual patients includes medication information, drug history, allergies and problems, and treatment plans Step 3: Build templates into EHRs missing key elements.										
Task EHR for individual patients includes medication information, drug history, allergies and problems, and treatment plans Step 4: Document compliance with goal with EHR screenshots.										
Milestone #4 Coordinate with Medicaid Managed Care Plans to improve medication adherence.										
Task PPS has engaged MCO to develop protocols for coordination of services under this project.										
Task PPS has engaged MCO Step 1: Identify key elements of service coordination.										
Task PPS has engaged MCO Step 2: Create draft protocols for coordination of services.										
Task PPS has engaged MCO Step 3: Identify MCOs and contacts.										
Task PPS has engaged MCO Step 4: Work with Finance Committee and PPS Board of Managers to negotiate service contracts.										

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 medication adherence program to improve behavioral health medication adherence through culturally-competent health literacy initiatives including methods based on the Fund for Public Health NY's Medication Adherence Project (MAP).										
Task PPS has an active medication adherence program which includes initiatives reflecting the Fund for Public Health NY's MAP.										
Task Project staff and participants receive training on PPS medication										

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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
adherence program initiatives, either utilizing MAP materials or similar materials developed by the PPS.										
Task PPS has an active medication adherence program Step 1: Review existing literature and DOHMH MAP program best practices.										
Task PPS has an active medication adherence program Step 2: Develop and refine PPS self management goal intervention content and template to engage patients.										
Task PPS has an active medication adherence program Step 3: Develop mobile Care4Today Mental Health Solutions (C4TMHS) intervention platform.										
Task PPS has an active medication adherence program Step 4: Pilot and refine interventions.										
Task PPS has an active medication adherence program Step 5: Create implementation protocol and module inclusive of IT integration for dissemination.										
Task Project staff and participants receive training on PPS medication adherence program initiatives Step 1: Review literature, including: DOHMH MAP and CDC SIMPLE Protocols, Motivational Interviewing, Health Literacy, Shared Decision Making, and Wellness Self Management principles.										
Task Project staff and participants receive training on PPS medication adherence program initiatives Step 2: Create draft training curriculum including introduction of self-management templates.										
Task Project staff and participants receive training on PPS medication adherence program initiatives Step 3: Pilot and refine training curriculum including use of C4TMHS.										
Task Project staff and participants receive training on PPS medication adherence program initiatives Step 4: Identify target training participants and initial and follow-up training schedules.										
Task Project staff and participants receive training on PPS medication adherence program initiatives Step 5: Maintain training rosters and submit for quarterly reports.										
Task Project staff and participants receive training on PPS medication adherence program initiatives Step 6: Ongoing assessment of										

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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
training program and monitoring of incorporation into practice.										
Milestone #2 Form care teams including practitioners, care managers including Health Home care managers, social workers and pharmacists who are engaged with the behavioral health population.										
Task PPS has assembled care teams focused on evidence-based medication adherence, including primary care and behavioral health practitioners as well as supporting practitioners, care managers, and others.										
Task Regularly scheduled formal meetings are held to develop and update operational protocols based on evidence-based medication adherence standards.	250	280	280	280	280	280	280	280	280	280
Task Regularly scheduled formal meetings are held to develop and update operational protocols based on evidence-based medication adherence standards.	28	29	29	29	29	29	29	29	29	29
Task PPS conducts follow-up evaluations to determine patient outcomes and progress towards therapy goals, including evaluation of appropriateness, effectiveness, safety and drug interactions, and adherence where applicable.										
Task PPS has assembled care teams focused on evidence-based medication adherence Step 1: Actively participate in Care Coordination Cross Functional Workgroup sessions to design a plan for engaging behavioral health population.										
Task PPS has assembled care teams focused on evidence-based medication adherence Step 2: Leverage Care Coordination Cross Functional Workgroup's resources.										
Task PPS has assembled care teams focused on evidence-based medication adherence Step 3: Collaborate with CCCFW to develop CCCFW processes, workflows, and protocols as they relate to the CCCFW Charter (uploaded in Clinical Integration, 9.1, Milestone 2).										
Task PPS has assembled care teams focused on evidence-based medication adherence Step 4: Review best practices for care teams focused on medication adherence.										
Task PPS has assembled care teams focused on evidence-based										

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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
medication adherence Step 5: Create care teams at sites and submit site care team roster and updates to PPS project team.										
Task PPS has assembled care teams focused on evidence-based medication adherence Step 6: Ongoing training of care teams and administrators in evidence based care team functions and project requirements.										
Task Regularly scheduled formal meetings are held to develop and update operational protocols Step 1: Implement regular care team meetings, sites submit meeting schedule to PPS project team.										
Task Regularly scheduled formal meetings are held to develop and update operational protocols Step 2: Project Workgroup creates customizable operational protocols for individual sites to adapt.										
Task Regularly scheduled formal meetings are held to develop and update operational protocols Step 3: Participating care teams review and adapt protocols.										
Task Regularly scheduled formal meetings are held to develop and update operational protocols Step 4: Review and update operational protocol quarterly.										
Task PPS conducts follow-up evaluations Step 1: Determine evaluation tools, including intervention template.										
Task PPS conducts follow-up evaluations Step 2: Create reports progress towards therapy goal.										
Task PPS conducts follow-up evaluations Step 3: Review representative sample of charts and / or electronic reports.										
Task PPS conducts follow-up evaluations Step 4: Review prescriptive practices when applicable.										
Task PPS conducts follow-up evaluations Step 5: Review issues with care teams and initiate corrective action plans.										
Milestone #3 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.										

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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 for individual patients includes medication information, drug history, allergies and problems, and treatment plans with expected duration.										
Task PPS identifies targeted patients and is able to track actively engaged patients Step 1: Finalize patient inclusion criteria and identification.										
Task PPS identifies targeted patients and is able to track actively engaged patients Step 2: Build discrete variables into EHR/Template to identify engaged patients.										
Task PPS identifies targeted patients and is able to track actively engaged patients Step 3: Create tracking and reporting system with IT/ Mobile Care4Today platform.										
Task PPS identifies targeted patients and is able to track actively engaged patients Step 4: Maintain ongoing monitoring of staff adherence and patient engagement reporting.										
Task EHR for individual patients includes medication information, drug history, allergies and problems, and treatment plans Step 1: Build EHR checklist review tool.										
Task EHR for individual patients includes medication information, drug history, allergies and problems, and treatment plans Step 2: Review EHRs for all participating partners.										
Task EHR for individual patients includes medication information, drug history, allergies and problems, and treatment plans Step 3: Build templates into EHRs missing key elements.										
Task EHR for individual patients includes medication information, drug history, allergies and problems, and treatment plans Step 4: Document compliance with goal with EHR screenshots.										
Milestone #4 Coordinate with Medicaid Managed Care Plans to improve medication adherence.										
Task PPS has engaged MCO to develop protocols for coordination of services under this project.										
Task PPS has engaged MCO Step 1: Identify key elements of service coordination.										

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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 engaged MCO Step 2: Create draft protocols for coordination of services.										
Task PPS has engaged MCO Step 3: Identify MCOs and contacts.										
Task PPS has engaged MCO Step 4: Work with Finance Committee and PPS Board of Managers to negotiate service contracts.										

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 medication adherence program to improve behavioral health medication adherence through culturally-competent health literacy initiatives including methods based on the Fund for Public Health NY's Medication Adherence Project (MAP).	
Form care teams including practitioners, care managers including Health Home care managers, social workers and pharmacists who are engaged with the behavioral health population.	
Use EHRs or other technical platforms to track all patients engaged in this project.	
Coordinate with Medicaid Managed Care Plans to improve medication adherence.	

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	

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IPQR Module 3.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 3.a.iii.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.

Many of the major risks within 3.b.i stem from a few underpinning topics: The difficulty of clinical workflow adjustments, patient engagement, and IT Integration dependencies

Due to the number and complexity of Clinical workflow adjustments, we need to pay particular attention when implementing changes to the workflow. For example, in order to be successful when implementing workflow changes, the CVD working group, and in coordination with the diabetes working group, we will develop practical CV disease screening and management protocols which can be implemented across the PPS. In another example, when the PPS implements the 5 A's for Tobacco control, the CVD workgroup will work with care teams to train office staff to initiate the 5 A's during the initial work-up of the patient, with completion of the 5 A's to be left up to the provider. With this change, the burden of completing the 5 A's will no longer exclusively fall on the provider. This is a practical workflow adjustment

There are several risks surrounding patient engagement and IT Integration. Typically, patients with elevated blood pressure but no formal diagnosis of hypertension will go undetected and untreated. To address this risk, the CVD Workgroup will work with IT to develop site reports of patients with elevated office blood pressure both with and without a formal diagnosis of hypertension. This strategy of leveraging IT to flag patients will be used across the project to mitigate risk. In another risk, the PPS may be unable to engage all participating providers in the 5 A's tobacco control program. To mitigate this sick, the CVD workgroup will work with IT to develop a hard-stop in EHR's to ensure the 5 A's are addressed prior to signing and locking a note.

Risk: Low patient compliance with lifestyle recommendations is a real and potential risk related to the implementation of this project.

Mitigation Strategy: To address these concerns, the PPS will ensure that its treatment protocols and lifestyle interventions are simple, efficacious and cost-effective. Furthermore, through the use of health coaches and care management teams, the PPS will ensure that engaged patients are actively participating and following up on recommendations for lifestyle modification.

Risk: Due to the varying levels of readiness of PPS members for PCMH Level 3 recognition, there is a risk that not all providers will meet this deliverable.

Mitigation Strategy: Through regular PPS meetings and monthly reports, providers not achieving PCMH level 3 will be identified and targeted for additional support to ensure adherence with DSRIP implementation plans. Additionally, the Clinical Committee is creating a task force/focus group specific to bringing providers to PCMH Level 3. These initiatives will mitigate the implementation risk.

Risk: Due to the nature of organizational change, there is a risk that providers will fail to adopt new clinical protocols and guidelines that the PPS adopts.

Mitigation Strategy: If participating providers are struggling to adopt new clinical guidelines, need assistance with implementing clinical guidelines, or simply fail to comply with clinical guidelines, the PPS will identify these providers as outliers, and ensure that adequate resources are allocated for additional support, guidance and/or oversight. Additionally, the PPS will develop templates that can be adopted to varying levels of organizational maturity. This will allow for flexible adoption.

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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**
DY4,Q4	41,963

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
1,759	3,435	81.86%	761	8.19%

Warning: Please note that your patients engaged to date does not meet your committed amount (4,196)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
et547873	Documentation/Certification	34_null_1_2_20151029174328_PartnerAttestation_TBHC_MSPPS_DY1Q2.pdf	The Brooklyn Hospital's partner attestation to aggregate actively engaged patient report	10/29/2015 05:44 PM
et547873	Documentation/Certification	34_null_1_2_20151029171939_Patient Registry_MountSinai_3bi_10.27.15.xlsx	Patient registry for actively engaged patients in project 3.b.i	10/29/2015 05:20 PM
et547873	Documentation/Certification	34_null_1_2_20151029171734_PartnerAttestation_Institute_MSPPS_DY1Q2.pdf	Institute for Family Health's partner attestation to aggregate actively engaged patient report	10/29/2015 05:18 PM
et547873	Documentation/Certification	34_null_1_2_20151029171614_PartnerAttestation_CHN_MSPPS_DY1Q2.pdf	Community Healthcare Network's partner attestation to aggregate actively engaged patient report	10/29/2015 05:16 PM
et547873	Documentation/Certification	34_null_1_2_20151029171443_PartnerAttestation_AMC_MSPPS_DY1Q2.pdf	AMC IPA's partner attestation to aggregate actively engaged patient report	10/29/2015 05:15 PM
et547873	Documentation/Certification	34_null_1_2_20151029171351_PartnerAttestation_SettlementHealth_MSPPS_DY1Q2.pdf	Settlement Health's partner attestation to aggregate actively engaged patient report	10/29/2015 05:14 PM

Narrative Text :

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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	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Identify evidence based best practices to improve management of cardiovascular disease in the ambulatory and community care setting.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Create an evidence-based screening and management program to improve the health of patients with known (or high risk for) cardiovascular disease in the ambulatory care and community care setting.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3. Receive approval from Clinical Committee on the use of the management program and protocols .	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Identify and inventory all ambulatory care practitioners and community care settings by provider type, services delivered, and geography served to identify locations to implement evidence-based strategies that improve management of cardiovascular disease.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 5. Set up monthly meetings with ambulatory care practitioners to design best practices for information management, and coordination across multiple settings to address patients with cardiovascular disease.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 6. Work with IT to develop quality measurements using new and existing HIT systems to facilitate screening at risk individuals and promote the identification of patients not meeting pre-specified targets for Cardiovascular disease risk reduction. (Cardiovascular disease screening and risk management protocols are based on the Million Hearts initiative.)	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 7. Develop training program for improving management of cardiovascular disease.	Project		In Progress	10/31/2015	03/31/2016	10/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 8. Identify ambulatory care practitioners for participation in training program.	Project		In Progress	10/31/2015	03/31/2016	10/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 9. Work with workforce to train and educate providers and other allied health professionals throughout the PPS on information management.	Project		In Progress	12/01/2015	03/31/2018	12/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 10. Pilot program within the PPS prior to widespread dissemination throughout the PPS using rapid cycle evaluation to revise model.	Project		In Progress	12/01/2015	12/31/2016	12/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 11. Continuous Quality Review results of pilot implementation sites against the baseline results from the PPS.	Project		In Progress	12/01/2015	03/31/2018	12/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 12. Implement PPS-wide established program.	Project		In Progress	12/31/2015	03/31/2018	12/31/2015	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	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 - Primary Care Provider (PCP)	In Progress	12/01/2015	03/31/2018	12/01/2015	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	12/01/2015	03/31/2018	12/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY	Provider	Safety Net Mental Health	In Progress	12/01/2015	03/31/2018	12/01/2015	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
requirements.									
Task PPS uses alerts and secure messaging functionality.	Project		In Progress	12/01/2015	03/31/2018	12/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Assess partner EMRs and identify bi-directional data interface capability / gaps to EHRs and other data source systems	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Develop and agree on the future state and a plan to close any gaps identified in step 1	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Provision MSPPS HIE eMPI for use with PPS data interfaces	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4. Develop, implement, and deploy CBO data entry portal and associated flat-file data collection and normalization process.	Project		In Progress	01/01/2016	06/30/2017	01/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task Step 5. Implement interfaces from EHRs including care management protocols and other data sources to partnering RHIOs, or directly to MS PPS system	Project		In Progress	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task Step 6. Develop, implement, and deploy direct messaging and referrals management tools	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	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	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	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	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Identify baseline and gaps in adoption of ONC-certified EHR technology among PPS participants as part of the current state assessment and gap analysis process	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
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
Step 2. Develop plan, detail around technical assistance services, and timeline for implementation of technical assistance program									
Task Step 3. Provide technical assistance, including purchasing decision support, dissemination of EHR implementation best practices via the PPS Learning Management System (LMS), and other modes of implementation support to be determined through the current state assessment and gap-analysis processes to providers that need to adopt a new EHR or upgrade their existing EHR - in time for achievement of PCMH III and adoption of MU eligible EHRs in DY3	Project		In Progress	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.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 1. Finalize patient inclusion criteria and identification per NYS and PPS criteria including risk stratification criteria	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Select an IT platform(s) to use for the PPS	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Build discrete variables to track patients into EHR/Template to identify engaged patients.	Project		In Progress	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Create tracking and reporting system with IT platform with the support of the IT Committee.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5. Train providers on how to input patient information and track patients in the IT Platform	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6. Develop ongoing webinars and trainings for providers to learn how to access, analyze and read the data inputted into the IT platform	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7. Maintain ongoing monitoring of staff adherence and patient engagement reporting by organization. When organizations actively engaged patient trends downward, the	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	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
PPS will follow-up									
Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	Project	N/A	In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate tobacco control protocols.	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Develop plan with IT to integrate prompt of 5 A's of tobacco control within EHR for patients identified as being active tobacco users. The prompts will direct providers to use the 5 A's of tobacco control to counsel, provide support and assist patients with smoking cessation.	Project		In Progress	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Create education plan teaching providers on how to use 5A's of tobacco control and NY Quits for at-risk patients.	Project		In Progress	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3. Work with workforce to incorporate 5 A's of tobacco control into Learning Management as a PPS wide training.	Project		In Progress	11/01/2015	09/30/2016	11/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 4. Implement training in learning management for providers on how to use EHR prompt of 5 A's of tobacco control.	Project		In Progress	11/01/2015	03/31/2017	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5. Assess using continuous quality review of providers completing 5 A's of tobacco.	Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6. Provide quarterly training to providers on how to use prompt of 5 A's of tobacco control.	Project		In Progress	03/31/2016	03/31/2017	03/31/2016	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	04/01/2015	03/31/2017	04/01/2015	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		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Identify team of providers who have treatment protocols	Project		In Progress	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)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
aligned with national guidelines such as National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).									
Task Step 2. Work with designated team to create plan to integrate standardized treatment protocols for hypertension and elevated cholesterol using screening and management guidelines set forth in the NCEP/ATP-III update. For hypertension, the PPS will follow the screening and management guidelines set forth by JNC-8.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3. Collaborate with IT to integrate standardize screening and treatment protocols into EHRs for the PPS.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Create education and training plan for providers working with the Stakeholder Engagement team and Clinical committee.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5. Work with workforce and IT to train providers on standardized treatment protocols for hypertension and elevated cholesterol.	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 6. Present to PPS leadership for approval of standardized treatment protocols.	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 7. Train providers on treatment protocols and procedures PPS wide.	Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 8. Implement hypertension and elevated cholesterol screening and management protocols to participating PPS organizations.	Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 9. Perform continuous quality improvement of process and improve accordingly.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task	Project		In Progress	03/01/2016	03/31/2017	03/01/2016	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
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.	Project		In Progress	03/01/2016	03/31/2017	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination processes are in place.	Project		In Progress	03/01/2016	03/31/2017	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Perform a network analysis of provider types according to geographic area, type of service and project participation.	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Work with care coordination workgroup to develop care coordination teams (consisting of physicians, nurse care managers, health home care managers, registered dietitians and health coaches) to screen and manage eligible patients with known (or high risk for developing) CVD.	Project		In Progress	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Working with care coordination workgroup to identify best practices on how to address life style changes, medication adherence, health literacy issues and patient self-efficacy and confidence in self management be standardized across the PPS	Project		In Progress	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Work with IT/partners and care coordination work group to assess interoperability systems are in place for implementation.	Project		In Progress	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5. Work with IT/partners to identify providers for engagement of existing care coordination teams as well as development of new care coordination teams to deliver appropriate services.	Project		In Progress	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6. Perform assessment of care coordination teams who are following protocol of assessing EHR to check for services to provide to patients.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7. Create care coordination teams (Include nursing staff, pharmacists, dieticians, community health workers, and health home care managers) to meet the needs of patients.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task	Project		In Progress	06/30/2016	03/31/2017	06/30/2016	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
Step 8. Work with workforce and care coordination work group to develop training materials, policies and procedures.									
Task Step 9. Present to PPS leadership for approval of standardized treatment protocols and training program.	Project		In Progress	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 10. With workforce and care coordination work group to train care coordination teams.	Project		In Progress	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 11. Measure training program for effectiveness.	Project		In Progress	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 12. Pilot care coordination teams at participating sites.	Project		In Progress	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 13. Performing Continuous Quality Improvement to identify effectiveness and areas of improvement for care coordination.	Project		In Progress	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 14. Implement to PPS wide participating partners.	Project		In Progress	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	Project	N/A	In Progress	09/01/2015	03/31/2018	09/01/2015	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)	In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Work with workforce to develop protocol for PCPs in PPS to provide follow up blood pressure checks without copayment or advanced appointments.	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Develop plan to train and educate primary care providers to follow-up on blood pressure checks.	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Work with workforce to design training of PCPs and supporting staff across the PPS on follow up blood pressure checks.	Project		In Progress	10/31/2015	03/31/2016	10/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Integrate training into Learning Management for all PCPs in PPS.	Project		In Progress	10/31/2015	06/30/2016	10/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5. Work with Stakeholder engagement team to socialize protocol to all primary care practices in the PPS on follow-up	Project		In Progress	10/31/2015	09/30/2016	10/31/2015	09/30/2016	09/30/2016	DY2 Q2

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blood pressure checks without copayment or advanced appointments.									
Task Step 6. Implement Learning Management tool for all PCPs to access.	Project		In Progress	10/31/2015	03/31/2018	10/31/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 7. Analyze data of number of PCPs completed Learning management on blood pressure checks.	Project		In Progress	10/31/2015	03/31/2018	10/31/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 8. Perform quality improvement to review design and implementation of process and correct accordingly.	Project		In Progress	10/31/2015	03/31/2018	10/31/2015	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	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.	Project		In Progress	11/01/2015	03/31/2017	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Design standard protocol for measuring and recording blood pressure using correct measurement techniques and equipment.	Project		In Progress	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Review protocol with clinical committee for approval.	Project		In Progress	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. Work with workforce to creating training program.	Project		In Progress	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4. Execute training and education of designate staff of standardized blood pressure screening and management protocols	Project		In Progress	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5. Hire new designate staff and train current staff throughout the PPS to continue to educate and monitor sites on the proper use of the BP equipment, as well as the screening and management protocols at the partner level.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 6. Collaborate with stakeholder engagement workgroup to develop communication materials and medium to inform partners of the standard protocols PPS wide.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 7. Deliver communication to partners of standard protocol.									
Task Step 8. Provide ongoing trainings through workforce, particularly for new staff that join the PPS.	Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 9. Perform continuous quality Improvement to identify effectiveness of training.	Project		In Progress	03/31/2016	03/31/2017	03/31/2016	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 have repeated elevated blood pressure but no diagnosis of hypertension.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.	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 to ensure effective patient identification and hypertension visit scheduling.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Develop plan on identifying patients with repeated elevated blood pressure reading but no diagnosis of hypertension.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Identify criteria for patient stratification for Cardiovascular patients (High, medium, low risk, confirmed diagnosis, etc.)	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Work with IT to create EMR alerts for patients with elevated blood pressure readings without the diagnosis of hypertension.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Work with IT to create aggregate list of patients who fall in the inclusion criteria.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5. Create training program for staff to learn to generate lists of patients who fall in inclusion criteria .	Project		In Progress	03/31/2016	06/30/2016	03/31/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6. Work with IT to create automated scheduling system that	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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will generate frequent lists of patients with elevated blood pressure without a diagnosis of hypertension and send out e-alerts and/or phone calls to these patients to scheduled follow-up visits and/or blood pressure checks.									
Task Step 7. Collaborate with workforce to execute trainings as staff are onboarded.	Project		In Progress	11/01/2015	03/31/2018	11/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 8. Work with IT to generate Compliance reports for monitoring compliance to protocols.	Project		In Progress	11/01/2015	03/31/2018	11/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 9. Work with workforce to train and educate staff on policies and protocols of identifying patients who meet inclusion criteria.	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 10. Perform continuous quality improvement of process and improve accordingly.	Project		In Progress	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	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Create plan using evidence-based screening and management guidelines set forth by JNC-8.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Identify current PPS protocols for determining preferential drugs based on ease of medication adherence.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Incorporate protocol and policy for providers through EHR reminder.	Project		In Progress	12/31/2015	09/30/2016	12/31/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 4. Work with IT to generate reports to ensure these regimens are followed.	Project		In Progress	12/31/2015	09/30/2016	12/31/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Collaborate with workforce committee to train staff on protocols.	Project		In Progress	12/31/2015	09/30/2016	12/31/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 6. Quality improve process and monitor participating	Project		In Progress	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4

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organizations for improvement.									
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		In Progress	11/01/2015	03/31/2018	11/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.	Project		In Progress	11/01/2015	03/31/2018	11/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Develop plan to determine the structure of self-management goals (i.e. free text or structured data), identify the workflow, and strategy on self-management goals	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Collaborate with project work groups and PCMH workgroup(s) to ensure both the PCMH and DSRIP workflows on Self-management goals align.	Project		In Progress	10/31/2015	03/31/2016	10/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Engage IT to build self-management goal templates into EMR. Explore hard stops, alerts, and flags to ask the clinician to complete the self-management goal. IT will also create reports to identify organizations with low rates of self-management goals	Project		In Progress	10/31/2015	06/30/2016	10/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4. Create documentation for self-management goals such as a self-management checklist, which patients can complete in the waiting room.	Project		In Progress	03/31/2016	06/30/2016	03/31/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 5. Education and train clinicians to review the patient's self management goal throughout the care of the patient. This will ensure compliance with the self-management goal.	Project		In Progress	03/31/2016	12/31/2016	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 6. Engage Workforce to train on self-management goal documenting. This may include online trainings and leveraging PCMH trainings to incorporate the self management goal into the training. The training will also educate the providers on the importance of patient engagement in their care.	Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7. Train providers on self management goal documenting.	Project		In Progress	03/31/2016	03/31/2018	03/31/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 8. Assess training efficacy through surveys.	Project		In Progress	03/31/2016	03/31/2018	03/31/2016	03/31/2018	03/31/2018	DY3 Q4

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Task Step 9. Perform continuous quality improvement of process by using the IT data and improve accordingly.	Project		In Progress	03/31/2016	03/31/2018	03/31/2016	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	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has developed referral and follow-up process and adheres to process.	Project		In Progress	11/01/2015	03/31/2018	11/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff on warm referral and follow-up process.	Project		In Progress	11/01/2015	03/31/2018	11/01/2015	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		In Progress	11/01/2015	03/31/2018	11/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Identify community based programs in the PPS to participate in design of referral program.	Project		In Progress	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Collaborate with care coordination cross functional workgroup to develop referral and follow up process with select with community based programs.	Project		In Progress	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Design a model to enable closed loop referrals with community based programs.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Work with Finance and Legal to secure contracts agreements with participating CBOs	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5. Work with workforce in creating training program for referrals and follow up protocol	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 6. Present at Clinical for approval of process.	Project		In Progress	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 7. Educate and train CBOs on documenting participation and behavioral and health status changes.	Project		In Progress	03/31/2016	09/30/2016	03/31/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 8. Work with CBO's to ensure the referral process includes	Project		In Progress	03/31/2016	09/30/2016	03/31/2016	09/30/2016	09/30/2016	DY2 Q2

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non-clinical services. When patients are identified at a CBO, the CBO can refer patients seamlessly into the PPS.									
Task Step 9. Work with stakeholder engagement group to communicate to providers to ensure the Care Coordination Strategy is communicated to all levels of the partner organizations	Project		In Progress	03/31/2016	09/30/2016	03/31/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 10. Establish ongoing trainings through workforce to train new and existing staff on Care Coordination processes with community organizations.	Project		In Progress	03/31/2016	03/31/2018	03/31/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 11. Work with IT to build in system with community organizations for interoperability.	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 12. Perform continuous quality improvement for processes where applicable.	Project		In Progress	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		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff on warm referral and follow-up process.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Develop specific protocols for home as well as ambulatory blood pressure monitoring.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Train Nurse educators within the PPS of protocols.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Nurse educators within the PPS will disseminate these protocols throughout the PPS to ensure a systematic approach to blood pressure screening and management is used. Offices within the PPS will assist patients with blood pressure	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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monitoring, feedback , equipment checks, medication adjustments, as well as follow routine follow-up blood pressure checks without a formal appointment or copayment.									
Task Step 4. IT will build fields in the EMR to collect data on Home Blood pressure monitoring	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Leverage community resources, such as the pharmacies, to offer Blood Pressure Monitoring	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 6. Train staff involved in referral process on the developed protocols	Project		In Progress	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7. IT will create a report, which will monitor the use of home blood pressure monitoring.	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 8. Educate providers of the benefits of ongoing/home blood pressure monitoring	Project		In Progress	03/01/2016	03/31/2017	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 9. Collect data on patients who received ongoing blood pressure monitoring and follow up.	Project		In Progress	03/01/2016	03/31/2017	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 10. Perform continuous quality improvement for processes where applicable.	Project		In Progress	03/01/2016	03/31/2017	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	Project	N/A	In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Define report criteria and automated alert criteria with risk stratification (outlined in above milestones) for lists of patients with hypertension who have not had a recent visit.	Project		In Progress	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. IT develops report and automated alert within EMR to aid schedulers within practices with identifying hypertensive patients.	Project		In Progress	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. Developing education materials to train staff on how to	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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use list of patients with hypertension.									
Task Step 4. Provide training to ensure the lists and tools IT has developed are adopted and scheduling system is adopted.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5. Evaluate log of patients to ensure these patients are scheduled for follow-up.	Project		In Progress	03/01/2016	03/31/2017	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed referral and follow-up process and adheres to process.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Design referral and follow up process for NYS Smokers Quit Line for the PPS.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Train providers and care coordinators on protocol to use NYS Smoker's Quit line.	Project		In Progress	03/31/2016	09/30/2016	03/31/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 3. Work with workforce to provide ongoing trainings to new hires into learning management tool.	Project		In Progress	03/31/2016	09/30/2016	03/31/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4. Develop communications material to share about NY Quits to patients.	Project		In Progress	06/30/2016	12/31/2016	06/30/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 5. Develop a referral network by working with care coordination work group.	Project		In Progress	03/31/2016	12/31/2016	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 6. Deploy training to providers in the PPS to complete an online smoking cessation counseling and treatment training module.	Project		In Progress	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7. Work with IT to build materials into EMR to include an after visit summary, which may be printed for patients with information on the NYS Smokers Quit Line.	Project		In Progress	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 8. Perform Continuous Quality Improvement to identify effectiveness and areas of improvement for care coordination.	Project		In Progress	03/30/2016	03/31/2017	03/30/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #17 Perform additional actions including "hot spotting" strategies in	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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high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.									
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task If applicable, PPS has established linkages to health homes for targeted patient populations.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Collaborate with Care Coordination Cross Functional Workgroup design model for hot spotting strategy of identifying high risk neighborhoods, linkages in health homes for highest risk patients, linkages to Health Homes for the highest risk population, and group visits.	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Develop plan and identifying the Stanford Model (if applicable), including self-management approaches. These will be documented in the EMR, so the providers/care coordinators can discuss the progress with the patient on an ongoing basis.	Project		In Progress	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Work with IT to establish REAL data collection of high risk populations.	Project		In Progress	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Create plan for group visits and programs, where a centralized PPS members can perform group visits. This may include events at churches, food pantries, etc. This will occur in conjunction with 3.c.i.	Project		In Progress	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5. Design education materials to train providers on Stanford Model.	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6. Work with workforce to design education materials to train providers on how to engage high risk populations around CV disease.	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1

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Task Step 7. Engage health homes that work with targeted patient populations.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 8. Work with workforce to train providers in using Stanford Model.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 9. Deploy Stanford Model to the PPS.	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 10. Quality improve based on IT reports to aid in understanding impact in identifying highest risk regions and areas throughout the PPS.	Project		In Progress	08/01/2016	03/31/2018	08/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #18 Adopt strategies from the Million Hearts Campaign.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Mental Health	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Develop screening and management protocols for CVD risk reduction which are consistent with the Million Hearts initiative.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 2. Implement Million Hearts initiative model throughout the PPS, leveraging the workforce committee and Stakeholder engagement workgroups.	Project		In Progress	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Work with IT to build policies and procedures reflective of Millions Hearts Campaign	Project		In Progress	12/01/2015	12/31/2016	12/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4. Train and educate providers on Million Hearts Campaign policies and procedures.	Project		In Progress	12/01/2015	12/31/2016	12/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Task Step 5. Evaluate provider education to ensure consistency and efficacy throughout the PPS.	Project		In Progress	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6. Monitor performance outcomes of providers throughout the PPS.	Project		In Progress	06/30/2016	03/31/2017	06/30/2016	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	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 1. Identify all Managed Medicaid payers and other payers within the providers serving the affected population under this project.	Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 2. Establish communication and training models (Town halls, webinars, in person meetings) with payers and PPS providers to understand and form agreements.	Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 3. Collect feedback on current agreements in place in PPS with MCOs throughout the PPS	Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 4. Perform analysis on current agreements as well as opportunities for collaboration with the MCO (specifically for services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services)	Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 5. PPS leadership will identify participants from the PPS with strong performance as well as risk contract experience to participate in risk arrangements.	Project		On Hold	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 6. Meet with MCOs to discuss collaboration.	Project		On Hold	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 7. Execute agreements with MCOs based on leadership	Project		On Hold	04/01/2016	03/31/2018	04/01/2016	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
discussions									
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 Step 1. Document project workgroups Key decisions(i.e. a master document containing models of care the PPS is pursuing, protocols, etc.), outlining PCP's responsibilities, roles, and description of the project	Project		In Progress	04/01/2015	11/01/2015	04/01/2015	11/01/2015	12/31/2015	DY1 Q3
Task Step 2. Work with PCMH workgroup to identify Primary Care providers in the network.	Project		In Progress	07/01/2015	11/01/2015	07/01/2015	11/01/2015	12/31/2015	DY1 Q3
Task Step 3. Engage primary care providers in project through outreach and communications by working with Stakeholder Engagement work group.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4. Create training materials for providers interested in the project	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5. Hire key positions to act as liaisons between the project and PCP's (i.e. Traveling Lab tech, Physician Champion Liaison)	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6. Negotiate and install financial incentives that connect pps goals with remuneration	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7. Create basic and advanced-type training materials for interested providers	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 8. Apply for CME credits with Office of Medical Education for selected pieces of provider education covered within the project	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 9. Work with IT to install dashboard to supervise implementation across PPS, which will highlight organizations metrics	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 10. Collect data on % of PCPs participating in project	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Task Step 11. Work in collaboration with Stakeholder engagement group to engage PCPs to participate in project	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 12. Work with network development team to continue to identify PCPs for engagement	Project		In Progress	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 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 Step 1. Identify evidence based best practices to improve management of cardiovascular disease in the ambulatory and community care setting.										
Task Step 2. Create an evidence-based screening and management program to improve the health of patients with known (or high risk for) cardiovascular disease in the ambulatory care and community care setting.										
Task Step 3. Receive approval from Clinical Committee on the use of the management program and protocols .										
Task Step 4. Identify and inventory all ambulatory care practitioners and community care settings by provider type, services delivered, and geography served to identify locations to implement evidence-based strategies that improve management of cardiovascular disease.										
Task Step 5. Set up monthly meetings with ambulatory care practitioners to design best practices for information management, and coordination across multiple settings to address patients with cardiovascular disease.										
Task Step 6. Work with IT to develop quality measurements using new and existing HIT systems to facilitate screening at risk individuals										

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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 promote the identification of patients not meeting pre-specified targets for Cardiovascular disease risk reduction. (Cardiovascular disease screening and risk management protocols are based on the Million Hearts initiative.)										
Task Step 7. Develop training program for improving management of cardiovascular disease.										
Task Step 8. Identify ambulatory care practitioners for participation in training program.										
Task Step 9. Work with workforce to train and educate providers and other allied health professionals throughout the PPS on information management.										
Task Step 10. Pilot program within the PPS prior to widespread dissemination throughout the PPS using rapid cycle evaluation to revise model.										
Task Step 11. Continuous Quality Review results of pilot implementation sites against the baseline results from the PPS.										
Task Step 12. Implement PPS-wide established program.										
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	50	125	180	200	230	280	480
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	25	35	40	50	100	200	300
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	5	10	15	20	25	35
Task PPS uses alerts and secure messaging functionality.										
Task Step 1. Assess partner EMRs and identify bi-directional data interface capability / gaps to EHRs and other data source systems										
Task Step 2. Develop and agree on the future state and a plan to close										

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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
any gaps identified in step 1										
Task Step 3. Provision MSPPS HIE eMPI for use with PPS data interfaces										
Task Step 4. Develop, implement, and deploy CBO data entry portal and associated flat-file data collection and normalization process.										
Task Step 5. Implement interfaces from EHRs including care management protocols and other data sources to partnering RHIOs, or directly to MS PPS system										
Task Step 6. Develop, implement, and deploy direct messaging and referrals management tools										
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	0	225	325	400	475	600	800
Task Step 1. Identify baseline and gaps in adoption of ONC-certified EHR technology among PPS participants as part of the current state assessment and gap analysis process										
Task Step 2. Develop plan, detail around technical assistance services, and timeline for implementation of technical assistance program										
Task Step 3. Provide technical assistance, including purchasing decision support, dissemination of EHR implementation best practices via the PPS Learning Management System (LMS), and other modes of implementation support to be determined through the current state assessment and gap-analysis processes to providers that need to adopt a new EHR or upgrade their existing EHR - in time for achievement of PCMH III and adoption of MU eligible EHRs in DY3										
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 Step 1. Finalize patient inclusion criteria and identification per NYS and PPS criteria including risk stratification criteria										
Task Step 2. Select an IT platform(s) to use for the PPS										
Task Step 3. Build discrete variables to track patients into EHR/Template to identify engaged patients.										
Task Step 4. Create tracking and reporting system with IT platform with the support of the IT Committee.										
Task Step 5. Train providers on how to input patient information and track patients in the IT Platform										
Task Step 6. Develop ongoing webinars and trainings for providers to learn how to access, analyze and read the data inputted into the IT platform										
Task Step 7. Maintain ongoing monitoring of staff adherence and patient engagement reporting by organization. When organizations actively engaged patient trends downward, the PPS will follow-up										
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 Step 1. Develop plan with IT to integrate prompt of 5 A's of tobacco control within EHR for patients identified as being active tobacco users. The prompts will direct providers to use the 5 A's of tobacco control to counsel, provide support and assist patients with smoking cessation.										
Task Step 2. Create education plan teaching providers on how to use 5A's of tobacco control and NY Quits for at-risk patients.										
Task Step 3. Work with workforce to incorporate 5 A's of tobacco										

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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
control into Learning Management as a PPS wide training.										
Task Step 4. Implement training in learning management for providers on how to use EHR prompt of 5 A's of tobacco control.										
Task Step 5. Assess using continuous quality review of providers completing 5 A's of tobacco.										
Task Step 6. Provide quarterly training to providers on how to use prompt of 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 Step 1. Identify team of providers who have treatment protocols aligned with national guidelines such as National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).										
Task Step 2. Work with designated team to create plan to integrate standardized treatment protocols for hypertension and elevated cholesterol using screening and management guidelines set forth in the NCEP/ATP-III update. For hypertension, the PPS will follow the screening and management guidelines set forth by JNC-8.										
Task Step 3. Collaborate with IT to integrate standardize screening and treatment protocols into EHRs for the PPS.										
Task Step 4. Create education and training plan for providers working with the Stakeholder Engagement team and Clinical committee.										
Task Step 5. Work with workforce and IT to train providers on standardized treatment protocols for hypertension and elevated cholesterol.										
Task Step 6. Present to PPS leadership for approval of standardized treatment protocols.										
Task Step 7. Train providers on treatment protocols and procedures PPS wide.										

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Task Step 8. Implement hypertension and elevated cholesterol screening and management protocols to participating PPS organizations.										
Task Step 9. Perform continuous quality improvement of process and improve accordingly.										
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 Step 1. Perform a network analysis of provider types according to geographic area, type of service and project participation.										
Task Step 2. Work with care coordination workgroup to develop care coordination teams (consisting of physicians, nurse care managers, health home care managers, registered dietitians and health coaches) to screen and manage eligible patients with known (or high risk for developing) CVD.										
Task Step 3. Working with care coordination workgroup to identify best practices on how to address life style changes, medication adherence, health literacy issues and patient self-efficacy and confidence in self management be standardized across the PPS										
Task Step 4. Work with IT/partners and care coordination work group to assess interoperability systems are in place for implementation.										
Task Step 5. Work with IT/partners to identify providers for engagement of existing care coordination teams as well as development of new care coordination teams to deliver appropriate services.										
Task Step 6. Perform assessment of care coordination teams who are										

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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
following protocol of assessing EHR to check for services to provide to patients.										
Task Step 7. Create care coordination teams (Include nursing staff, pharmacists, dieticians, community health workers, and health home care managers) to meet the needs of patients.										
Task Step 8. Work with workforce and care coordination work group to develop training materials, policies and procedures.										
Task Step 9. Present to PPS leadership for approval of standardized treatment protocols and training program.										
Task Step 10. With workforce and care coordination work group to train care coordination teams.										
Task Step 11. Measure training program for effectiveness.										
Task Step 12. Pilot care coordination teams at participating sites.										
Task Step 13. Performing Continuous Quality Improvement to identify effectiveness and areas of improvement for care coordination.										
Task Step 14. Implement to PPS wide participating partners.										
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	175	200	300	350	400	600	800
Task Step 1. Work with workforce to develop protocol for PCPs in PPS to provide follow up blood pressure checks without copayment or advanced appointments.										
Task Step 2. Develop plan to train and educate primary care providers to follow-up on blood pressure checks.										
Task Step 3. Work with workforce to design training of PCPs and supporting staff across the PPS on follow up blood pressure checks.										
Task Step 4. Integrate training into Learning Management for all PCPs in PPS.										
Task Step 5. Work with Stakeholder engagement team to socialize										

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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
protocol to all primary care practices in the PPS on follow-up blood pressure checks without copayment or advanced appointments.										
Task Step 6. Implement Learning Management tool for all PCPs to access.										
Task Step 7. Analyze data of number of PCPs completed Learning management on blood pressure checks.										
Task Step 8. Perform quality improvement to review design and implementation of process and correct accordingly.										
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 Step 1. Design standard protocol for measuring and recording blood pressure using correct measurement techniques and equipment.										
Task Step 2. Review protocol with clinical committee for approval.										
Task Step 3. Work with workforce to creating training program.										
Task Step 4. Execute training and education of designate staff of standardized blood pressure screening and management protocols										
Task Step 5. Hire new designate staff and train current staff throughout the PPS to continue to educate and monitor sites on the proper use of the BP equipment, as well as the screening and management protocols at the partner level.										
Task Step 6. Collaborate with stakeholder engagement workgroup to develop communication materials and medium to inform partners of the standard protocols PPS wide.										
Task Step 7. Deliver communication to partners of standard protocol.										
Task Step 8. Provide ongoing trainings through workforce, particularly for new staff that join the PPS.										

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Task Step 9. Perform continuous quality Improvement to identify effectiveness of training.										
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 Step 1. Develop plan on identifying patients with repeated elevated blood pressure reading but no diagnosis of hypertension.										
Task Step 2. Identify criteria for patient stratification for Cardiovascular patients (High, medium, low risk, confirmed diagnosis, etc.)										
Task Step 3. Work with IT to create EMR alerts for patients with elevated blood pressure readings without the diagnosis of hypertension.										
Task Step 4. Work with IT to create aggregate list of patients who fall in the inclusion criteria.										
Task Step 5. Create training program for staff to learn to generate lists of patients who fall in inclusion criteria .										
Task Step 6. Work with IT to create automated scheduling system that will generate frequent lists of patients with elevated blood pressure without a diagnosis of hypertension and send out e-alerts and/or phone calls to these patients to scheduled follow-up visits and/or blood pressure checks.										
Task Step 7. Collaborate with workforce to execute trainings as staff are onboarded.										
Task Step 8. Work with IT to generate Compliance reports for monitoring compliance to protocols.										

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Task Step 9. Work with workforce to train and educate staff on policies and protocols of identifying patients who meet inclusion criteria.										
Task Step 10. Perform continuous quality improvement of process and improve accordingly.										
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 Step 1. Create plan using evidence-based screening and management guidelines set forth by JNC-8.										
Task Step 2. Identify current PPS protocols for determining preferential drugs based on ease of medication adherence.										
Task Step 3. Incorporate protocol and policy for providers through EHR reminder.										
Task Step 4. Work with IT to generate reports to ensure these regimens are followed.										
Task Step 5. Collaborate with workforce committee to train staff on protocols.										
Task Step 6. Quality improve process and monitor participating organizations for improvement.										
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 Step 1. Develop plan to determine the structure of self-management goals (i.e. free text or structured data), identify the workflow, and strategy on self-management goals										
Task Step 2. Collaborate with project work groups and PCMH workgroup(s) to ensure both the PCMH and DSRIP workflows on										

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Self-management goals align.										
Task Step 3. Engage IT to build self-management goal templates into EMR. Explore hard stops, alerts, and flags to ask the clinician to complete the self-management goal. IT will also create reports to identify organizations with low rates of self-management goals										
Task Step 4. Create documentation for self-management goals such as a self-management checklist, which patients can complete in the waiting room.										
Task Step 5. Education and train clinicians to review the patient's self management goal throughout the care of the patient. This will ensure compliance with the self-management goal.										
Task Step 6. Engage Workforce to train on self-management goal documenting. This may include online trainings and leveraging PCMH trainings to incorporate the self management goal into the training. The training will also educate the providers on the importance of patient engagement in their care.										
Task Step 7. Train providers on self management goal documenting.										
Task Step 8. Assess training efficacy through surveys.										
Task Step 9. Perform continuous quality improvement of process by using the IT data and improve accordingly.										
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 Step 1. Identify community based programs in the PPS to participate in design of referral program.										

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Task Step 2. Collaborate with care coordination cross functional workgroup to develop referral and follow up process with select with community based programs.										
Task Step 3. Design a model to enable closed loop referrals with community based programs.										
Task Step 4. Work with Finance and Legal to secure contracts agreements with participating CBOs										
Task Step 5. Work with workforce in creating training program for referrals and follow up protocol										
Task Step 6. Present at Clinical for approval of process.										
Task Step 7. Educate and train CBOs on documenting participation and behavioral and health status changes.										
Task Step 8. Work with CBO's to ensure the referral process includes non-clinical services. When patients are identified at a CBO, the CBO can refer patients seamlessly into the PPS.										
Task Step 9. Work with stakeholder engagement group to communicate to providers to ensure the Care Coordination Strategy is communicated to all levels of the partner organizations										
Task Step 10. Establish ongoing trainings through workforce to train new and existing staff on Care Coordination processes with community organizations.										
Task Step 11. Work with IT to build in system with community organizations for interoperability.										
Task Step 12. Perform continuous quality improvement for processes where applicable.										
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-										

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up if blood pressure results are abnormal.										
Task PPS provides periodic training to staff on warm referral and follow-up process.										
Task Step 1. Develop specific protocols for home as well as ambulatory blood pressure monitoring.										
Task Step 2. Train Nurse educators within the PPS of protocols.										
Task Step 3. Nurse educators within the PPS will disseminate these protocols throughout the PPS to ensure a systematic approach to blood pressure screening and management is used. Offices within the PPS will assist patients with blood pressure monitoring, feedback , equipment checks, medication adjustments, as well as follow routine follow-up blood pressure checks without a formal appointment or copayment.										
Task Step 4. IT will build fields in the EMR to collect data on Home Blood pressure monitoring										
Task Step 5. Leverage community resources, such as the pharmacies, to offer Blood Pressure Monitoring										
Task Step 6. Train staff involved in referral process on the developed protocols										
Task Step 7. IT will create a report, which will monitor the use of home blood pressure monitoring.										
Task Step 8. Educate providers of the benefits of ongoing/home blood pressure monitoring										
Task Step 9. Collect data on patients who received ongoing blood pressure monitoring and follow up.										
Task Step 10. Perform continuous quality improvement for processes where applicable.										
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.										

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Task Step 1. Define report criteria and automated alert criteria with risk stratification (outlined in above milestones) for lists of patients with hypertension who have not had a recent visit.										
Task Step 2. IT develops report and automated alert within EMR to aid schedulers within practices with identifying hypertensive patients.										
Task Step 3. Developing education materials to train staff on how to use list of patients with hypertension.										
Task Step 4. Provide training to ensure the lists and tools IT has developed are adopted and scheduling system is adopted.										
Task Step 5. Evaluate log of patients to ensure these patients are scheduled for follow-up.										
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task Step 1. Design referral and follow up process for NYS Smokers Quit Line for the PPS.										
Task Step 2. Train providers and care coordinators on protocol to use NYS Smoker's Quit line.										
Task Step 3. Work with workforce to provide ongoing trainings to new hires into learning management tool.										
Task Step 4. Develop communications material to share about NY Quits to patients.										
Task Step 5. Develop a referral network by working with care coordination work group.										
Task Step 6. Deploy training to providers in the PPS to complete an online smoking cessation counseling and treatment training module.										
Task Step 7. Work with IT to build materials into EMR to include an after visit summary, which may be printed for patients with information on the NYS Smokers Quit Line.										
Task Step 8. Perform Continuous Quality Improvement to identify										

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effectiveness and areas of improvement for care coordination.										
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 Step 1. Collaborate with Care Coordination Cross Functional Workgroup design model for hot spotting strategy of identifying high risk neighborhoods, linkages in health homes for highest risk patients, linkages to Health Homes for the highest risk population, and group visits.										
Task Step 2. Develop plan and identifying the Stanford Model (if applicable), including self-management approaches. These will be documented in the EMR, so the providers/care coordinators can discuss the progress with the patient on an ongoing basis.										
Task Step 3. Work with IT to establish REAL data collection of high risk populations.										
Task Step 4. Create plan for group visits and programs, where a centralized PPS members can perform group visits. This may include events at churches, food pantries, etc. This will occur in conjunction with 3.c.i.										
Task Step 5. Design education materials to train providers on Stanford Model.										
Task Step 6. Work with workforce to design education materials to train providers on how to engage high risk populations around CV disease.										
Task Step 7. Engage health homes that work with targeted patient										

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populations.										
Task Step 8. Work with workforce to train providers in using Stanford Model.										
Task Step 9. Deploy Stanford Model to the PPS.										
Task Step 10. Quality improve based on IT reports to aid in understanding impact in identifying highest risk regions and areas throughout the PPS.										
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	175	200	300	350	1,386	1,386	1,386
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	0	0	160	180	205	255	1,255	1,255	1,255
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	0	0	5	10	10	20	100	100	100
Task Step 1. Develop screening and management protocols for CVD risk reduction which are consistent with the Million Hearts initiative.										
Task Step 2. Implement Million Hearts initiative model throughout the PPS, leveraging the workforce committee and Stakeholder engagement workgroups.										
Task Step 3. Work with IT to build policies and procedures reflective of Millions Hearts Campaign										
Task Step 4. Train and educate providers on Million Hearts Campaign policies and procedures.										
Task Step 5. Evaluate provider education to ensure consistency and efficacy throughout the PPS.										
Task Step 6. Monitor performance outcomes of providers throughout the PPS.										

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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 Step 1. Identify all Managed Medicaid payers and other payers within the providers serving the affected population under this project.										
Task Step 2. Establish communication and training models (Town halls, webinars, in person meetings) with payers and PPS providers to understand and form agreements.										
Task Step 3. Collect feedback on current agreements in place in PPS with MCOs throughout the PPS										
Task Step 4. Perform analysis on current agreements as well as opportunities for collaboration with the MCO (specifically for services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services)										
Task Step 5. PPS leadership will identify participants from the PPS with strong performance as well as risk contract experience to participate in risk arrangements.										
Task Step 6. Meet with MCOs to discuss collaboration.										
Task Step 7. Execute agreements with MCOs based on leadership discussions										
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	175	200	300	350	1,386	1,386	1,386
Task Step 1. Document project workgroups Key decisions(i.e. a master document containing models of care the PPS is pursuing, protocols, etc.), outlining PCP's responsibilities, roles, and description of the project										

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Task Step 2. Work with PCMH workgroup to identify Primary Care providers in the network.										
Task Step 3. Engage primary care providers in project through outreach and communications by working with Stakeholder Engagement work group.										
Task Step 4. Create training materials for providers interested in the project										
Task Step 5. Hire key positions to act as liaisons between the project and PCP's (i.e. Traveling Lab tech, Physician Champion Liaison)										
Task Step 6. Negotiate and install financial incentives that connect pps goals with remuneration										
Task Step 7. Create basic and advanced-type training materials for interested providers										
Task Step 8. Apply for CME credits with Office of Medical Education for selected pieces of provider education covered within the project										
Task Step 9. Work with IT to install dashboard to supervise implementation across PPS, which will highlight organizations metrics										
Task Step 10. Collect data on % of PCPs participating in project										
Task Step 11. Work in collaboration with Stakeholder engagement group to engage PCPs to participate in project										
Task Step 12. Work with network development team to continue to identify PCPs for engagement										

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										

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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
ambulatory and community care setting.										
Task Step 1. Identify evidence based best practices to improve management of cardiovascular disease in the ambulatory and community care setting.										
Task Step 2. Create an evidence-based screening and management program to improve the health of patients with known (or high risk for) cardiovascular disease in the ambulatory care and community care setting.										
Task Step 3. Receive approval from Clinical Committee on the use of the management program and protocols .										
Task Step 4. Identify and inventory all ambulatory care practitioners and community care settings by provider type, services delivered, and geography served to identify locations to implement evidence-based strategies that improve management of cardiovascular disease.										
Task Step 5. Set up monthly meetings with ambulatory care practitioners to design best practices for information management, and coordination across multiple settings to address patients with cardiovascular disease.										
Task Step 6. Work with IT to develop quality measurements using new and existing HIT systems to facilitate screening at risk individuals and promote the identification of patients not meeting pre-specified targets for Cardiovascular disease risk reduction. (Cardiovascular disease screening and risk management protocols are based on the Million Hearts initiative.)										
Task Step 7. Develop training program for improving management of cardiovascular disease.										
Task Step 8. Identify ambulatory care practitioners for participation in training program.										
Task Step 9. Work with workforce to train and educate providers and other allied health professionals throughout the PPS on information management.										
Task Step 10. Pilot program within the PPS prior to widespread dissemination throughout the PPS using rapid cycle evaluation to revise model.										

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Task Step 11. Continuous Quality Review results of pilot implementation sites against the baseline results from the PPS.										
Task Step 12. Implement PPS-wide established program.										
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.	680	880	880	880	880	880	880	880	880	880
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	448	648	648	648	648	648	648	648	648	648
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	40	49	49	49	49	49	49	49	49	49
Task PPS uses alerts and secure messaging functionality.										
Task Step 1. Assess partner EMRs and identify bi-directional data interface capability / gaps to EHRs and other data source systems										
Task Step 2. Develop and agree on the future state and a plan to close any gaps identified in step 1										
Task Step 3. Provision MSPPS HIE eMPI for use with PPS data interfaces										
Task Step 4. Develop, implement, and deploy CBO data entry portal and associated flat-file data collection and normalization process.										
Task Step 5. Implement interfaces from EHRs including care management protocols and other data sources to partnering RHIOs, or directly to MS PPS system										
Task Step 6. Develop, implement, and deploy direct messaging and referrals management tools										
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.										

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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.	1,000	1,386	1,386	1,386	1,386	1,386	1,386	1,386	1,386	1,386
Task Step 1. Identify baseline and gaps in adoption of ONC-certified EHR technology among PPS participants as part of the current state assessment and gap analysis process										
Task Step 2. Develop plan, detail around technical assistance services, and timeline for implementation of technical assistance program										
Task Step 3. Provide technical assistance, including purchasing decision support, dissemination of EHR implementation best practices via the PPS Learning Management System (LMS), and other modes of implementation support to be determined through the current state assessment and gap-analysis processes to providers that need to adopt a new EHR or upgrade their existing EHR - in time for achievement of PCMH III and adoption of MU eligible EHRs in DY3										
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 Step 1. Finalize patient inclusion criteria and identification per NYS and PPS criteria including risk stratification criteria										
Task Step 2. Select an IT platform(s) to use for the PPS										
Task Step 3. Build discrete variables to track patients into EHR/Template to identify engaged patients.										
Task Step 4. Create tracking and reporting system with IT platform with the support of the IT Committee.										
Task Step 5. Train providers on how to input patient information and track patients in the IT Platform										
Task Step 6. Develop ongoing webinars and trainings for providers to										

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learn how to access, analyze and read the data inputted into the IT platform										
Task Step 7. Maintain ongoing monitoring of staff adherence and patient engagement reporting by organization. When organizations actively engaged patient trends downward, the PPS will follow-up										
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 Step 1. Develop plan with IT to integrate prompt of 5 A's of tobacco control within EHR for patients identified as being active tobacco users. The prompts will direct providers to use the 5 A's of tobacco control to counsel, provide support and assist patients with smoking cessation.										
Task Step 2. Create education plan teaching providers on how to use 5A's of tobacco control and NY Quits for at-risk patients.										
Task Step 3. Work with workforce to incorporate 5 A's of tobacco control into Learning Management as a PPS wide training.										
Task Step 4. Implement training in learning management for providers on how to use EHR prompt of 5 A's of tobacco control.										
Task Step 5. Assess using continuous quality review of providers completing 5 A's of tobacco.										
Task Step 6. Provide quarterly training to providers on how to use prompt of 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 Step 1. Identify team of providers who have treatment protocols										

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aligned with national guidelines such as National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).										
Task Step 2. Work with designated team to create plan to integrate standardized treatment protocols for hypertension and elevated cholesterol using screening and management guidelines set forth in the NCEP/ATP-III update. For hypertension, the PPS will follow the screening and management guidelines set forth by JNC-8.										
Task Step 3. Collaborate with IT to integrate standardize screening and treatment protocols into EHRs for the PPS.										
Task Step 4. Create education and training plan for providers working with the Stakeholder Engagement team and Clinical committee.										
Task Step 5. Work with workforce and IT to train providers on standardized treatment protocols for hypertension and elevated cholesterol.										
Task Step 6. Present to PPS leadership for approval of standardized treatment protocols.										
Task Step 7. Train providers on treatment protocols and procedures PPS wide.										
Task Step 8. Implement hypertension and elevated cholesterol screening and management protocols to participating PPS organizations.										
Task Step 9. Perform continuous quality improvement of process and improve accordingly.										
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.										

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Task Care coordination processes are in place.										
Task Step 1. Perform a network analysis of provider types according to geographic area, type of service and project participation.										
Task Step 2. Work with care coordination workgroup to develop care coordination teams (consisting of physicians, nurse care managers, health home care managers, registered dietitians and health coaches) to screen and manage eligible patients with known (or high risk for developing) CVD.										
Task Step 3. Working with care coordination workgroup to identify best practices on how to address life style changes, medication adherence, health literacy issues and patient self-efficacy and confidence in self management be standardized across the PPS										
Task Step 4. Work with IT/partners and care coordination work group to assess interoperability systems are in place for implementation.										
Task Step 5. Work with IT/partners to identify providers for engagement of existing care coordination teams as well as development of new care coordination teams to deliver appropriate services.										
Task Step 6. Perform assessment of care coordination teams who are following protocol of assessing EHR to check for services to provide to patients.										
Task Step 7. Create care coordination teams (Include nursing staff, pharmacists, dieticians, community health workers, and health home care managers) to meet the needs of patients.										
Task Step 8. Work with workforce and care coordination work group to develop training materials, policies and procedures.										
Task Step 9. Present to PPS leadership for approval of standardized treatment protocols and training program.										
Task Step 10. With workforce and care coordination work group to train care coordination teams.										
Task Step 11. Measure training program for effectiveness.										
Task Step 12. Pilot care coordination teams at participating sites.										

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Task Step 13. Performing Continuous Quality Improvement to identify effectiveness and areas of improvement for care coordination.										
Task Step 14. Implement to PPS wide participating partners.										
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.	1,000	1,386	1,386	1,386	1,386	1,386	1,386	1,386	1,386	1,386
Task Step 1. Work with workforce to develop protocol for PCPs in PPS to provide follow up blood pressure checks without copayment or advanced appointments.										
Task Step 2. Develop plan to train and educate primary care providers to follow-up on blood pressure checks.										
Task Step 3. Work with workforce to design training of PCPs and supporting staff across the PPS on follow up blood pressure checks.										
Task Step 4. Integrate training into Learning Management for all PCPs in PPS.										
Task Step 5. Work with Stakeholder engagement team to socialize protocol to all primary care practices in the PPS on follow-up blood pressure checks without copayment or advanced appointments.										
Task Step 6. Implement Learning Management tool for all PCPs to access.										
Task Step 7. Analyze data of number of PCPs completed Learning management on blood pressure checks.										
Task Step 8. Perform quality improvement to review design and implementation of process and correct accordingly.										
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.										

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Task Step 1. Design standard protocol for measuring and recording blood pressure using correct measurement techniques and equipment.										
Task Step 2. Review protocol with clinical committee for approval.										
Task Step 3. Work with workforce to creating training program.										
Task Step 4. Execute training and education of designate staff of standardized blood pressure screening and management protocols										
Task Step 5. Hire new designate staff and train current staff throughout the PPS to continue to educate and monitor sites on the proper use of the BP equipment, as well as the screening and management protocols at the partner level.										
Task Step 6. Collaborate with stakeholder engagement workgroup to develop communication materials and medium to inform partners of the standard protocols PPS wide.										
Task Step 7. Deliver communication to partners of standard protocol.										
Task Step 8. Provide ongoing trainings through workforce, particularly for new staff that join the PPS.										
Task Step 9. Perform continuous quality Improvement to identify effectiveness of training.										
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 Step 1. Develop plan on identifying patients with repeated elevated blood pressure reading but no diagnosis of										

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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
hypertension.										
Task Step 2. Identify criteria for patient stratification for Cardiovascular patients (High, medium, low risk, confirmed diagnosis, etc.)										
Task Step 3. Work with IT to create EMR alerts for patients with elevated blood pressure readings without the diagnosis of hypertension.										
Task Step 4. Work with IT to create aggregate list of patients who fall in the inclusion criteria.										
Task Step 5. Create training program for staff to learn to generate lists of patients who fall in inclusion criteria .										
Task Step 6. Work with IT to create automated scheduling system that will generate frequent lists of patients with elevated blood pressure without a diagnosis of hypertension and send out e-alerts and/or phone calls to these patients to scheduled follow-up visits and/or blood pressure checks.										
Task Step 7. Collaborate with workforce to execute trainings as staff are onboarded.										
Task Step 8. Work with IT to generate Compliance reports for monitoring compliance to protocols.										
Task Step 9. Work with workforce to train and educate staff on policies and protocols of identifying patients who meet inclusion criteria.										
Task Step 10. Perform continuous quality improvement of process and improve accordingly.										
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 Step 1. Create plan using evidence-based screening and management guidelines set forth by JNC-8.										
Task Step 2. Identify current PPS protocols for determining preferential drugs based on ease of medication adherence.										

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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 Step 3. Incorporate protocol and policy for providers through EHR reminder.										
Task Step 4. Work with IT to generate reports to ensure these regimens are followed.										
Task Step 5. Collaborate with workforce committee to train staff on protocols.										
Task Step 6. Quality improve process and monitor participating organizations for improvement.										
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 Step 1. Develop plan to determine the structure of self-management goals (i.e. free text or structured data), identify the workflow, and strategy on self-management goals										
Task Step 2. Collaborate with project work groups and PCMH workgroup(s) to ensure both the PCMH and DSRIP workflows on Self-management goals align.										
Task Step 3. Engage IT to build self-management goal templates into EMR. Explore hard stops, alerts, and flags to ask the clinician to complete the self-management goal. IT will also create reports to identify organizations with low rates of self-management goals										
Task Step 4. Create documentation for self-management goals such as a self-management checklist, which patients can complete in the waiting room.										
Task Step 5. Education and train clinicians to review the patient's self management goal throughout the care of the patient. This will ensure compliance with the self-management goal.										
Task Step 6. Engage Workforce to train on self-management goal documenting. This may include online trainings and leveraging PCMH trainings to incorporate the self management goal into the training. The training will also educate the providers on the										

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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
importance of patient engagement in their care.										
Task Step 7. Train providers on self management goal documenting.										
Task Step 8. Assess training efficacy through surveys.										
Task Step 9. Perform continuous quality improvement of process by using the IT data and improve accordingly.										
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 Step 1. Identify community based programs in the PPS to participate in design of referral program.										
Task Step 2. Collaborate with care coordination cross functional workgroup to develop referral and follow up process with select with community based programs.										
Task Step 3. Design a model to enable closed loop referrals with community based programs.										
Task Step 4. Work with Finance and Legal to secure contracts agreements with participating CBOs										
Task Step 5. Work with workforce in creating training program for referrals and follow up protocol										
Task Step 6. Present at Clinical for approval of process.										
Task Step 7. Educate and train CBOs on documenting participation and behavioral and health status changes.										
Task Step 8. Work with CBO's to ensure the referral process includes										

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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
non-clinical services. When patients are identified at a CBO, the CBO can refer patients seamlessly into the PPS.										
Task Step 9. Work with stakeholder engagement group to communicate to providers to ensure the Care Coordination Strategy is communicated to all levels of the partner organizations										
Task Step 10. Establish ongoing trainings through workforce to train new and existing staff on Care Coordination processes with community organizations.										
Task Step 11. Work with IT to build in system with community organizations for interoperability.										
Task Step 12. Perform continuous quality improvement for processes where applicable.										
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 Step 1. Develop specific protocols for home as well as ambulatory blood pressure monitoring.										
Task Step 2. Train Nurse educators within the PPS of protocols.										
Task Step 3. Nurse educators within the PPS will disseminate these protocols throughout the PPS to ensure a systematic approach to blood pressure screening and management is used. Offices within the PPS will assist patients with blood pressure monitoring, feedback , equipment checks, medication adjustments, as well as follow routine follow-up blood pressure checks without a formal appointment or copayment.										
Task Step 4. IT will build fields in the EMR to collect data on Home Blood pressure monitoring										

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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 Step 5. Leverage community resources, such as the pharmacies, to offer Blood Pressure Monitoring										
Task Step 6. Train staff involved in referral process on the developed protocols										
Task Step 7. IT will create a report, which will monitor the use of home blood pressure monitoring.										
Task Step 8. Educate providers of the benefits of ongoing/home blood pressure monitoring										
Task Step 9. Collect data on patients who received ongoing blood pressure monitoring and follow up.										
Task Step 10. Perform continuous quality improvement for processes where applicable.										
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 Step 1. Define report criteria and automated alert criteria with risk stratification (outlined in above milestones) for lists of patients with hypertension who have not had a recent visit.										
Task Step 2. IT develops report and automated alert within EMR to aid schedulers within practices with identifying hypertensive patients.										
Task Step 3. Developing education materials to train staff on how to use list of patients with hypertension.										
Task Step 4. Provide training to ensure the lists and tools IT has developed are adopted and scheduling system is adopted.										
Task Step 5. Evaluate log of patients to ensure these patients are scheduled for follow-up.										
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.										
Task PPS has developed referral and follow-up process and adheres to 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
Task Step 1. Design referral and follow up process for NYS Smokers Quit Line for the PPS.										
Task Step 2. Train providers and care coordinators on protocol to use NYS Smoker's Quit line.										
Task Step 3. Work with workforce to provide ongoing trainings to new hires into learning management tool.										
Task Step 4. Develop communications material to share about NY Quits to patients.										
Task Step 5. Develop a referral network by working with care coordination work group.										
Task Step 6. Deploy training to providers in the PPS to complete an online smoking cessation counseling and treatment training module.										
Task Step 7. Work with IT to build materials into EMR to include an after visit summary, which may be printed for patients with information on the NYS Smokers Quit Line.										
Task Step 8. Perform Continuous Quality Improvement to identify effectiveness and areas of improvement for care coordination.										
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 Step 1. Collaborate with Care Coordination Cross Functional Workgroup design model for hot spotting strategy of identifying high risk neighborhoods, linkages in health homes for highest										

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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
risk patients, linkages to Health Homes for the highest risk population, and group visits.										
Task Step 2. Develop plan and identifying the Stanford Model (if applicable), including self-management approaches. These will be documented in the EMR, so the providers/care coordinators can discuss the progress with the patient on an ongoing basis.										
Task Step 3. Work with IT to establish REAL data collection of high risk populations.										
Task Step 4. Create plan for group visits and programs, where a centralized PPS members can perform group visits. This may include events at churches, food pantries, etc. This will occur in conjunction with 3.c.i.										
Task Step 5. Design education materials to train providers on Stanford Model.										
Task Step 6. Work with workforce to design education materials to train providers on how to engage high risk populations around CV disease.										
Task Step 7. Engage health homes that work with targeted patient populations.										
Task Step 8. Work with workforce to train providers in using Stanford Model.										
Task Step 9. Deploy Stanford Model to the PPS.										
Task Step 10. Quality improve based on IT reports to aid in understanding impact in identifying highest risk regions and areas throughout the PPS.										
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.	1,386	1,386	1,386	1,386	1,386	1,386	1,386	1,386	1,386	1,386
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255
Task Provider can demonstrate implementation of policies and	100	100	100	100	100	100	100	100	100	100

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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
procedures which reflect principles and initiatives of Million Hearts Campaign.										
Task Step 1. Develop screening and management protocols for CVD risk reduction which are consistent with the Million Hearts initiative.										
Task Step 2. Implement Million Hearts initiative model throughout the PPS, leveraging the workforce committee and Stakeholder engagement workgroups.										
Task Step 3. Work with IT to build policies and procedures reflective of Millions Hearts Campaign										
Task Step 4. Train and educate providers on Million Hearts Campaign policies and procedures.										
Task Step 5. Evaluate provider education to ensure consistency and efficacy throughout the PPS.										
Task Step 6. Monitor performance outcomes of providers throughout the PPS.										
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 Step 1. Identify all Managed Medicaid payers and other payers within the providers serving the affected population under this project.										
Task Step 2. Establish communication and training models (Town halls, webinars, in person meetings) with payers and PPS providers to understand and form agreements.										
Task Step 3. Collect feedback on current agreements in place in PPS with MCOs throughout the PPS										
Task Step 4. Perform analysis on current agreements as well as opportunities for collaboration with the MCO (specifically for services for high risk populations, including smoking cessation										

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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
services, hypertension screening, cholesterol screening, and other preventive services)										
Task Step 5. PPS leadership will identify participants from the PPS with strong performance as well as risk contract experience to participate in risk arrangements.										
Task Step 6. Meet with MCOs to discuss collaboration.										
Task Step 7. Execute agreements with MCOs based on leadership discussions										
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.	1,386	1,386	1,386	1,386	1,386	1,386	1,386	1,386	1,386	1,386
Task Step 1. Document project workgroups Key decisions(i.e. a master document containing models of care the PPS is pursuing, protocols, etc.), outlining PCP's responsibilities, roles, and description of the project										
Task Step 2. Work with PCMH workgroup to identify Primary Care providers in the network.										
Task Step 3. Engage primary care providers in project through outreach and communications by working with Stakeholder Engagement work group.										
Task Step 4. Create training materials for providers interested in the project										
Task Step 5. Hire key positions to act as liaisons between the project and PCP's (i.e. Traveling Lab tech, Physician Champion Liaison)										
Task Step 6. Negotiate and install financial incentives that connect pps goals with remuneration										
Task Step 7. Create basic and advanced-type training materials for interested providers										
Task Step 8. Apply for CME credits with Office of Medical Education for selected pieces of provider education covered within the project										
Task Step 9. Work with IT to install dashboard to supervise										

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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
implementation across PPS, which will highlight organizations metrics										
Task Step 10. Collect data on % of PCPs participating in project										
Task Step 11. Work in collaboration with Stakeholder engagement group to engage PCPs to participate in project										
Task Step 12. Work with network development team to continue to identify PCPs for engagement										

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	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	
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	

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #3	Pass & Ongoing	
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Ongoing	
Milestone #9	Pass & Ongoing	
Milestone #10	Pass & Ongoing	
Milestone #11	Pass & Ongoing	
Milestone #12	Pass & Ongoing	
Milestone #13	Pass & Ongoing	
Milestone #14	Pass & Ongoing	
Milestone #15	Pass & Ongoing	
Milestone #16	Pass & Ongoing	
Milestone #17	Pass & Ongoing	
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.c.i – Evidence-based strategies for disease management in high risk/affected populations (adults only)

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

Instructions :

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

The Diabetes Management project has a number of risks documented below with an associated mitigation plan:

Risk: Linguistic, cultural diversity, as well as variation in learning and literacy levels: Vulnerable populations face greater barriers in self-management of health and navigating services due to low/no literacy, language barriers, poverty and other factors. In some clinical environments, patients do not have a consistent point of contact with a clinician educator to support better self-management, answer questions and help coordinate with external services. This is disruptive to the patient experience and thus challenges the likelihood that the patient will make and maintain behavior changes.

Mitigation strategy:
1. Locally hired Health Coaches will follow patients longitudinally across settings while keeping the full care team abreast of developments in the individual's self-management, self-monitoring, urgent medical needs, and psycho-social challenges. The Health Coach can serve as a central, trusted point of contact to the health system, community resources / health homes, etc. to develop greater trust between patient and caregivers in larger care team.
2. Because the Coaches are hired from the neighborhood they serve, they serve as ambassadors to clinics to help with translation during clinic visits, culturally appropriate education and social support.
3) Large number of staff that needs to be trained: will be mitigated by HR processes in place to recruit adequate number of suitable trainers

Risk: Resource Utilization: Using too many resources (particularly through the time of providers) on patients; overlapping use of resources.

Mitigation: Create tiered risk profiling tool to provide varying levels of intensity of support to patients with varying levels of medical, social, behavioral and economic risk profiles.

Risk: Quality monitoring and Flexible adaptation: Coordinating across sectors while maintaining quality: Expanding these specific programs in a standardized way while maintaining quality of care will require a strong data collection and a continuous quality improvement component aiming at coordination between the various layers/components of the overall program.

Mitigation strategies:
1. Conduct assessments at each primary care site to determine existing care team structures, staffing roles, and approaches used to provide disease prevention and management coaching and care coordination.
2. Create blueprint for Care Coordination Teams and care processes that should apply across sites, with a framework to enable flexible adaptation of features to small and large sites. Include steps to ensure the blueprint is culturally appropriate for the context / neighborhood that each clinic serves.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	29,000

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
7,836	22,520	250.22%	-13,520	77.66%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
et547873	Documentation/Certification	34_null_1_2_20151029171107_PartnerAttestation_SettlementHealth_MSPPS_DY1Q2.pdf	Settlement Health's partner attestation to aggregate actively engaged patient report	10/29/2015 05:11 PM
tomfitz	Documentation/Certification	34_null_1_2_20151028124319_PartnerAttestation_CHN_MSPPS_DY1Q2.pdf	Community Healthcare Network's attestation to aggregated actively engaged patients report	10/28/2015 12:44 PM
tomfitz	Documentation/Certification	34_null_1_2_20151028124159_Patient Registry_MountSinai_3ci_10.27.15.xlsx	Patient registry of actively engaged patients in project 3.c.i	10/28/2015 12:42 PM

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Evidence-based strategies for the management and control of diabetes in the PPS designated area are developed and implemented for all participating providers. Protocols for disease management are developed and training of staff is completed.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Develop an evidence-based screening and management program to improve the health of patients with high risk, known, and out of control Diabetes (DM) in the ambulatory care and community setting.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Receive approval from Clinical Committee on the use of the DM screening and management program protocols	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Work with Workforce Committee to train all necessary staff for both ambulatory care and community sites on the use of the DM screening and management tools	Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4. Develop policies and procedures for clinical committee approval on patient flow through the DM program	Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 5. Train program staff and all hires on the policies and procedures for patient flow	Project		In Progress	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Step 6. Work with IT committee to develop new systems as well as to enhance existing IT systems to facilitate screening at risk individuals and promote the identification of patients not meeting	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
pre-specified targets for DM.									
Task Step 7. Implement training of program staff on the new IT systems to identify DM patients	Project		In Progress	01/01/2017	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task Step 8. Develop and implement a quiz to test the effectiveness of the training program to be administered immediately following the training to all staff who received the training	Project		In Progress	01/01/2017	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task Step 9. Conduct educational sessions for providers and other allied health professionals on the best practices working through the Workforce Committee and Stakeholder Engagement Workgroup.	Project		In Progress	04/01/2016	06/30/2017	04/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task Step 10. Identify appropriate ambulatory care and community sites in the PPS to pilot the DM program	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 11. Pilot the model at the identified PPS sites	Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 12. Evaluate the results of the DM pilot against the baseline to determine if changes should be made to the model	Project		In Progress	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Step 13. Review PPS provider list to determine appropriate other community partners to be included in the project for each site and invite an appropriate community partners to participate	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 14. Implement the revised model in all ambulatory and community sites in the PPS	Project		In Progress	04/01/2017	03/31/2018	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.	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 engaged at least 80% of their PCPs in this activity.	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 Step 1. With Stakeholder Engagement, identify the PCPs that are ready to pilot the project	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Conduct outreach to engage additional PCPs in the PPS's network with the support of the Stakeholder Engagement	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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

DSRIP Implementation Plan Project

Mount Sinai PPS, LLC (PPS ID:34)

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
Workgroup through community forums, town halls and outreach activities									
Task Step 3. Develop with Stakeholder Engagement and Workforce Committee the training materials needed for providers participating in the project	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Implement with Workforce Committee the training sessions for providers participating in the project to learn about project workflow and protocols	Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 5. Develop and implement a quiz to test the effectiveness of the training program to be administered immediately following the training to all staff who received the training	Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 6. Hire key positions to act as liaisons between the project and PCP's (i.e. Traveling Lab tech, Physician Champion Liaison, CDE to visit practices and supervise implementation)	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 7. Install POC A1c machines in at least 10 PPS practices, including at least 5 community partner practices, to help increase interest of PCP's within the PPS	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 8. Apply for CME credits with Office of Medical Education for selected pieces of provider education covered within the project	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 9. Work with IT to develop the project dashboard to be able to track engagement and monitor use of best practices by PCPs	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 10. Work with IT to install and train on use of the dashboard to supervise implementation across PPS, which will highlight organizations metrics.	Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 11. Track hemoglobin A1c testing by creating a tracking template and check with partners how best to track with the support of the IT Committee	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 12. Implement performance evaluations of participating providers and organizations including monitoring the health	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

Mount Sinai PPS, LLC (PPS ID:34)

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
outcomes of the care coordinator teams									
Task Step 13. Implement a process for making improvements to participating providers and organizations if health outcomes are below average	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.	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 providers.	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination processes are established and implemented.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Identify the appropriate teams members to help identify and recruit care coordination teams to screen and manage eligible patients with known (or high risk for developing) Diabetes.	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Identify the established protocols to be used for this project in conjunction with the Clinical Committee and Care Coordination Cross Functional Workgroup	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Recruit team members for care coordination team to screen and manage patients using established protocols including Health home, health coaches, and Community Health Workers	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Collaborate with the Care Coordination Cross Functional Workgroup and Health home, health coaches, and Community Health Workers to address the needs for this project to be consistent with the PPS to ensure uniformity and to implement a clinically interoperable system for care coordination across the	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4

New York State Department Of Health
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DSRIP Implementation Plan Project

Mount Sinai PPS, LLC (PPS ID:34)

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
PPS									
Task Step 5. Train care coordination teams on patient flow and protocols in conjunction with the Care Coordination Cross Functional Workgroup	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6. Develop and implement a quiz to test the effectiveness of the training program to be administered immediately following the training to all staff who received the training	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 7. Establish an annual training session to ensure that care coordination teams are up to speed on the latest protocols and well-versed in the workflow for this project	Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 8. Coordinate with IT Committee and pharmacy representatives to promote medication safety and adherence, as well as develop optimal dosing best practices to share with all participating sites	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 9. All identified high-risk patients will work with Registered dietitians, Health Homes, community health coaches (care coordination team) to identify health behavior change, health literacy and patient self-efficacy.	Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 10. Develop a report to monitor the effectiveness of the implemented care model, including linkages to care.	Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 11. Perform a site specific assessment of information sharing capabilities to be used to define the approach and the deployment to be taken by the Care Coordinator at that site to communicate information with the PPS and other providers	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 12. Implement performance evaluations of participating providers and organizations including monitoring the health outcomes of the care coordinator teams	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 13. Implement a process for making improvements to participating providers and organizations if health outcomes are below average	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4	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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Mount Sinai PPS, LLC (PPS ID:34)

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 "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.									
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task If applicable, PPS has established linkages to health homes for targeted patient populations.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Participate in Care Coordination Cross Functional Workgroup sessions to develop a Care Coordination Model for this project.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Identify criteria for data selection to identify high-risk groups. Identify reliable and valid data points to help identify high risk populations	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3. Implement data selection and collection to identify high risk populations	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4. Analyze data to identify high risk populations	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 5. Develop and implement improvement plan to address high-risk population. Create strategy to implement improvement plan in high risk population	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6. Define clinical criteria for patient referral to a model such as Stanford	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 7. Select community based organization(s) group to deliver the model by outreaching to Partners with interested CBO with support of Stakeholder Engagement Workgroup	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 8. Make partnership agreement with community based	Project		In Progress	07/01/2016	09/30/2016	07/01/2016	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
organization to deliver the model with support of Stakeholder Engagement Workgroup									
Task Step 9. Train staff to deliver the model in the PPS	Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 10. Develop and implement a quiz to test the effectiveness of the training program to be administered immediately following the training to all staff who received the training	Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 11. Employ strategies identified in the Stanford Model, including self-management approaches and document in the EMR so the providers/care coordinators can discuss the progress with the patient on an ongoing basis by establishing linkage with health homes in PPS.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 12. In conjunction with 3bi, implement group visits and programs, where a centralized PPS members can perform group visits.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 13. IT committee to assist in the delivery of IT/EHR "prompts" for referrals to the model	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 14. Instruct PCP's core managers in use of QTAC electronic patient referral portal to Stanford classes.	Project		In Progress	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Step 15. Community group/ peer outreach to patients living in hot spots	Project		In Progress	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Step 16. Provide the Stanford course or other such courses to designated populations such as patients in high risk neighborhoods	Project		In Progress	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Step 17. Work with IT to create dashboards highlighting engagement and goal achievement by geography and by PPS partner	Project		In Progress	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Ensure coordination with the Medicaid Managed Care organizations serving the target population.	Project	N/A	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has agreement in place with MCO related to coordination of	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4

Mount Sinai PPS, LLC (PPS ID:34)

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
services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.									
Task Step 1. Collect feedback on current agreements in place in PPS with MCOs throughout the PPS	Project		In Progress	11/01/2015	06/30/2016	11/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2. Perform analysis on current agreements as well as opportunities for collaboration with the MCO (specifically for services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services)	Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Identify organizations interested in obtaining PPS agreements	Project		In Progress	04/01/2017	06/30/2017	04/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task Step 4. Meet with MCOs to discuss possible areas of collaboration. If an MCO does not like any of the proposed areas of collaboration, the PPS will request other options from the MCO. This will be done in conjunction with 3.c.i	Project		In Progress	07/01/2017	09/30/2017	07/01/2017	09/30/2017	09/30/2017	DY3 Q2
Task Step 5. Execute agreements with MCOs based on above discussions	Project		In Progress	10/01/2017	03/31/2018	10/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Use EHRs or other technical platforms to track all patients engaged 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 identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS uses a recall system that allows staff to report which patients are overdue for which preventive services and to track when and how patients were notified of needed services.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Finalize patient inclusion criteria and identification per NYS and PPS criteria including risk stratification criteria	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Select an IT platform to use for the PPS	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 3. Build discrete variables to track patients into	Project		In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Mount Sinai PPS, LLC (PPS ID:34)

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/Template to identify engaged patients.									
Task Step 4. Create tracking and reporting system with IT platform with the support of the IT Committee.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5. Train providers on how to input patient information and track patients in the IT Platform	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6. Develop and implement a quiz to test the effectiveness of the training program to be administered immediately following the training to all staff who received the training	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7. Develop ongoing webinars and trainings for providers to learn how to access, analyze and read the data inputted into the IT platform	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 8. Maintain ongoing monitoring of staff adherence and patient engagement reporting by organization. When organizations actively engaged patient trends downward, the PPS will follow-up	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	Provider	Safety Net Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Mount Sinai PPS, LLC (PPS ID:34)

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 Step 1. Identify baseline and gaps in adoption of ONC-certified EHR technology among PPS participants as part of the current state assessment and gap analysis process	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Develop plan, detail around technical assistance services, and timeline for implementation of technical assistance program	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Provide technical assistance, including purchasing decision support, dissemination of EHR implementation best practices via the PPS Learning Management System (LMS), and other modes of implementation support to be determined through the current state assessment and gap-analysis processes to providers that need to adopt a new EHR or upgrade their existing EHR - in time for achievement of PCMH III and adoption of MU eligible EHRs in DY3	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 4. Assess partner EMRs and identify bi-directional data interface capability / gaps to EHRs and other data source systems	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 5. Develop and agree on the future state and a plan to close any gaps identified in step 1	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 6. Provision MSPPS HIE eMPI for use with PPS data interfaces	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7. Develop, implement, and deploy CBO data entry portal and associated flat-file data collection and normalization process	Project		In Progress	01/01/2016	06/30/2017	01/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task Task 8. Implement interfaces from EHRs and other data sources to partnering RHIOs, or directly to MS PPS system	Project		In Progress	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task Task 9. Develop, implement, and deploy Direct messaging and referrals management tools	Project		In Progress	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)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.										
Task Evidence-based strategies for the management and control of diabetes in the PPS designated area are developed and implemented for all participating providers. Protocols for disease management are developed and training of staff is completed.										
Task Step 1. Develop an evidence-based screening and management program to improve the health of patients with high risk, known, and out of control Diabetes (DM) in the ambulatory care and community setting.										
Task Step 2. Receive approval from Clinical Committee on the use of the DM screening and management program protocols										
Task Step 3. Work with Workforce Committee to train all necessary staff for both ambulatory care and community sites on the use of the DM screening and management tools										
Task Step 4. Develop policies and procedures for clinical committee approval on patient flow through the DM program										
Task Step 5. Train program staff and all hires on the policies and procedures for patient flow										
Task Step 6. Work with IT committee to develop new systems as well as to enhance existing IT systems to facilitate screening at risk individuals and promote the identification of patients not meeting pre-specified targets for DM.										
Task Step 7. Implement training of program staff on the new IT systems to identify DM patients										
Task Step 8. Develop and implement a quiz to test the effectiveness of the training program to be administered immediately following the training to all staff who received the training										
Task Step 9. Conduct educational sessions for providers and other allied health professionals on the best practices working through the Workforce Committee and Stakeholder Engagement Workgroup.										

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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 Step 10. Identify appropriate ambulatory care and community sites in the PPS to pilot the DM program										
Task Step 11. Pilot the model at the identified PPS sites										
Task Step 12. Evaluate the results of the DM pilot against the baseline to determine if changes should be made to the model										
Task Step 13. Review PPS provider list to determine appropriate other community partners to be included in the project for each site and invite an appropriate community partners to participate										
Task Step 14. Implement the revised model in all ambulatory and community sites in the PPS										
Milestone #2 Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.										
Task PPS has engaged at least 80% of their PCPs in this activity.	0	0	0	175	200	300	350	1,386	1,386	1,386
Task Step 1. With Stakeholder Engagement, identify the PCPs that are ready to pilot the project										
Task Step 2. Conduct outreach to engage additional PCPs in the PPS's network with the support of the Stakeholder Engagement Workgroup through community forums, town halls and outreach activities										
Task Step 3. Develop with Stakeholder Engagement and Workforce Committee the training materials needed for providers participating in the project										
Task Step 4. Implement with Workforce Committee the training sessions for providers participating in the project to learn about project workflow and protocols										
Task Step 5. Develop and implement a quiz to test the effectiveness of the training program to be administered immediately following the training to all staff who received the training										
Task Step 6. Hire key positions to act as liaisons between the project and PCP's (i.e. Traveling Lab tech, Physician Champion Liaison, CDE to visit practices and supervise implementation)										

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

DSRIP Implementation Plan Project

Mount Sinai PPS, LLC (PPS ID:34)

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 Step 7. Install POC A1c machines in at least 10 PPS practices, including at least 5 community partner practices, to help increase interest of PCP's within the PPS										
Task Step 8. Apply for CME credits with Office of Medical Education for selected pieces of provider education covered within the project										
Task Step 9. Work with IT to develop the project dashboard to be able to track engagement and monitor use of best practices by PCPs										
Task Step 10. Work with IT to install and train on use of the dashboard to supervise implementation across PPS, which will highlight organizations metrics.										
Task Step 11. Track hemoglobin A1c testing by creating a tracking template and check with partners how best to track with the support of the IT Committee										
Task Step 12. Implement performance evaluations of participating providers and organizations including monitoring the health outcomes of the care coordinator teams										
Task Step 13. Implement a process for making improvements to participating providers and organizations if health outcomes are below average										
Milestone #3 Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient 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 established and implemented.										
Task Step 1. Identify the appropriate teams members to help identify and recruit care coordination teams to screen and manage eligible patients with known (or high risk for developing)										

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DSRIP Implementation Plan Project

Mount Sinai PPS, LLC (PPS ID:34)

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
Diabetes.										
Task Step 2. Identify the established protocols to be used for this project in conjunction with the Clinical Committee and Care Coordination Cross Functional Workgroup										
Task Step 3. Recruit team members for care coordination team to screen and manage patients using established protocols including Health home, health coaches, and Community Health Workers										
Task Step 4. Collaborate with the Care Coordination Cross Functional Workgroup and Health home, health coaches, and Community Health Workers to address the needs for this project to be consistent with the PPS to ensure uniformity and to implement a clinically interoperable system for care coordination across the PPS										
Task Step 5. Train care coordination teams on patient flow and protocols in conjunction with the Care Coordination Cross Functional Workgroup										
Task Step 6. Develop and implement a quiz to test the effectiveness of the training program to be administered immediately following the training to all staff who received the training										
Task Step 7. Establish an annual training session to ensure that care coordination teams are up to speed on the latest protocols and well-versed in the workflow for this project										
Task Step 8. Coordinate with IT Committee and pharmacy representatives to promote medication safety and adherence, as well as develop optimal dosing best practices to share with all participating sites										
Task Step 9. All identified high-risk patients will work with Registered dietitians, Health Homes, community health coaches (care coordination team) to identify health behavior change, health literacy and patient self-efficacy.										
Task Step 10. Develop a report to monitor the effectiveness of the implemented care model, including linkages to care.										
Task Step 11. Perform a site specific assessment of information sharing capabilities to be used to define the approach and the										

Mount Sinai PPS, LLC (PPS ID:34)

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
deployment to be taken by the Care Coordinator at that site to communicate information with the PPS and other providers										
Task Step 12. Implement performance evaluations of participating providers and organizations including monitoring the health outcomes of the care coordinator teams										
Task Step 13. Implement a process for making improvements to participating providers and organizations if health outcomes are below average										
Milestone #4 Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.										
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 Step 1. Participate in Care Coordination Cross Functional Workgroup sessions to develop a Care Coordination Model for this project.										
Task Step 2. Identify criteria for data selection to identify high-risk groups. Identify reliable and valid data points to help identify high risk populations										
Task Step 3. Implement data selection and collection to identify high risk populations										
Task Step 4. Analyze data to identify high risk populations										
Task Step 5. Develop and implement improvement plan to address high-risk population. Create strategy to implement improvement plan in high risk population										
Task Step 6. Define clinical criteria for patient referral to a model such as Stanford										

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Mount Sinai PPS, LLC (PPS ID:34)

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 Step 7. Select community based organization(s) group to deliver the model by outreaching to Partners with interested CBO with support of Stakeholder Engagement Workgroup										
Task Step 8. Make partnership agreement with community based organization to deliver the model with support of Stakeholder Engagement Workgroup										
Task Step 9. Train staff to deliver the model in the PPS										
Task Step 10. Develop and implement a quiz to test the effectiveness of the training program to be administered immediately following the training to all staff who received the training										
Task Step 11. Employ strategies identified in the Stanford Model, including self-management approaches and document in the EMR so the providers/care coordinators can discuss the progress with the patient on an ongoing basis by establishing linkage with health homes in PPS.										
Task Step 12. In conjunction with 3bi, implement group visits and programs, where a centralized PPS members can perform group visits.										
Task Step 13. IT committee to assist in the delivery of IT/EHR "prompts" for referrals to the model										
Task Step 14. Instruct PCP's core managers in use of QTAC electronic patient referral portal to Stanford classes.										
Task Step 15. Community group/ peer outreach to patients living in hot spots										
Task Step 16. Provide the Stanford course or other such courses to designated populations such as patients in high risk neighborhoods										
Task Step 17. Work with IT to create dashboards highlighting engagement and goal achievement by geography and by PPS partner										
Milestone #5 Ensure coordination with the Medicaid Managed Care organizations serving the target population.										
Task PPS has agreement in place with MCO related to coordination of										

Mount Sinai PPS, LLC (PPS ID:34)

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
services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.										
Task Step 1. Collect feedback on current agreements in place in PPS with MCOs throughout the PPS										
Task Step 2. Perform analysis on current agreements as well as opportunities for collaboration with the MCO (specifically for services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services)										
Task Step 3. Identify organizations interested in obtaining PPS agreements										
Task Step 4. Meet with MCOs to discuss possible areas of collaboration. If an MCO does not like any of the proposed areas of collaboration, the PPS will request other options from the MCO. This will be done in conjunction with 3.c.i										
Task Step 5. Execute agreements with MCOs based on above discussions										
Milestone #6 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 PPS uses a recall system that allows staff to report which patients are overdue for which preventive services and to track when and how patients were notified of needed services.										
Task Step 1. Finalize patient inclusion criteria and identification per NYS and PPS criteria including risk stratification criteria										
Task Step 2. Select an IT platform to use for the PPS										
Task Step 3. Build discrete variables to track patients into EHR/Template to identify engaged patients.										
Task Step 4. Create tracking and reporting system with IT platform with the support of the IT Committee.										
Task Step 5. Train providers on how to input patient information and										

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Mount Sinai PPS, LLC (PPS ID:34)

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
track patients in the IT Platform										
Task Step 6. Develop and implement a quiz to test the effectiveness of the training program to be administered immediately following the training to all staff who received the training										
Task Step 7. Develop ongoing webinars and trainings for providers to learn how to access, analyze and read the data inputted into the IT platform										
Task Step 8. Maintain ongoing monitoring of staff adherence and patient engagement reporting by organization. When organizations actively engaged patient trends downward, the PPS will follow-up										
Milestone #7 Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.										
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	175	200	300	350	400	600	800
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	0	0	0	50	125	150	180	230	280	480
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	0	0	0	25	35	40	50	100	200	300
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	0	0	0	0	5	10	15	20	25	35
Task Step 1. Identify baseline and gaps in adoption of ONC-certified EHR technology among PPS participants as part of the current state assessment and gap analysis process										
Task Step 2. Develop plan, detail around technical assistance services, and timeline for implementation of technical assistance program										
Task Step 3. Provide technical assistance, including purchasing decision support, dissemination of EHR implementation best practices via the PPS Learning Management System (LMS), and other modes of implementation support to be determined through the current state assessment and gap-analysis processes to										

Mount Sinai PPS, LLC (PPS ID:34)

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
providers that need to adopt a new EHR or upgrade their existing EHR - in time for achievement of PCMH III and adoption of MU eligible EHRs in DY3										
Task Step 4. Assess partner EMRs and identify bi-directional data interface capability / gaps to EHRs and other data source systems										
Task Step 5. Develop and agree on the future state and a plan to close any gaps identified in step 1										
Task Step 6. Provision MSPPS HIE eMPI for use with PPS data interfaces										
Task Step 7. Develop, implement, and deploy CBO data entry portal and associated flat-file data collection and normalization process										
Task Task 8. Implement interfaces from EHRs and other data sources to partnering RHIOs, or directly to MS PPS system										
Task Task 9. Develop, implement, and deploy Direct messaging and referrals management tools										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.										
Task Evidence-based strategies for the management and control of diabetes in the PPS designated area are developed and implemented for all participating providers. Protocols for disease management are developed and training of staff is completed.										
Task Step 1. Develop an evidence-based screening and management program to improve the health of patients with high risk, known, and out of control Diabetes (DM) in the ambulatory care and community setting.										
Task Step 2. Receive approval from Clinical Committee on the use of the DM screening and management program protocols										
Task Step 3. Work with Workforce Committee to train all necessary staff for both ambulatory care and community sites on the use of										

Mount Sinai PPS, LLC (PPS ID:34)

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
the DM screening and management tools										
Task Step 4. Develop policies and procedures for clinical committee approval on patient flow through the DM program										
Task Step 5. Train program staff and all hires on the policies and procedures for patient flow										
Task Step 6. Work with IT committee to develop new systems as well as to enhance existing IT systems to facilitate screening at risk individuals and promote the identification of patients not meeting pre-specified targets for DM.										
Task Step 7. Implement training of program staff on the new IT systems to identify DM patients										
Task Step 8. Develop and implement a quiz to test the effectiveness of the training program to be administered immediately following the training to all staff who received the training										
Task Step 9. Conduct educational sessions for providers and other allied health professionals on the best practices working through the Workforce Committee and Stakeholder Engagement Workgroup.										
Task Step 10. Identify appropriate ambulatory care and community sites in the PPS to pilot the DM program										
Task Step 11. Pilot the model at the identified PPS sites										
Task Step 12. Evaluate the results of the DM pilot against the baseline to determine if changes should be made to the model										
Task Step 13. Review PPS provider list to determine appropriate other community partners to be included in the project for each site and invite an appropriate community partners to participate										
Task Step 14. Implement the revised model in all ambulatory and community sites in the PPS										
Milestone #2 Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.										
Task PPS has engaged at least 80% of their PCPs in this activity.	1,386	1,386	1,386	1,386	1,386	1,386	1,386	1,386	1,386	1,386

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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 Step 1. With Stakeholder Engagement, identify the PCPs that are ready to pilot the project										
Task Step 2. Conduct outreach to engage additional PCPs in the PPS's network with the support of the Stakeholder Engagement Workgroup through community forums, town halls and outreach activities										
Task Step 3. Develop with Stakeholder Engagement and Workforce Committee the training materials needed for providers participating in the project										
Task Step 4. Implement with Workforce Committee the training sessions for providers participating in the project to learn about project workflow and protocols										
Task Step 5. Develop and implement a quiz to test the effectiveness of the training program to be administered immediately following the training to all staff who received the training										
Task Step 6. Hire key positions to act as liaisons between the project and PCP's (i.e. Traveling Lab tech, Physician Champion Liaison, CDE to visit practices and supervise implementation)										
Task Step 7. Install POC A1c machines in at least 10 PPS practices, including at least 5 community partner practices, to help increase interest of PCP's within the PPS										
Task Step 8. Apply for CME credits with Office of Medical Education for selected pieces of provider education covered within the project										
Task Step 9. Work with IT to develop the project dashboard to be able to track engagement and monitor use of best practices by PCPs										
Task Step 10. Work with IT to install and train on use of the dashboard to supervise implementation across PPS, which will highlight organizations metrics.										
Task Step 11. Track hemoglobin A1c testing by creating a tracking template and check with partners how best to track with the support of the IT Committee										
Task Step 12. Implement performance evaluations of participating providers and organizations including monitoring the health										

Mount Sinai PPS, LLC (PPS ID:34)

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
outcomes of the care coordinator teams										
Task Step 13. Implement a process for making improvements to participating providers and organizations if health outcomes are below average										
Milestone #3 Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient 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 established and implemented.										
Task Step 1. Identify the appropriate teams members to help identify and recruit care coordination teams to screen and manage eligible patients with known (or high risk for developing) Diabetes.										
Task Step 2. Identify the established protocols to be used for this project in conjunction with the Clinical Committee and Care Coordination Cross Functional Workgroup										
Task Step 3. Recruit team members for care coordination team to screen and manage patients using established protocols including Health home, health coaches, and Community Health Workers										
Task Step 4. Collaborate with the Care Coordination Cross Functional Workgroup and Health home, health coaches, and Community Health Workers to address the needs for this project to be consistent with the PPS to ensure uniformity and to implement a clinically interoperable system for care coordination across the PPS										
Task Step 5. Train care coordination teams on patient flow and protocols in conjunction with the Care Coordination Cross Functional Workgroup										

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Mount Sinai PPS, LLC (PPS ID:34)

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 Step 6. Develop and implement a quiz to test the effectiveness of the training program to be administered immediately following the training to all staff who received the training										
Task Step 7. Establish an annual training session to ensure that care coordination teams are up to speed on the latest protocols and well-versed in the workflow for this project										
Task Step 8. Coordinate with IT Committee and pharmacy representatives to promote medication safety and adherence, as well as develop optimal dosing best practices to share with all participating sites										
Task Step 9. All identified high-risk patients will work with Registered dietitians, Health Homes, community health coaches (care coordination team) to identify health behavior change, health literacy and patient self-efficacy.										
Task Step 10. Develop a report to monitor the effectiveness of the implemented care model, including linkages to care.										
Task Step 11. Perform a site specific assessment of information sharing capabilities to be used to define the approach and the deployment to be taken by the Care Coordinator at that site to communicate information with the PPS and other providers										
Task Step 12. Implement performance evaluations of participating providers and organizations including monitoring the health outcomes of the care coordinator teams										
Task Step 13. Implement a process for making improvements to participating providers and organizations if health outcomes are below average										
Milestone #4 Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.										
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 Step 1. Participate in Care Coordination Cross Functional Workgroup sessions to develop a Care Coordination Model for this project.										
Task Step 2. Identify criteria for data selection to identify high-risk groups. Identify reliable and valid data points to help identify high risk populations										
Task Step 3. Implement data selection and collection to identify high risk populations										
Task Step 4. Analyze data to identify high risk populations										
Task Step 5. Develop and implement improvement plan to address high-risk population. Create strategy to implement improvement plan in high risk population										
Task Step 6. Define clinical criteria for patient referral to a model such as Stanford										
Task Step 7. Select community based organization(s) group to deliver the model by outreaching to Partners with interested CBO with support of Stakeholder Engagement Workgroup										
Task Step 8. Make partnership agreement with community based organization to deliver the model with support of Stakeholder Engagement Workgroup										
Task Step 9. Train staff to deliver the model in the PPS										
Task Step 10. Develop and implement a quiz to test the effectiveness of the training program to be administered immediately following the training to all staff who received the training										
Task Step 11. Employ strategies identified in the Stanford Model, including self-management approaches and document in the EMR so the providers/care coordinators can discuss the progress with the patient on an ongoing basis by establishing linkage with health homes in PPS.										
Task Step 12. In conjunction with 3bi, implement group visits and programs, where a centralized PPS members can perform group										

Mount Sinai PPS, LLC (PPS ID:34)

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
visits.										
Task Step 13. IT committee to assist in the delivery of IT/EHR "prompts" for referrals to the model										
Task Step 14. Instruct PCP's core managers in use of QTAC electronic patient referral portal to Stanford classes.										
Task Step 15. Community group/ peer outreach to patients living in hot spots										
Task Step 16. Provide the Stanford course or other such courses to designated populations such as patients in high risk neighborhoods										
Task Step 17. Work with IT to create dashboards highlighting engagement and goal achievement by geography and by PPS partner										
Milestone #5 Ensure coordination with the Medicaid Managed Care organizations serving the target population.										
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 Step 1. Collect feedback on current agreements in place in PPS with MCOs throughout the PPS										
Task Step 2. Perform analysis on current agreements as well as opportunities for collaboration with the MCO (specifically for services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services)										
Task Step 3. Identify organizations interested in obtaining PPS agreements										
Task Step 4. Meet with MCOs to discuss possible areas of collaboration. If an MCO does not like any of the proposed areas of collaboration, the PPS will request other options from the MCO. This will be done in conjunction with 3.c.i										
Task Step 5. Execute agreements with MCOs based on above										

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Mount Sinai PPS, LLC (PPS ID:34)

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
discussions										
Milestone #6 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 PPS uses a recall system that allows staff to report which patients are overdue for which preventive services and to track when and how patients were notified of needed services.										
Task Step 1. Finalize patient inclusion criteria and identification per NYS and PPS criteria including risk stratification criteria										
Task Step 2. Select an IT platform to use for the PPS										
Task Step 3. Build discrete variables to track patients into EHR/Template to identify engaged patients.										
Task Step 4. Create tracking and reporting system with IT platform with the support of the IT Committee.										
Task Step 5. Train providers on how to input patient information and track patients in the IT Platform										
Task Step 6. Develop and implement a quiz to test the effectiveness of the training program to be administered immediately following the training to all staff who received the training										
Task Step 7. Develop ongoing webinars and trainings for providers to learn how to access, analyze and read the data inputted into the IT platform										
Task Step 8. Maintain ongoing monitoring of staff adherence and patient engagement reporting by organization. When organizations actively engaged patient trends downward, the PPS will follow-up										
Milestone #7 Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated										

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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
into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	1,000	1,386	1,386	1,386	1,386	1,386	1,386	1,386	1,386	1,386
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	680	880	880	880	880	880	880	880	880	880
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	448	648	648	648	648	648	648	648	648	648
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	40	86	86	86	86	86	86	86	86	86
Task Step 1. Identify baseline and gaps in adoption of ONC-certified EHR technology among PPS participants as part of the current state assessment and gap analysis process										
Task Step 2. Develop plan, detail around technical assistance services, and timeline for implementation of technical assistance program										
Task Step 3. Provide technical assistance, including purchasing decision support, dissemination of EHR implementation best practices via the PPS Learning Management System (LMS), and other modes of implementation support to be determined through the current state assessment and gap-analysis processes to providers that need to adopt a new EHR or upgrade their existing EHR - in time for achievement of PCMH III and adoption of MU eligible EHRs in DY3										
Task Step 4. Assess partner EMRs and identify bi-directional data interface capability / gaps to EHRs and other data source systems										
Task Step 5. Develop and agree on the future state and a plan to close any gaps identified in step 1										
Task Step 6. Provision MSPPS HIE eMPI for use with PPS data interfaces										
Task Step 7. Develop, implement, and deploy CBO data entry portal and associated flat-file data collection and normalization process										
Task Task 8. Implement interfaces from EHRs and other data sources to partnering RHIOs, or directly to MS PPS system										
Task Task 9. Develop, implement, and deploy Direct messaging 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
referrals management tools										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.	
Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.	
Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.	
Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.	
Ensure coordination with the Medicaid Managed Care organizations serving the target population.	
Use EHRs or other technical platforms to track all patients engaged in this project.	
Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.	

Milestone Review Status

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

New York State Department Of Health
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Mount Sinai PPS, LLC (PPS ID:34)

Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

DSRIP Implementation Plan Project

Mount Sinai PPS, LLC (PPS ID:34)

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

Instructions :

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

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Mount Sinai PPS, LLC (PPS ID:34)

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

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

Instructions :

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

Risk: Important to this project are patient engagement, patient education and self-management skills which lead to compliance of services. Challenges include difficulty in navigating the system, language barriers, lack of education of preventive services, access and availability to services (see #3), and lack of culturally appropriate education materials. Mitigation: Our patient and community interventions will use culturally appropriate traditional and nontraditional media and communications to build awareness of disease prevention through seminars. We will assess and improve our trust and engagement with patients in the community through culturally appropriate training programs for staff and providers by: improving cultural competency, increasing health literacy, use of motivational interviewing and patient empowerment through shared decision making.
Risk: Our patient population lives in health professional shortage areas. Complaints include long appointment wait times, languages barriers, difficulty navigating the health delivery system, lack of transportation to services and affordable care (see #5). There is a high no show rate of this population. There is difficulty tracking referrals, diagnostic test results and confirming diagnostic test results and specialist reports sent to the primary care physicians.
Mitigation: In DY1 we will assess our current workflows on care coordination to identify gaps. For PCMH accredited practices with gaps in care coordination we will use the IHI PDSA cycle to make rapid progress including IT infrastructure and staff changes. We will assess our current workflows on access and availability, phone triage, diagnostic test tracking including receipt of completed reports, referral tracking including the receipt of completed specialist reports and referrals to community based programs.
Risk: We will increase specific preventive services in concert with the New York State Prevention Agenda. Challenges include lack of continuity of care and patient engagement, difficulty in the access and availability to services, unaffordable preventive services, provider beliefs about screening, limited physician time during office visit, lack of reminders in the EMR for preventive services, difficulty getting timely completed reports of diagnostic tests, limited workforce for outreach, lack of patient education of preventive services and lack of a registry of patients who need screening.
Mitigation: Over the past 3 years, the Mount Sinai St. Luke's/Roosevelt (MSLR) and Mount Sinai Beth Israel (MSBI) hospitals have performed in the top 10 of 30 hospitals in the Healthfirst HEDIS/QARR quality incentive programs. They built systems outside the office visit using a team of patient navigators, nurses and a data analyst. This team has been successful at improving quality improvement scores for these hospitals and will be able to provide technical support to designated or newly hired staff at other practices. In DY1, we plan to collect baseline data on our screening rates of colorectal, breast cancer, cervical/chlamydia screening and preventive visits for children aged 3-6 and adolescents. We will build a registry of patients who qualify for the various preventive screenings and visits. The teams from MSLR and MSBI will share best practices with other hospitals by providing technical support through, webinars, seminars and designating clinical leads at each site to champion the PDSA cycles needed to systematically address and improve preventive screening services and/or connection to specialized disease management programs. In DY1, we will educate primary care providers on high-risk populations to screen for Hepatitis C. We will increase community awareness of Hepatitis C transmission, screening and treatment by providing culturally appropriate educational seminars through traditional and nontraditional media.

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone 1. Convene a Learning Collaborative on Colorectal Cancer, Cervical cancer, Breast Cancer and Chlamydia screening	In Progress	1. Convene a Learning Collaborative on Colorectal Cancer, Cervical cancer, Breast Cancer and Chlamydia screening	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify community members and providers to serve as the leadership for this project	In Progress	Identify community members and providers to serve as the leadership for this project	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Invite community members and providers to participate as leadership on this project	In Progress	Invite community members and providers to participate as leadership on this project	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Establish regular meetings for the project leadership	In Progress	Establish regular meetings for the project leadership	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Establish a quarterly Learning Collaborative schedule	In Progress	Establish a quarterly Learning Collaborative schedule	04/01/2016	03/31/2020	04/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task Develop the agendas (Topics) for the quarterly learning collaboratives to share best practices and review key workflows for each specific disease.	In Progress	Develop the agendas (Topics) for the quarterly learning collaboratives to share best practices and review key workflows for each specific disease.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Identify any outside experts or experts internal to the PPS that should be included in the quarterly learning collaboratives	In Progress	Identify any outside experts or experts internal to the PPS that should be included in the quarterly learning collaboratives	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Convene Learn Collaboratives quarterly and advertise within the PPS to attract providers	In Progress	Convene Learn Collaboratives quarterly and advertise within the PPS to attract providers	01/01/2017	03/31/2020	01/01/2017	03/31/2020	03/31/2020	DY5 Q4
Task Identify opportunities for quality improvement and use of rapid cycle improvement	In Progress	Identify opportunities for quality improvement and use of rapid cycle improvement methodologies	01/01/2016	03/31/2020	01/01/2016	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
methodologies								
Milestone 2. Establish a shared work plan and timeline for project implementation	In Progress	2. Establish a shared work plan and timeline for project implementation	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify members to serve on the project leadership committee	In Progress	Identify members to serve on the project leadership committee	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Schedule and hold regular project meetings to discussion strategy and an approach to implementation	In Progress	Schedule and hold regular project meetings to discussion strategy and an approach to implementation	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Project leadership committee will draft a project work plan	In Progress	Project leadership committee will draft a project work plan	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Clinical Committee will review draft work plan and provide comments/edits	In Progress	Clinical Committee will review draft work plan and provide comments/edits	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Finalize and deploy work plan	In Progress	Finalize and deploy work plan	07/01/2016	03/31/2020	07/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task Establish a system to review and modify work plan as necessary	In Progress	Establish a system to review and modify work plan as necessary	07/01/2016	03/31/2020	07/01/2016	03/31/2020	03/31/2020	DY5 Q4
Milestone 3. Schedule a Speaker Series to inform providers on national best practices, payment and care delivery for selected diseases (Colorectal Cancer, Cervical cancer, Breast Cancer and Chlamydia screening	In Progress	3. Schedule a Speaker Series to inform providers on national best practices, payment and care delivery for selected diseases (Colorectal Cancer, Cervical cancer, Breast Cancer and Chlamydia screening	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Assess interest in a Speaker Series focusing on topics identified in the CNA (Colorectal Cancer, Cervical cancer, Breast Cancer and Chlamydia screening	In Progress	Assess interest in a Speaker Series focusing on topics identified in the CNA (Colorectal Cancer, Cervical cancer, Breast Cancer and Chlamydia screening	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Identify key topics for the speaker series informed by the project participants, CNA, and project leads	In Progress	Identify key topics for the speaker series informed by the project participants, CNA, and project leads	11/01/2015	09/30/2016	11/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Identify speakers to address topics of interest	In Progress	Identify speakers to address topics of interest	04/01/2016	03/31/2020	04/01/2016	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
Task Schedule dates for speaker series accordingly on all key topics identified above	In Progress	Schedule dates for speaker series accordingly on all key topics identified above	04/01/2016	03/31/2020	04/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task Advertise the Speaker series on best practices throughout the PPS on Colorectal Cancer, Cervical cancer, Breast Cancer and Chlamydia screening	In Progress	Advertise the Speaker series on best practices throughout the PPS on Colorectal Cancer, Cervical cancer, Breast Cancer and Chlamydia screening	10/01/2016	03/31/2020	10/01/2016	03/31/2020	03/31/2020	DY5 Q4
Milestone 4. Increase specific Preventive services: Colorectal Cancer, Cervical cancer, Breast Cancer and Chlamydia screening	In Progress	4. Increase specific Preventive services: Colorectal Cancer, Cervical cancer, Breast Cancer and Chlamydia screening	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Conduct an assessment of workforce needs in order to increase access to preventive services in the PPS	In Progress	Conduct an assessment of workforce needs in order to increase access to preventive services in the PPS	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Develop a standardized clinical quality improvement work plan based on best practices which will be also be site specific	In Progress	Develop a standardized clinical quality improvement work plan based on best practices which will be also be site specific	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Develop and implement a strategic plan to link hospital and community based patient navigators as well as Health home social workers	In Progress	Develop and implement a strategic plan to link hospital and community based patient navigators as well as Health home social workers	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Develop and implement a strategic plan to link primary care with specialty care as well as diagnostic centers	In Progress	Develop and implement a strategic plan to link primary care with specialty care as well as diagnostic centers	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Pilot the Healthfirst Pay for Performance for Medicaid population for these measures across hospitals/community organizations taking part in project	In Progress	Pilot the Healthfirst Pay for Performance for Medicaid population for these measures across hospitals/community organizations taking part in project	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Retrain current staff with the aid of workforce committee	In Progress	Retrain current staff with the aid of workforce committee	10/01/2015	06/30/2018	10/01/2015	06/30/2018	06/30/2018	DY4 Q1
Task Hire and Train any additional new staff needed	In Progress	Hire and Train any additional new staff needed for the project with the aide of Workforce Committee	10/01/2015	06/30/2018	10/01/2015	06/30/2018	06/30/2018	DY4 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
for the project with the aide of Workforce Committee								
Task Assess the clinical quality improvement work plan, strategic plans and success and barriers to success for DY 1 using Healthfirst per for performance as a benchmark	In Progress	Assess the clinical quality improvement work plan, strategic plans and success and barriers to success for DY 1 using Healthfirst per for performance as a benchmark	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Identify additional payers (plans) in the PPS to expand the Pay for Performance workplan	In Progress	Identify additional payers (plans) in the PPS to expand the Pay for Performance workplan	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Expand Healthfirst Pay for Performance strategic work plan to payers involved in the PPS	In Progress	Expand Healthfirst Pay for Performance strategic work plan to payers involved in the PPS	04/01/2017	03/31/2020	04/01/2017	03/31/2020	03/31/2020	DY5 Q4
Task Expand strategic Quality improvement work plan to other Medicaid managed care plans	In Progress	Expand strategic Quality improvement work plan to other Medicaid managed care plans	04/01/2017	03/31/2020	04/01/2017	03/31/2020	03/31/2020	DY5 Q4
Task Review strategic plan on an annual basis and modify as necessary	In Progress	Review strategic plan on an annual basis and modify as necessary	07/01/2016	03/31/2020	07/01/2016	03/31/2020	03/31/2020	DY5 Q4
Milestone 5. Increase Hep C screening and Management	In Progress	5. Increase Hep C screening and Management	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Assessment of success of Hep C screening and management at the hospitals and community organizations in the PPS	In Progress	Assessment of success of Hep C screening and management at the hospitals and community organizations in the PPS	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Develop an improvement plan for implementation at hospitals and community organizations on improvements to be made to Hep C screening and management	In Progress	Develop an improvement plan for implementation at hospitals and community organizations on improvements to be made to Hep C screening and management	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Annual assessment of changes that could be made to the improvement for Hep C screening and Management	In Progress	Annual assessment of changes that could be made to the improvement for Hep C screening and Management	04/01/2016	03/31/2020	04/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task Assessment of effectiveness of linkage and referrals to speciality care when needed	In Progress	Assessment of effectiveness of linkage and referrals to speciality care when needed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task	In Progress	Develop an improvement plan for making changes to the linkage and	04/01/2016	12/31/2016	04/01/2016	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
Develop an improvement plan for making changes to the linkage and referrals to care in the PPS for this population		referrals to care in the PPS for this population						
Task Work with Stakeholder engagement to deploy improvement plan	In Progress	Work with Stakeholder engagement to deploy improvement plan	04/01/2016	03/31/2020	04/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task Work with Workforce Committee to train primary care providers, PAs and NPs in hepatitis C management through monthly meetings via webinars and other activities	In Progress	Work with Workforce Committee to train primary care providers, PAs and NPs in hepatitis C management through monthly meetings via webinars and other activities	04/01/2016	03/31/2020	04/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task Expand access and referral services for advance hepatitis cases in the PPS	In Progress	Expand access and referral services for advance hepatitis cases in the PPS	10/01/2015	03/31/2020	10/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop a database for HCC monitoring for community and hospital sites	In Progress	Develop a database for HCC monitoring for community and hospital sites	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone 6. Enhance patient engagement, patient education, self-management and compliance to preventive services	In Progress	6. Enhance patient engagement, patient education, self-management and compliance to preventive services	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Assessment of current referral process/system, care coordination, hospital/community patient navigator workforce	In Progress	Assessment of current referral process/system, care coordination, hospital/community patient navigator workforce	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Develop a strategic plan for allocation of resources for the patient engagement, education, self-management and compliance to preventive services	In Progress	Develop a strategic plan for allocation of resources for the patient engagement, education, self-management and compliance to preventive services	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Implement the strategic plan with approval from Clinical Committee	In Progress	Implement the strategic plan with approval from Clinical Committee	04/01/2016	03/31/2020	04/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task Development and implementation of education materials consistent with cultural and linguistic needs of the population detailing prevention and management of chronic diseases	In Progress	Development and implementation of education materials consistent with cultural and linguistic needs of the population detailing prevention and management of chronic diseases	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
Task Distribute education materials throughout PPS sites	In Progress	Distribute education materials throughout PPS sites	04/01/2016	09/30/2017	04/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Work with workforce to develop training curriculum for staff on use of education materials	In Progress	Work with workforce to develop training curriculum for staff on use of education materials	04/01/2016	09/30/2017	04/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Develop a database of training dates and include the number of staff trained	In Progress	Develop a database of training dates and include the number of staff trained	04/01/2016	03/31/2020	04/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task Develop a public list of training dates for patients/families	In Progress	Develop a public list of training dates for patients/families	04/01/2016	03/31/2020	04/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task Work with IT to track patient engagement, patient education, and compliance to preventive services	In Progress	Work with IT to track patient engagement, patient education, and compliance to preventive services	04/01/2016	03/31/2020	04/01/2016	03/31/2020	03/31/2020	DY5 Q4
Milestone 7. Developing best practice for coordinating with other PPS's using the MIX	In Progress	7. Developing best practice for coordinating with other PPS's using the MIX	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Create accounts for all project workgroup members on the MIX	In Progress	Create accounts for all project workgroup members on the MIX	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Create posts for key issues on MIX, as identified, for the PPS and project to post and share	In Progress	Create posts for key issues on MIX, as identified, for the PPS and project to post and share	01/01/2016	03/31/2020	01/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task Coordinate with other PPS' as appropriate for postings and responses on the MIX to share information and best practices	In Progress	Coordinate with other PPS' as appropriate for postings and responses on the MIX to share information and best practices	01/01/2016	03/31/2020	01/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task Develop and implement webinars for the project workgroup based on topics that come out the MIX around best practices	In Progress	Develop and implement webinars for the project workgroup based on topics that come out the MIX around best practices	01/01/2016	03/31/2020	01/01/2016	03/31/2020	03/31/2020	DY5 Q4
Milestone 8. Establishing Quality Improvement (QI) Teams to manage implementation pieces that require technical support	In Progress	8. Establishing Quality Improvement (QI) Teams to manage implementation pieces that require technical support	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Identify project members or leaders in the PPS to be part of the QI team	In Progress	Identify project members or leaders in the PPS to be part of the QI team	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Convene QI Team as appropriate	In Progress	Convene QI Team as appropriate	11/01/2015	03/31/2020	11/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Train QI team on protocols and types of technical support they are to provide	In Progress	Train QI team on protocols and types of technical support they are to provide	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Define deployment strategies including key baseline measures for the diseases outlined above	In Progress	Define deployment strategies including key baseline measures for the diseases outlined above	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Identify key issues that will need a technical team to address including Hard stops in the EMR, alerts, registers for patient populations (outlined above)	In Progress	Identify key issues that will need a technical team to address including Hard stops in the EMR, alerts, registers for patient populations (outlined above)	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Develop materials needed to be used by the QI team to provide support	In Progress	Develop materials needed to be used by the QI team to provide support	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Work with the IT Committee to build out functionality, which will be used to monitor progress throughout deployment	In Progress	Work with the IT Committee to build out functionality, which will be used to monitor progress throughout deployment	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone 9. Increasing access and availability to services	In Progress	9. Increasing access and availability to services	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop a strategy to increase access and availability to services in the PPS	In Progress	Develop a strategy to increase access and availability to services in the PPS	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Conduct an assessment of availability of adult/preventive/specialty services available at hospital/community organizations in the PPS	In Progress	Conduct an assessment of availability of adult/preventive/specialty services available at hospital/community organizations in the PPS	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Convene focus groups of patients to understand the challenges and problems with the availability of adult/preventive/specialty services available at hospital/community	In Progress	Convene focus groups of patients to understand the challenges and problems with the availability of adult/preventive/specialty services available at hospital/community organizations in the PPS	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
organizations in the PPS								
Task Develop a referral system or network for speciality care with tracking and follow up of referrals in conjunction with the Care Coordination Cross Functional Workgroup	In Progress	Develop a referral system or network for speciality care with tracking and follow up of referrals in conjunction with the Care Coordination Cross Functional Workgroup	11/01/2015	09/30/2016	11/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Create and implement an electronic referral system that providers in the PPS can access to gain information about services available to their patients	In Progress	Create and implement an electronic referral system that providers in the PPS can access to gain information about services available to their patients	11/01/2015	09/30/2016	11/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Design a care coordination team who will offer comprehensive care management, care coordination, health coaching, psychosocial support	In Progress	Design a care coordination team who will offer comprehensive care management, care coordination, health coaching, psychosocial support	11/01/2015	06/30/2016	11/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Recruit for members of the care coordination team	In Progress	Recruit for members of the care coordination team	11/01/2015	12/31/2016	11/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Monitor the effectiveness of the Care Coordination teams through the use of surveys	In Progress	Monitor the effectiveness of the Care Coordination teams through the use of surveys	10/01/2016	03/31/2020	10/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task Adjust the Care Coordination teams and strategy annually as needed	In Progress	Adjust the Care Coordination teams and strategy annually as needed	10/01/2016	03/31/2020	10/01/2016	03/31/2020	03/31/2020	DY5 Q4

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
1. Convene a Learning Collaborative on Colorectal Cancer, Cervical cancer, Breast Cancer and Chlamydia screening	

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
2. Establish a shared work plan and timeline for project implementation	
3. Schedule a Speaker Series to inform providers on national best practices, payment and care delivery for selected diseases (Colorectal Cancer, Cervical cancer, Breast Cancer and Chlamydia screening	
4. Increase specific Preventive services: Colorectal Cancer, Cervical cancer, Breast Cancer and Chlamydia screening	
5. Increase Hep C screening and Management	
6. Enhance patient engagement, patient education, self-management and compliance to preventive services	
7. Developing best practice for coordinating with other PPS's using the MIX	
8. Establishing Quality Improvement (QI) Teams to manage implementation pieces that require technical support	
9. Increasing access and availability to services	

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

DSRIP Implementation Plan Project

Mount Sinai PPS, LLC (PPS ID:34)

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

Instructions :

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Delivery System Reform Incentive Payment Project

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Mount Sinai PPS, LLC (PPS ID:34)

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. Individuals may not feel welcomed by providers/healthcare centers. There may also be continued resistance from some providers who inappropriately perceive they have sufficient knowledge to provide quality PEP, PrEp and/or primary care. We will work with other PPS organizations that have experience with outreach, community engagement programs that attract targeted populations, and peer education models. We will increase cultural competency training for medical providers and health services staff and use the participation of members of the target populations in the development and distribution of educational and promotional materials.
2. Funds and resources must be aligned to support needed 4cii services. Resources will be aligned to support services; Funds appropriated based on need to ensure desired outcomes. Patients will be screened for insurance eligibility and enrollment into exchange or other coverage. Uninsured partners linked to enrollers and patient assistance programs. Provide Technical Assistance to implement Sexually Transmitted Injection rapid testing through stand-alone services. Training provided on increasing 3rd party billing revenues.
3. Clinical providers and CBOs work in silos, hindering collaboration and integration. Share/align information/message among CBOs, private sector, RHIOs, and HEALTHX using open forums (MRT Exchange), best practices and resources/tools. Establish relationships with training centers and other grant funded projects. Cross collaborate with city-wide PPSs and other PPS projects to increase resource and funding opportunities; as well as increase the menu of service options for providers.
4. Currently there is no standardized certification criteria and no funding stream for peer health navigators. Create and resource peer credentialing that is integrated into DSRIP care teams, providing health education; case finding; enrollment; referral follow-up; escorts to appointments; adherence support.

5. Current HIV practitioners are aging and retiring. Young physicians replacing them generally lack the knowledge necessary to treat the disease. There is also a lack of incentives to treat HIV patients. Create HIV and cultural competency trainings for providers, using a Model of assessment, training, and ongoing implementation. Use existing training resources from CBOs, NYS, and NYC DOH. Promote NYSDOH SNP standards for HIV PCP credentialing for all MCO plans. Incorporate HIV continuum of care and treatment cascades in PPS activities and provide technical assistance for utilizing data such as VL and adherence monitoring. Trainings will incorporate information on End of AIDS campaign. Require all providers to achieve standard certifications attained via state and AAHIVM.
6. Enhance IT capacity to increase the quality of HIV care: Limited IT expertise and use of tech tools across PPS. Use capital requests for user friendly, integrated system and capacity building (equipment/staff training) for all PPS partners. Develop IT training programs for patients i.e. education on accessing charts on their smartphones/computers. Staff training will provide IT skills, tech support and incentives to use new technology.
7. Create safe environment for HIV community. Move to strength based approach in one-to-one interactions, group settings and marketing. Adapt language to create positive engagement and response. Develop materials for both individual and group interventions to address prevention, empowerment, disclosure, and assertiveness in negotiating with providers, at a minimum. Train providers about communication to increase patient's comfort and security to improve visit engagement and treatment discussion. Use peer educators to teach, encourage and empower patients.

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Mount Sinai PPS, LLC (PPS ID:34)

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 Participating in a cross PPS joint planning committee	In Progress	Participating in a cross PPS joint planning committee	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Meet with Amidacare, and the NYCDOHMH to determine course of action to create across PPS joint planning committee	Completed	Meet with Amidacare, and the NYCDOHMH to determine course of action to create a cross PPS joint planning committee	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Participate with Joint Planning Committee in determining leadership through consensus, and in determining deliverables from each PPS participant yet all partners in collaboration will be independent and have ultimate authority over own operations.	In Progress	Participate with Joint Planning Committee in determining leadership through consensus, and in determining deliverables from each PPS participant yet all partners in collaboration will be independent and have ultimate authority over own operations.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Collaborate with PPS Domain 4cii projects across New York City to determine best practices, advocacy needs, cost per unit of service, areas performing under par across all PPS projects, etc	In Progress	Collaborate with PPS Domain 4cii projects across New York City to determine best practices, advocacy needs, cost per unit of service, areas performing under par across all PPS projects, etc	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone Establishing a shared workplan and timeline for project implementation	In Progress	Establishing a shared workplan and timeline for project implementation	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify the data sources available to PPS through NYCDOHMH as well as partners in PPS itself	In Progress	Identify the data sources available to PPS through NYCDOHMH as well as partners in PPS itself	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify how often data should be collected (i.e. quarterly, semi-annually, annually) also determine our own delivery schedule for data	In Progress	Identify how often data should be collected (i.e. quarterly, semi-annually, annually) also determine our own delivery schedule for data as required	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

Mount Sinai PPS, LLC (PPS ID:34)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
as required								
Task Identify a process for how reports will be structured and how data will be created to allow for manipulation for various uses.	In Progress	Identify a process for how reports will be structured and how data will be created to allow for manipulation for various uses.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify a process for utilizing the data reports to make adjustments to the project/intervention for improved outcomes.	In Progress	Identify a process for utilizing the data reports to make adjustments to the project/intervention for improved outcomes.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Formulate a process for identifying low performing partners. Definition of acceptable performance and low performance and how to track this status yet to be determined.	In Progress	Formulate a process for identifying low performing partners. Definition of acceptable performance and low performance and how to track this status yet to be determined.	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Formulate a remediation strategy to promote better performance for the low-performers; require time to collect data to determine potential impact of strategies and involvement of each participant in the PPS. Definition of acceptable performance and low performance and how to track this status yet to be determined.	In Progress	Formulate a remediation strategy to promote better performance for the low-performers; require time to collect data to determine potential impact of strategies and involvement of each participant in the PPS. Definition of acceptable performance and low performance and how to track this status yet to be determined.	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify the types of staff needed for DY1 of DSRIP to implement this project; needs will be further developed for each remaining year of DSRIP project.	Completed	Identify the types of staff needed for DY1 of DSRIP to implement this project; needs will be further developed for each remaining year of DSRIP project.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task With Workforce Committee, Identify the existing workforce that this project can build upon	Completed	With Workforce Committee, Identify the existing workforce that this project can build upon	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Review discussed interventions, approve selected interventions, develop subcommittees for each proposed intervention	In Progress	Review discussed interventions, approve selected interventions, develop subcommittees for each proposed intervention	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone Reaching consensus on project milestones	Completed	Reaching consensus on project milestones	04/01/2015	07/15/2015	04/01/2015	07/15/2015	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
Task Create a subgroup to review metrics and lead the development of the metrics	Completed	Create a subgroup to review metrics and lead the development of the metrics	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Identify the set of supplemental metrics that will be tracked in addition to the Attachment J & the Measure Specification & Reporting Manual	Completed	Identify the set of supplemental metrics that will be tracked in addition to the Attachment J & the Measure Specification & Reporting Manual	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Solicit buy-in from the rest of the project team on supplemental metrics; ultimately vote for consensus based on presentation by all partners participating in project.	Completed	Solicit buy-in from the rest of the project team on supplemental metrics; ultimately vote for consensus based on presentation by all partners participating in project.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Milestone Reaching agreement on shared resources	In Progress	Reaching agreement on shared resources	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify party responsible for collecting the data: e.g. NYCDOHMH, NYSDOH, PPS	In Progress	Identify party responsible for collecting the data: e.g. NYCDOHMH, NYSDOH, PPS	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Create a portfolio/inventory of current programs that have potential impact upon DSRIP goals and objectives and are now in operation by PPS partners	Completed	Create a portfolio/inventory of current programs that have potential impact upon DSRIP goals and objectives and are now in operation by PPS partners	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Analyze the inputs to identify implications for DSRIP that can then be leveraged for training opportunities across the PPS; analysis will be ongoing over the course of the PPS but the first years agreement has been achieved.	In Progress	Analyze the inputs to identify implications for DSRIP that can then be leveraged for training opportunities across the PPS; analysis will be ongoing over the course of the PPS but the first years agreement has been achieved.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Create a training syllabus which can be distributed to all PPS partners	In Progress	Create a training syllabus which can be distributed to all PPS partners	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify gaps in training that can be filled by new interventions	In Progress	Identify gaps in training that can be filled by new interventions	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify gaps that may require the creation of new training modules beyond the current inventory	In Progress	Identify gaps that may require the creation of new training modules beyond the current inventory	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Mount Sinai PPS, LLC (PPS ID:34)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task With Workforce Committee, identify staffing resources for DY1 of DSRIP.	In Progress	With Workforce Committee, identify staffing resources for DY1 of DSRIP.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Work toward HEI status for HRC as a preferred provider of LGBT health services. Inventory partners to determine who has the designation and who would be eligible as well as benefits to certification.	In Progress	Work toward HEI status for HRC as a preferred provider of LGBT health services. Inventory partners to determine who has the designation and who would be eligible as well as benefits to certification.	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Actively participate in Stakeholder Engagement Cross Functional Workgroup sessions	In Progress	Actively participate in Stakeholder Engagement Cross Functional Workgroup sessions	08/13/2015	03/31/2020	08/13/2015	03/31/2020	03/31/2020	DY5 Q4
Task Actively participate in Care Coordination Cross Functional Workgroup sessions	In Progress	Actively participate in Care Coordination Cross Functional Workgroup sessions	07/20/2015	03/31/2020	07/20/2015	03/31/2020	03/31/2020	DY5 Q4
Task Achieve PCMH level 3 for all clinical providers, aligned with 2.a.i process	On Hold	Achieve PCMH level 3 for all clinical providers, aligned with 2.a.i process	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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
Participating in a cross PPS joint planning committee	
Establishing a shared workplan and timeline for project implementation	
Reaching consensus on project milestones	The 4.c.ii project work group decided to review the project's metrics in the Measurement Specification and Reporting Manual and explore any additional measures that might be useful. To that end, a subgroup was formed to lead this effort and develop any supplemental metrics for the group. At the work group meeting on May 13, 2015 the subgroup presented their recommendations. The following week, May 20, 2015, the subgroup's recommendations were discussed and consensus reached on five additional metrics:

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
	1. Engaged in Care as measured by number of people who had two visits for primary care for HIV related care with at least one visit during each half of the past year. 2. Viral Load Monitoring as measured by the number of people who had two viral load tests performed with at least one test during each half of the past year. 3. Syphilis Screening as measured by the number of people living with HIV/AIDS, ages 19 years and older. 4. Viral Load Suppression as measured by the number of people whose most recent viral load result was below 200 copies. 5. Syphilis screening is performed annually. So done once in each calendar year.
Reaching agreement on shared resources	

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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Mount Sinai PPS, LLC (PPS ID:34)

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

Instructions :

New York State Department Of Health
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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 'Mount Sinai PPS, LLC ', 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:	MOUNT SINAI HOSPITAL
Secondary Lead PPS Provider:	
Lead Representative:	Jill Huck
Submission Date:	12/16/2015 08:21 AM

Comments:

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Status Log				
Quarterly Report (DY,Q)	**Status**	**Lead Representative Name**	**User ID**	**Date Timestamp**
DY1, Q2	Adjudicated	Jill Huck	sv590918	12/31/2015 09:26 PM
DY1, Q2	Submitted	Jill Huck	jh609205	12/16/2015 08:21 AM
DY1, Q2	Returned	Jill Huck	emcgill	12/01/2015 12:25 PM
DY1, Q2	Submitted	Jill Huck	jh609205	10/30/2015 02:28 PM
DY1, Q2	In Process		ETL	10/01/2015 12:14 AM

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Comments Log			
Status	**Comments**	**User ID**	**Date Timestamp**
Returned	DY1 Q2 Quarterly Report has been returned for remediation.	emcgill	12/01/2015 12:25 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
	IPQR Module 4.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed

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Section	Module Name	Status
	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
	IPQR Module 7.6 - Key Stakeholders	Completed

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Section	Module Name	Status
	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
	IPQR Module 10.8 - IA Monitoring	

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

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Project ID	Module Name	Status
	IPQR Module 3.a.iii.5 - IA Monitoring	
3.b.i	IPQR Module 3.b.i.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 3.b.i.2 - Patient Engagement Speed	Completed
	IPQR Module 3.b.i.3 - Prescribed Milestones	Completed
	IPQR Module 3.b.i.4 - PPS Defined Milestones	Completed
	IPQR Module 3.b.i.5 - IA Monitoring	
3.c.i	IPQR Module 3.c.i.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 3.c.i.2 - Patient Engagement Speed	Completed
	IPQR Module 3.c.i.3 - Prescribed Milestones	Completed
	IPQR Module 3.c.i.4 - PPS Defined Milestones	Completed
	IPQR Module 3.c.i.5 - IA Monitoring	
4.b.ii	IPQR Module 4.b.ii.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 4.b.ii.2 - PPS Defined Milestones	Completed
	IPQR Module 4.b.ii.3 - IA Monitoring	
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 & Ongoing	
	Module 1.5 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
Section 02	Module 2.1 - Prescribed Milestones		
	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	
	Milestone #9	Pass & Ongoing	
Section 03	Module 3.1 - Prescribed Milestones		
	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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Section	Module Name / Milestone #	Review Status	
	Milestone #8	Pass & Ongoing	
Section 04	Module 4.1 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
Section 05	Module 5.1 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
	Milestone #3	Pass & Ongoing	
	Milestone #4	Pass & Ongoing	
	Milestone #5	Pass & Ongoing	
Section 06	Module 6.1 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
Section 07	Module 7.1 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
Section 08	Module 8.1 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
Section 09	Module 9.1 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
Section 11	Module 11.2 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
	Milestone #3	Pass & Ongoing	

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Section	Module Name / Milestone #	Review Status	
	Milestone #4	Pass & Ongoing	
	Milestone #5	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	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	
2.b.iv	Module 2.b.iv.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.b.iv.3 - Prescribed Milestones		
	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	
2.b.viii	Module 2.b.viii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.b.viii.3 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	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	
2.c.i	Module 2.c.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.c.i.3 - Prescribed Milestones		
	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	
3.a.i	Module 3.a.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.a.i.3 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
	Milestone #3	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #4	Pass & Ongoing	
	Milestone #5	Pass & Ongoing	
	Milestone #6	Pass & Ongoing	
	Milestone #7	Pass & Ongoing	
	Milestone #8	Pass & Ongoing	
	Milestone #9	Pass & Ongoing	
	Milestone #10	Pass & Ongoing	
	Milestone #11	Pass & Ongoing	
	Milestone #12	Pass & Ongoing	
	Milestone #13	Pass & Ongoing	
	Milestone #14	Pass & Ongoing	
	Milestone #15	Pass & Ongoing	
3.a.iii	Module 3.a.iii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.a.iii.3 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
	Milestone #3	Pass & Ongoing	
	Milestone #4	Pass & Ongoing	
3.b.i	Module 3.b.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.b.i.3 - Prescribed Milestones		
	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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Project ID	Module Name / Milestone #	Review Status	
	Milestone #7	Pass & Ongoing	
	Milestone #8	Pass & Ongoing	
	Milestone #9	Pass & Ongoing	
	Milestone #10	Pass & Ongoing	
	Milestone #11	Pass & Ongoing	
	Milestone #12	Pass & Ongoing	
	Milestone #13	Pass & Ongoing	
	Milestone #14	Pass & Ongoing	
	Milestone #15	Pass & Ongoing	
	Milestone #16	Pass & Ongoing	
	Milestone #17	Pass & Ongoing	
	Milestone #18	Pass & Ongoing	
	Milestone #19	Pass & Ongoing	
	Milestone #20	Pass & Ongoing	
3.c.i	Module 3.c.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.c.i.3 - Prescribed Milestones		
	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	
4.b.ii	Module 4.b.ii.2 - PPS Defined Milestones	Pass & Ongoing	
4.c.ii	Module 4.c.ii.2 - PPS Defined Milestones	Pass & Ongoing	