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

DSRIP Implementation Plan Project

SBH Health System (PPS ID:36)

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

DSRIP Implementation Plan Project

SBH Health System (PPS ID:36)

Quarterly Report - Implementation Plan for SBH Health System

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

Status By Section

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

Status By Project

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

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

DSRIP Implementation Plan Project

SBH Health System (PPS ID:36)

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	26,930,696	28,699,271	46,410,322	41,096,163	26,930,696	170,067,148
Cost of Project Implementation & Administration	**12,926,734**	**13,775,650**	**22,276,955**	**19,726,158**	**12,926,734**	**81,632,231**
Administration	10,876,612	7,060,285	6,279,660	6,468,050	6,662,091	37,346,698
Project Implementation	2,050,122	6,715,365	15,997,295	13,258,108	6,264,643	44,285,533
Revenue Loss	**4,039,604**	**4,304,891**	**6,961,548**	**6,164,425**	**4,039,604**	**25,510,072**
Internal PPS Provider Bonus Payments	**5,924,753**	**6,313,840**	**10,210,271**	**9,041,156**	**5,924,753**	**37,414,773**
Cost of non-covered services	**1,346,535**	**1,434,964**	**2,320,516**	**2,054,808**	**1,346,535**	**8,503,358**
Other	**2,693,070**	**2,869,927**	**4,641,032**	**4,109,616**	**2,693,070**	**17,006,715**
Contingency	2,693,070	2,869,927	4,641,032	4,109,616	2,693,070	17,006,715
Total Expenditures	**26,930,696**	**28,699,272**	**46,410,322**	**41,096,163**	**26,930,696**	**170,067,149**
Undistributed Revenue	**0**	**0**	**0**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Pass & Complete	

NYS Confidentiality – High

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

DSRIP Implementation Plan Project

SBH Health System (PPS ID:36)

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
26,930,696	170,067,148	18,978,185	162,114,637

Budget Items	DY1 Q3 Quarterly Amount - Update	Cumulative Spending to Date (DY1 - DY5)	Remaining Balance in Current DY	Percent Remaining in Current DY	Cumulative Remaining Balance	Percent Remaining of Cumulative Balance
Cost of Project Implementation & Administration	**2,091,386**	**7,952,511**	**4,974,223**	**38.48%**	**73,679,720**	**90.26%**
Administration	993,164					
Project Implementation	1,098,222					
Revenue Loss	**0**	**0**	**4,039,604**	**100.00%**	**25,510,072**	**100.00%**
Internal PPS Provider Bonus Payments	**0**	**0**	**5,924,753**	**100.00%**	**37,414,773**	**100.00%**
Cost of non-covered services	**0**	**0**	**1,346,535**	**100.00%**	**8,503,358**	**100.00%**
Other	**0**	**0**	**2,693,070**	**100.00%**	**17,006,715**	**100.00%**
Contingency	0					
Total Expenditures	**2,091,386**	**7,952,511**				

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

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

DSRIP Implementation Plan Project

SBH Health System (PPS ID:36)

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

SBH Health System (PPS ID:36)

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	26,930,696	28,699,271	46,410,322	41,096,163	26,930,696	170,067,148
Practitioner - Primary Care Provider (PCP)	1,553,901	1,607,159	3,420,441	2,784,265	1,386,931	10,752,697
Practitioner - Non-Primary Care Provider (PCP)	675,960	717,482	1,327,335	1,160,967	693,465	4,575,209
Hospital	4,263,129	5,639,407	9,690,475	10,541,166	9,594,060	39,728,237
Clinic	1,553,901	2,673,226	4,873,850	2,977,914	1,386,931	13,465,822
Case Management / Health Home	2,738,852	5,083,903	8,312,658	4,845,979	2,433,862	23,415,254
Mental Health	810,614	1,408,217	2,982,505	2,065,860	1,151,287	8,418,483
Substance Abuse	371,105	347,262	936,560	918,499	528,515	3,101,941
Nursing Home	1,268,436	1,334,516	2,441,183	2,321,933	1,528,317	8,894,385
Pharmacy	202,519	198,025	539,288	663,703	504,951	2,108,486
Hospice	1,012,594	932,726	1,675,413	1,469,188	693,465	5,783,386
Community Based Organizations	1,621,228	1,678,908	3,930,954	3,400,707	1,844,753	12,476,550
All Other	0	0	0	0	0	0
PPS PMO	10,858,457	7,078,440	6,279,660	7,945,982	5,184,159	37,346,698
Total Funds Distributed	**26,930,696**	**28,699,271**	**46,410,322**	**41,096,163**	**26,930,696**	**170,067,148**
Undistributed Revenue	**0**	**0**	**0**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

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SBH Health System (PPS ID:36)

Module Review Status

Review Status	IA Formal Comments
Pass & Complete	

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

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SBH Health System (PPS ID:36)

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
26,930,696	170,067,148	18,978,365	162,114,817

Funds Flow Items	DY1 Q3 Quarterly Amount - Update	Total Amount Disbursed	Percent Spent By Project										DY Adjusted Difference	Cumulative Difference
			Projects Selected By PPS											
			2.a.i	2.a.iii	2.b.iii	2.b.iv	3.a.i	3.b.i	3.c.i	3.d.ii	4.a.iii	4.c.ii		
Practitioner - Primary Care Provider (PCP)	0	0	0	0	0	0	0	0	0	0	0	0	1,553,901	10,752,697
Practitioner - Non-Primary Care Provider (PCP)	0	0	0	0	0	0	0	0	0	0	0	0	675,960	4,575,209
Hospital	129,167	5,701,506	19	6	14	13	5	9	10	10	7	7	-1,438,377	34,026,731
Clinic	27,500	27,500	17	13	12	12	11	8	9	9	3	6	1,526,401	13,438,322
Case Management / Health Home	0	0	0	0	0	0	0	0	0	0	0	0	2,738,852	23,415,254
Mental Health	0	188,606	0	0	0	0	0	0	0	0	0	0	622,008	8,229,877
Substance Abuse	0	0	0	0	0	0	0	0	0	0	0	0	371,105	3,101,941
Nursing Home	0	0	0	0	0	0	0	0	0	0	0	0	1,268,436	8,894,385
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	202,519	2,108,486
Hospice	0	0	0	0	0	0	0	0	0	0	0	0	1,012,594	5,783,386
Community Based Organizations	0	100,000	0	0	0	0	0	0	0	0	0	0	1,521,228	12,376,550
All Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PPS PMO	1,934,719	1,934,719	16	13	12	12	11	8	8	9	6	5	8,923,738	35,411,979
Total Funds Distributed	**2,091,386**	**7,952,331**												

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

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

Administrative Expenses allocated to "Hospital" are reclassified as PPS PMO

Module Review Status

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

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SBH Health System (PPS ID:36)

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.	05/01/2015	03/31/2016	05/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task Obtain final attribution and valuation	Completed	Receive final PPS attribution and valuation from the state.	05/12/2015	12/31/2015	05/12/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish schedule for flow of funds	Completed	Define PPS baseline funding schedule and distribution plan. Present for review and approval by the Executive Committee.	06/01/2015	07/31/2015	06/01/2015	07/31/2015	09/30/2015	DY1 Q2	
Task Share flow of funds information with PPS members	Completed	Conduct All PPS meeting describing the baseline funding schedule and approach for the development of project and provider specific funding schedules to be included as an attachment in the Master DSRIP Service Agreement (MDSA) as a rolling statement of work. .	08/01/2015	10/31/2015	08/01/2015	10/31/2015	12/31/2015	DY1 Q3	
Task Develop budgets	Completed	Develop initial project specific budgets based on specific clinical project implementation requirements and performance expectations using the baseline funding schedule as a guidepost. Present for review and approval to the Executive Committee.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Finalize funding schedules	Completed	Finalize the initial project and partner specific funding schedules with PPS partners to be included as an attachment in the MDSA as a rolling statement of work.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Initiate reporting process	Completed	Initiate quarterly reporting process for earned waiver revenue and partner payments.	08/15/2015	09/30/2015	08/15/2015	09/30/2015	09/30/2015	DY1 Q2	
Task	Completed	Define annual review and update process for the PPS	10/01/2015	11/30/2015	10/01/2015	11/30/2015	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
Establish annual review and update process		baseline funding schedule and distribution plan. Present for review and approval by the Executive Committee.							
Task Establish criteria for bonus payments and revenue loss funds	In Progress	Engage PPS Committees and stakeholders to develop criteria and processes for administering DSRIP internal PPS provider bonus payments and revenue loss funds.	10/15/2015	01/31/2016	10/15/2015	01/31/2016	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
Complete funds flow budget and distribution plan and communicate with network	Update: The funds flow budget and payment schedule by quarter was presented to the Finance & Sustainability subcommittee and received approval; BPHC is awaiting final approval from the Executive Committee, early in DY1Q4. A quarterly reporting process has been established in which BPHC presents monthly reports to the Finance & Sustainability Subcommittee on its actual funds flow, as well as a distribution forecast based on actual waiver revenue received and funds expected. An annual review and update process for the PPS baseline funding schedule and distribution plan has been defined. Baseline funding is based on patient attribution and PPS members' needs. A Request for Information (RFI), our PPS-wide clinical integration (funding) needs assessment, was distributed among the major primary care organization partners, and the CSO is currently finalizing the Assessment of the responses. Partner-specific funding will be determined according to needs identified in relation to the population served, and will be approved by the Executive Committee during DY1Q4. This milestone is on track for completion.

Milestone Review Status

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

New York State Department Of Health
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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

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

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IPQR Module 1.7 - IA Monitoring

Instructions :

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

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SBH Health System (PPS ID:36)

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	05/01/2015	04/01/2015	05/01/2015	06/30/2015	DY1 Q1	YES
Task Establish committee charters	Completed	Develop and finalize charters for Executive Committee, Nominating Committee, Quality and Care Innovation Sub-Committee, Finance and Sustainability Sub-Committee, Workforce Sub-Committee and Information Technology Sub-Committee (collectively, the "Governance Charters"). The Governance Charters will describe the responsibilities of each committee, the process for appointing members to each committee, meeting frequency and the consensus-based decision making process of each committee.	04/01/2015	05/01/2015	04/01/2015	05/01/2015	06/30/2015	DY1 Q1	
Task Appoint EC members	Completed	Appoint members of the Executive Committee.	04/23/2015	05/01/2015	04/23/2015	05/01/2015	06/30/2015	DY1 Q1	
Task Initiate EC work	Completed	Convene Executive Committee, provide orientation to Executive Committee on roles and responsibilities, and initiate Committee work.	04/23/2015	04/23/2015	04/23/2015	04/23/2015	06/30/2015	DY1 Q1	
Task Appoint Sub-Committee members	Completed	Appoint members of the Quality and Care Innovation Sub-Committee, Finance and Sustainability Sub-Committee, Workforce Sub-Committee and Information Technology Sub-Committee (collectively, the "Sub-Committees").	04/23/2015	05/01/2015	04/23/2015	05/01/2015	06/30/2015	DY1 Q1	
Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Completed	This milestone must be completed by 12/31/2015. Clinical Quality Committee charter and committee structure chart	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task	Completed	Develop and finalize charter for Quality and Care Innovation	04/01/2015	05/01/2015	04/01/2015	05/01/2015	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
Establish QCIS charter		Sub-Committee. The charter will describe the responsibilities of the Quality and Care Innovation Sub-Committee, the process for appointing members to the Quality and Care Innovation Sub-Committee, meeting frequency and the consensus-based decision making process of the Quality and Care Innovation Sub-Committee.							
Task Establish QCIS membership	Completed	Solicit and appoint members of the Quality and Care Innovation Sub-Committee. The Sub-Committee is composed of PPS Members with clinical experience relevant to the selected projects, including (but not limited to) participation of members with expertise in primary care, emergency medicine, intellectual and developmental disabilities, behavioral and mental health, long-term care, housing services and substance abuse services.	04/01/2015	05/01/2015	04/01/2015	05/01/2015	06/30/2015	DY1 Q1	
Task Initiate QCIS work	Completed	Convene Quality and Care Innovation Sub-Committee, review charter, and initiate Quality and Care Innovation Sub-Committee work.	06/05/2015	06/05/2015	06/05/2015	06/05/2015	06/30/2015	DY1 Q1	
Task Create work groups	Completed	Establish project-specific work groups comprised of partner providers and CBOs (e.g., primary care physicians, subspecialists, nurses, mental health professionals and social workers) to develop detailed clinical operational plans for deployment of the clinical projects under the oversight of the Quality and Care Innovation Sub-Committee.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Select membership for rapid deployment collaboratives	Completed	Work with key PPS organizations and CBOs to select thought leaders from among the major practitioner groups/CBOs (including primary care physicians, subspecialists, nurses, mental health professionals, social workers, and peers) who will form rapid deployment colloaboratives that will develop engagement strategies specific to the PPS quality improvement agenda and DSRIP projects. These workgroups will also serve as project clinical quality councils.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish reporting format and schedule	Completed	Develop a Quality and Care Innovation Sub-Committee and rapid deployment collaboratives reporting format and schedule to track progress and metrics.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #3	Completed	This milestone must be completed by 9/30/2015. Upload of	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES

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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
Finalize bylaws and policies or Committee Guidelines where applicable		bylaws and policies document or committee guidelines.							
Task Establish PPS governance by-laws	Completed	Develop and finalize approval of Governance Charters, which are the functional equivalent of by-laws for the PPS governance structure.	04/01/2015	04/01/2015	04/01/2015	04/01/2015	06/30/2015	DY1 Q1	
Task Establish PPS polices and procedures	Completed	Develop and finalize PPS policies and procedures, including dispute resolution policy, conflicts of interest policy, anti-trust policy, data sharing policies, and policies regarding non- or under-performing partners. The Executive Committee and SBH will approve policies and procedures.	07/23/2015	09/30/2015	07/23/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Share policies and procedures	Completed	Share policies and procedures with other Sub-Committees and partner organizations.	07/23/2015	09/30/2015	07/23/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Establish process for review of policies and procedures	Completed	Develop a process and schedule for reviewing, revising and updating policies and procedures.	07/23/2015	09/30/2015	07/23/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #4 Establish governance structure reporting and monitoring processes	Completed	This milestone must be completed by 12/31/2015. Governance and committee structure document, including description of two-way reporting processes and governance monitoring processes	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Establish reporting framework across PPS governance	Completed	Designate reporting oversight responsibilities to Executive Committee, Quality and Care Innovation Sub-Committee and Finance and Sustainability Sub-Committee. BPHC Senior Director for Quality Management and Analytics will be responsible for working with the Quality and Care Innovation Sub-Committee on performance reporting activities.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Establish procedures for meeting minutes	Completed	Draft procedures by which the Executive Committee and Committees will (a) keep minutes and (b) send minutes to the Executive Committee, other Sub-Committees and SBH, as applicable.	07/23/2015	09/30/2015	07/23/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Establish governance section in online portal for report and information sharing purposes.	Completed	Establish governance section on an online document-sharing portal to post minutes, reports and other key documents from Executive Committee and Sub-Committees.	04/01/2015	04/23/2015	04/01/2015	04/23/2015	06/30/2015	DY1 Q1	
Task Develop project tracking dashboard	Completed	Create a dashboard to track quarterly progress of each DSRIP project.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop MSAs with schedules	Completed	Create Master Service Agreements with schedules to be executed with each PPS member receiving DSRIP funds that	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
		will hold each member responsible for tracking their progress toward achieving identified milestones, performance on metrics and reporting to the BPHC Central Services Organization (CSO).							
Task Compile performance data for review	Completed	Compile performance data into reports highlighting trends and gaps and submit to the appropriate subcommittee(s) for review.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop feedback mechanisms	Completed	Create mechanisms for feedback to members on their performance.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish response mechanisms for underperformance	Completed	Develop policy and procedure on how to address underperformance by member organizations.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish milestones and metrics for organizational work streams	Completed	Identify key milestones and metrics quarterly for organizational workstreams (finance, IT, workforce, governance and clinical).	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish CSO Planning Team	Completed	Establish CSO Planning Team to coordinate the work of all the governance committees/subcommittees.	06/01/2015	06/15/2015	06/01/2015	06/15/2015	06/30/2015	DY1 Q1	
Task Develop DSRIP planning calendars	Completed	Develop DSRIP planning calendars for each committee/subcommittee to ensure that overlapping and interdependent tasks and responsibilities vis-a-vis quarterly DSRIP milestones and metrics are met.	06/01/2015	06/15/2015	06/01/2015	06/15/2015	06/30/2015	DY1 Q1	
Task Establish regular cross-committee conference calls	Completed	Establish monthly conference calls of the subcommittee chairs/co-chairs to review their respective DSRIP planning calendars and meeting minutes and identify action items for the coming month.	07/01/2015	07/17/2015	07/01/2015	07/17/2015	09/30/2015	DY1 Q2	
Task Create and disseminate tools for quarterly reporting by partners	Completed	Identify, develop and deploy tools for collecting and reporting quarterly data for all partner organizations. Theese tools will be used by our CSO clinical projects management staff, as well as DSRIP Liaisons/Senior Program Managers located at PPS Partner sites , to track each DSRIP project and communicate in real-time to monitor progress.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	Completed	Community engagement plan, including plans for two-way communication with stakeholders.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	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
Task Create an inventory of CBO services.	Completed	Finalize and administer survey to create an inventory of services offered by CBOs within the PPS area that participate in activities that impact population health. The PPS area covers all the neighborhoods and communities of the Bronx. The CSO implemented a survey of current CBO members of our PPS to profile their services, interest and capacity to participate as partner organizations in our DSRIP projects. Our current CBO members encompass a wide array of service providers, including services for intellectual and development disabilities(IDD); food banks, community gardens and farmer's markets; foster children agencies; HIV prevention/outreach and social services; housing services, including advocacy groups, housing providers and homeless services; individual employment support services; financial assistance and support, including clothing and furniture banks; not-for profit health and welfare agencies; nutrition and exercise programs; peer, family support, training and self advocacy organizations; reentry organizations and alternatives to incarceration; transportation services; youth development programs; syringe access programs; and services for special populations, including immigrants, LGBT, seniors, uninsured and women.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Recruit CBO representatives for engagement in committee work	Completed	Director of Collaboration to recruit representatives from CBOs to participate in patient engagement groups, Sub-Committees and the Executive Committee, as appropriate.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop community engagement strategy	Completed	Identify strategies to facilitate connections with the community and develop associated time line.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Establish community engagement plan	Completed	Draft community engagement plan and obtain feedback from patient engagement group and Executive Committee.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop budget for community engagement	Completed	Review community engagement plan with Director of Collaboration to determine costs associated with outreach and the development and production of communication and marketing materials.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Finalize community engagement budget	Completed	Obtain approval from Finance and Sustainability Subcommittee for community engagement budget.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #6	In Progress	Signed CBO partnership agreements or contracts.	04/01/2015	06/30/2016	04/01/2015	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
Finalize partnership agreements or contracts with CBOs									
Task Identify partner CBOs for DY1 contracts	Completed	Identify CBOs to contract with in DY1, via: 1) project-specific work groups identifying CBOs to target and engage based on the services they provide and how those services address the predominant social determinants of health in the Bronx by primary condition (diabetes, CVD, asthma, etc), based on the initial Bronx CNA (November 2014); 2) CSO implement a survey of current CBO members of our PPS to profile their services and their interest and capacity to participate as partner organizations in our DSRIP projects; 3) hosting forums with groups of CBOs designed to inform them about the CBO role as member organizations and to facilitate their participation in our DSRIP projects.	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Draft MSA for CBOs	Completed	Draft Master Services Agreement (MSA) and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure.	04/01/2015	05/21/2015	04/01/2015	05/21/2015	06/30/2015	DY1 Q1	
Task Obtain feedback on MSA	Completed	Solicit comments on MSA from PPS members through distribution to members, opportunity for submission of written comments, and review in Committee and Sub-Committee meetings.	05/21/2015	06/08/2015	05/21/2015	06/08/2015	06/30/2015	DY1 Q1	
Task Finalize MSA	Completed	Finalize MSA.	07/01/2015	07/23/2015	07/01/2015	07/23/2015	09/30/2015	DY1 Q2	
Task Finalize CBO project schedules	In Progress	Develop and finalize CBO project schedules in concert with Clinical Operational Plans.	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Review schedules with CBO partners	In Progress	Review and negotiate project schedules with CBOs.	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Execute agreements with CBOs	In Progress	Execute agreements and project schedules for CBOs.	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1	
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.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Identify state and local agencies	Completed	Identify all state and local agencies in the PPS area. Initiate contacts with various agencies and programs of the New York	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		City Department of Health and Mental Hygiene, including Healthy Homes Program (for asthma services); Primary Care Information Project (health IT); NYC Reach (practice transformation support services to receive PCMH recognition under 2014 standard); Center for Health Equity; Bronx District Public Health Office; Correctional Health Services and services for HIV and treating tobacco use.							
Task Identify additional agencies for engagement and participation	Completed	Director of Collaboration will work with existing partners to identify additional agencies for engagement and participation in DSRIP implementation	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Recruit agency representatives for engagement in committee work	Completed	Director of Collaboration to recruit staff from state and local agencies to serve as liaisons to PPS.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish agency coordination plan	Not Started	Develop a plan for coordinating agency activities and obtain feedback from agencies on draft plan.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
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).	05/22/2015	02/28/2016	05/22/2015	02/28/2016	03/31/2016	DY1 Q4	NO
Task Establish and convene Workforce Project Team	Completed	Establish and convene Workforce Project Team (including Workforce Sub-Committee, Workforce Workgroups, Director of Workforce Innovation and other supportive staff from the CSO, 1199 SEIU Training and Employment Funds (TEF), subject matter experts and stakeholders) responsible for implementing and executing workforce activities.	05/22/2015	08/30/2015	05/22/2015	08/30/2015	09/30/2015	DY1 Q2	
Task Identify workforce engagement needs	Completed	Identify all levels of the workforce that will need to be engaged to ensure the successful implementation of DSRIP projects, by identifying the requirements for each DSRIP project, the new services that will be delivered, the types and estimated numbers of workers needed for each DSRIP project and the competencies, skills, training and roles required for each DSRIP project.	07/17/2015	12/31/2015	07/17/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Convene Workforce Communications Workgroup	Completed	Convene Workforce Communications Workgroup (under the Workforce Committee) to recommend strategies to identify communication needs, key messages, and communication channels to ensure frontline workers are informed of and	05/22/2015	07/31/2015	05/22/2015	07/31/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		engaged in the deployment of DSRIP projects.							
Task Obtain input on workforce communication and engagement plan	Completed	Develop workforce communication and engagement plan goals, objectives and potential barriers and obtain feedback from Workforce Communications Workgroup.	07/31/2015	10/30/2015	07/31/2015	10/30/2015	12/31/2015	DY1 Q3	
Task Draft workforce communication and engagement plan	Completed	Draft workforce communication plan, including channels to be used/audiences/ milestones to measure effectiveness, and obtain feedback from all levels of the workforce and the Workforce Communications Workgroup.	07/31/2015	12/31/2015	07/31/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Finalize workforce communication and engagement plan	In Progress	Obtain sign-off on workforce communication and engagement plan from Workforce Sub-Committee and Executive Committee.	11/09/2015	02/28/2016	11/09/2015	02/28/2016	03/31/2016	DY1 Q4	
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 Draft MSA for CBOs	Completed	Draft Master Services Agreement (MSA) and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure.	04/01/2015	05/21/2015	04/01/2015	05/21/2015	06/30/2015	DY1 Q1	
Task Obtain feedback on MSA	Completed	Solicit comments on MSA from PPS members through distribution to members, opportunity for submission of written comments, and review in Committee and Sub-Committee meetings.	05/21/2015	06/08/2015	05/21/2015	06/08/2015	06/30/2015	DY1 Q1	
Task Finalize MSA	Completed	Finalize MSA	07/01/2015	07/23/2015	07/01/2015	07/23/2015	09/30/2015	DY1 Q2	
Task Finalize CBO project schedules	In Progress	Develop and finalize CBO project schedules in concert with Clinical Operational Plans.	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Review schedules with CBO partners	In Progress	Review and negotiate project schedules with CBOs.	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Execute MSA with a.i.r. nyc	In Progress	Execute agreement and project schedules with a.i.r. nyc	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Execute MSA with Health People	Not Started	Execute agreement and project schedules with Health People	01/01/2016	06/30/2016	01/01/2016	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.
Finalize bylaws and policies or Committee Guidelines where applicable	If there have been changes, please describe those changes and upload any supporting documentation as necessary.	Please state if there have been any changes during this reporting quarter. Please state yes or no in the corresponding narrative box.

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize governance structure and sub-committee structure	lrobsbh	Other	36_MDL0203_1_3_20160121134124_Gov_M1_Meeting_Schedule_DY1Q3.xlsx	Meeting schedules	01/21/2016 01:41 PM
	lrobsbh	Rosters	36_MDL0203_1_3_20160121134034_Gov_M1_Governance_Committee_DY1Q3.xlsx	Governance committee.	01/21/2016 01:40 PM
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	lrobsbh	Other	36_MDL0203_1_3_20160121135055_Gov_M2_Meeting_Schedule_DY1Q3.xlsx	Meeting schedule	01/21/2016 01:50 PM
	lrobsbh	Other	36_MDL0203_1_3_20160121134953_Gov_M2_Clinical_Governance_Committees_DY1Q3.xlsx	Clinical governance committees	01/21/2016 01:49 PM
	lrobsbh	Other	36_MDL0203_1_3_20160121134849_Gov_M2_BPHC_QCI_Subcommittee_Charter.pdf	Quality and Care Innovation Subcommittee charter	01/21/2016 01:48 PM
	lrobsbh	Other	36_MDL0203_1_3_20160121134714_Gov_M2_BPHC_Governance_Structure_-_Organizational_Chart_w-IWGs.pdf	BPHC governance structure organizational chart.	01/21/2016 01:47 PM
Establish governance structure reporting and monitoring processes	zstopak	Policies/Procedures	36_MDL0203_1_3_20160127183427_Governance_M4_BPHC_Reporting_and_Monitoring_Processes.pdf	Reporting and Monitoring Processes	01/27/2016 06:34 PM
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	lrobsbh	Templates	36_MDL0203_1_3_20160121141316_Gov_M5_Community_Engagement_Template__DY1Q3.xlsx	CE template	01/21/2016 02:13 PM
Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	lrobsbh	Templates	36_MDL0203_1_3_20160121142400_Gov_M7_Public_Sector_Agency_Template_DY1Q3.xlsx	Public sector agency template	01/21/2016 02:24 PM
Finalize workforce communication and engagement plan	lrobsbh	Other	36_MDL0203_1_3_20160121143031_Gov_M8_Workforce_Communication_&_Engagement_Meeting_Schedule_DY1Q3.xlsx	Workforce communication and engagement work group meeting schedule	01/21/2016 02:30 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	lrobsbh	Rosters	36_MDL0203_1_3_20160121142936_Gov_M8_Workforce_Committee_DY1Q3.xlsx	Workforce committee	01/21/2016 02:29 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize governance structure and sub-committee structure	No changes during this reporting quarter. Please see attached supporting documentation.
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Update: The Quality and Care Innovation (QCI) Subcommittee, the name given our clinical quality committee, was established in DY1Q1. Implementation work groups (IWGs, or "rapid deployment collaboratives") were established in Q3 for the clinical projects, including Asthma, CVD & Diabetes, Primary Care/Behavioral Health Integration, Care Transitions/ED Care Triage, Health Home at Risk, Mental Health & Substance Abuse (MHSA) and HIV Care. These groups are part of clinical governance structure and function as clinical quality committees for each DSRIP project. The QCI Subcommittee met twice during Q3 and four of the IWGs also met Q3. The other three IWGs are scheduled to meet for the first time in DY1Q4.
Finalize bylaws and policies or Committee Guidelines where applicable	Templates have not been uploaded this quarter, as no changes to committee or subcommittee charters and no new policies were created or adopted.
Establish governance structure reporting and monitoring processes	Update: The governance and committee structure document including a description of the reporting and monitoring processes was completed. We also executed Schedule A's for DSRIP Project Directors for the seven largest primary care organization members of our PPS; these Schedule A's are exhibits to the Master Services Agreements that were executed with the same seven organizations in September 2015.
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	Update: No updates were made to the Community Engagement Plan this quarter. Community Engagement Template attached.
Finalize partnership agreements or contracts with CBOs	Update: A Master Services Agreement (partnership agreement) with one CBO, a.i.r. NYC, was executed during Q3 and we are in the process of negotiating a Schedule A with them. This milestone is on track for on time completion.
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.)	Update: Several public sector agencies were identified for engagement in the PPS and invited to participate in clinical project implementation work groups (see attached Public Sector Agency Template).
Finalize workforce communication and engagement plan	Update: The Workforce Communications and Engagement Workgroup met monthly during Q3 and continued to develop the workforce communication and engagement plan. The Workforce Communication & Engagement Plan has been drafted by the workgroup. An earlier draft version was reviewed by the Workforce Subcommittee and the final draft of the Plan will reviewed again during DY1Q4 for final approval. This milestone is on track for on time completion.
Inclusion of CBOs in PPS Implementation.	Update: A Master Services Agreement (partnership agreement) with one CBO, a.i.r. nyc, was executed during Q3 and an accompanying Schedule A is currently under negotiation.

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Milestone Review Status

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

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IPQR Module 2.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

One challenge will be developing and negotiating the Base Agreement, the project schedules and funding schedules among the partners due to the broad range of partners by type and size. The various partners will have different interests, capabilities and limitations. The planned review of the Base Agreement and project schedules with partners' legal counsel will be transparent and will aim to reach mutually agreeable terms among all partners.

Another challenge will be engaging members of the Committees/Sub-Committees in a meaningful and productive way to achieve the PPS's goals over a short timeline. In order to build a strong and working governance structure, the members appointed to the various committees must prepare for meetings (e.g., read materials distributed in advance of meetings), attend and be attentive during meetings and otherwise be actively involved in the committees. However, SBH recognizes that committee members have significant obligations to their organizations outside of the PPS and will aim to be respectful of their time commitments. To ensure that committee and subcommittee members are able to stay abreast of PPS developments, SBH will utilize a wide range of online tools to support efficient information sharing. Specifically, SBH has already developed a BPHC website (www.bronxphc.org) to provide information about PPS activities to PPS members and the community. SBH has also developed a PAC member portal through the platform Directors Desk, where meeting materials are posted and stored. Additionally, SBH has begun hosting all-member and PAC webinars to inform and engage its members.

Additionally, the management of partner organizations must be willing to make the investments and changes needed to transform the way care is delivered in the Bronx. Their buy-in is crucial to the success of DSRIP. To ensure buy-in at the highest levels within partner organizations, BPHC has designed a highly inclusive governance structure which enables meaningful participation in PPS decision making by leaders (as well as staff) within partner organizations. In addition, BPHC central staff is establishing member profiles and engaging in one-on-one meetings with partner organizations to help understand their capacity, priorities and potential barriers to success. These findings will inform the design and deployment of PPS programs and policies. Finally, the structure of the MDSA will enable agreements to be tailored to the terms of each member organization and will be negotiated with partner management, requiring sign-off of executive management to execute.

Given that BPHC will be implementing ten clinical projects, another challenge is creating an administratively simple clinical governance structure that reduces the burden on major practitioner groups/CBOs that are supporting the clinical operational planning. To mitigate this risk, BPHC is grouping clinical projects that require similar thought leadership and that are providing care in similar settings (e.g., hospital, home-based). For example, ED triage and care transitions are grouped because they are both hospital-based interventions.

IPQR Module 2.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

The ability to develop the project schedules that are part of the partnership agreements with CBOs will depend on the development of Clinical Operational Plans which will detail work plans and partner obligations by DSRIP project. Creation of the funding schedules is dependent upon outputs of the finance workstream, which will include the funding amount that the SBH will receive, the distribution of Participants among the projects and the allocation of funding to each project-level budget.

Additionally, SBH and its partners will need to engage frontline workers to ensure the success of each DSRIP project. To achieve this, SBH will need to, among other things, forge strong relationships with the unions.

Finally, it is critical that the IT systems and processes are capable of collecting key data in a timely fashion so that SBH can monitor its performance on an ongoing basis and target areas in need of improvement.

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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
SBH COO	Len Walsh	BPHC governance strategy and fiduciary oversight, including policymaking and policy execution
Executive Director, BPHC CSO	Irene Kaufmann	Organize and facilitate committee meetings - Provides committees with relevant data, reports and communications - Records/files meeting minutes - Responsible for policy execution
BPHC Executive Committee	Len Walsh, Chair	Oversight of all aspects of deployment of DSRIP projects and evolution of BPHC into fully integrated delivery network - Responsible for policymaking
BPHC Nominating Committee	Patricia Belair, Chair, SBH Health System	Recommend members of committees and Sub-committees to Executive committee - Responsible for policymaking
BPHC Finance & Sustainability Subcommittee	David Menashy, Co-Chair, Montefiore Medical Center Todd Gorlewski, Co-Chair, SBH Health System	Make recommendations on distribution of project Partner implementation funds - Monitor budget and compliance - Review financial Oversight structure - Oversee provision of assistance to financially frail Partners - Advise on development and implementation of sustainability and financial compliance plans - Responsible for policymaking
BPHC Information Technology Sub-Committee	Dr. Jitendra Barmecha, Chair, SBH Health System	Create and update processes and protocols for adoption and use of information technology that will be applicable to all members -Responsible for policymaking
BPHC Quality & Care Innovation Sub-Committee	Co-Chairs, Quality & Care Innovation Sub-Committee, David Collymore & Debbie Pantin	Establish evidence-based practice and quality standards and metrics - Oversee clinical management processes - Hold providers and PPS accountable for achieving targeted metrics and clinical outcomes - Responsible for policymaking
Workforce Sub-Committee	Mary Morris, Co-Chair, SBH Health System	Develop and implement comprehensive workforce strategy to

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
	Rosa Mejias, Co-Chair, 1199 TEF	ensure BPHC retains, trains and hires staff needed to support implementation of DSRIP projects - Responsible for policymaking
BPHC Compliance Officer	Suzette Gordon	Review and evaluate compliance issues/concerns within BPHC to ensure compliance with the rules and regulations of regulatory agencies and that BPHC's bylaws and policies and procedures are being followed - Responsible for policy execution
CEO of PPS Lead Organization	Dr. Scott Cooper	Make final determination of removal of committee members recommended for removal by Executive Committee

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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		
Attributed Patients and Families/Caregivers	Recipients of and partners in care, social and other services delivered by BPHC members	- Interaction sufficient to participate and take limited accountability for health, healthcare and other services activities
BPHC CSO Senior Staff (Irene Kaufmann, Executive Director; Janine Dimitrakakis, Senior Director for Analytics; Robin Moon, Senior Director for Care Delivery and Practice Innovations, Amanda Ascher, Chief Medical Officer; Benny Turner, Director of Capital Projects an Vendor Services, and Mary Morris, Dirctor of Workforce Innovation)	Facilitate evolution of BPHC into Integrated Delivery System	- Conduct operations, communication and coordination with BPHC Partners and other stakeholders to support all DSRIP-related activities
BPHC Member Organizations	Participation in BPHC projects	- Commit resources and provide BPHC project-related data to BPHC - participate in BPHC governance committees and work groups as opportunities exist
SEIU 1199 Labor Union (Tom Cloutier, Teresa Pica, Gladys Wrenick, and Rosa Mejias)	Collaborate with BPHC on workforce strategy and implementation	- 1199 SEIU Labor Management Project will facilitate Workforce Advisory Workgroup of Workforce Sub-Committee - Project Advisory Committee member
External Stakeholders		
Bronx RHIO (Charles Scaglione, Executive Director)	Accountable for integration of Bronx RHIO-supplied HIE functionality for BPHC support	- Oversight and integration of Bronx RHIO HIE technology into BPHC operations - Training staff of BPHC Partners on use of Bronx RHIO system - Executive Committee member - IT Sub-Committee member
SEIU 1199 Training and Employment Fund (TEF) (Rosa Mejias, co-chair of the Workforce Sub-Committee)	Collaborate with BPHC on workforce strategy and implementation	- Work with Workforce Sub-Committee to identify competency and training gaps, provide trainers and training to meet identified training needs, hold joint training sessions and coordinate recruitment strategies
Other Bronx PPS	Collaborate with BPHC to identify commonalities for more effective use of resources	- Collaborate with BPHC on Bronx-wide force and DSRIP communication strategies, e.g., a single tool for communications

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
		and messaging to public and possibly unified workforce recruitment strategies and training initiatives

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.

Shared IT infrastructure will be important because it will enable the Executive Committee and the Sub-Committees to analyze data obtained from all participating providers in order to effectively monitor and improve the PPS's performance.

SBH has created a public-facing website for the PPS (www.bronxphc.org), on which materials from all-Member meetings, updates from the Rapid Deployment Collaboratives, and other important documents will be posted. The website contains a calendar of key events for stakeholders, and a jobs page to connect community members and frontline workers to DSRIP-related employment opportunities. In addition, SBH has created a member portal for PAC members through the platform Directors Desk. Materials and minutes from all Committee and Sub-Committee meetings will be posted to the PAC portal unless deemed confidential.

IPQR Module 2.8 - Progress Reporting

Instructions :

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

Success will be measured by (1) the occurrence of meetings of the Executive Committee, Finance and Sustainability Sub-Committee, Workforce Sub-Committee, Quality and Care Innovation Sub-Committee, Information Technology Sub-Committee, and Nominating Committee at a frequency in accordance with the applicable charter, (2) implementation of PPS policies and procedures, and (3) execution of the Base Agreement and project schedules by SBH and Participants (including CBOs) and performance by SBH and Participants (including CBOs) of obligations against the Base Agreement. We will also monitor the performance reporting dashboard in order to track the progress of each DSRIP project against key quarterly milestones and metrics and produce progress reports that summarize the status for review by the Executive Committee and the Sub-Committees. A subset of key indicators will be posted to the BPHC website to ensure all PPS members and the community are kept up to speed on PPS progress.

IPQR Module 2.9 - IA Monitoring

Instructions :

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Section 03 – Financial Stability

IPQR Module 3.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize PPS finance structure, including reporting structure	Completed	This milestone must be completed by 12/31/2015. PPS finance structure chart / document, signed off by PPS Board.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Develop Finance and Sustainability Sub-Committee charter	Completed	Develop Finance and Sustainability Sub-Committee charter and present to Executive Committee for review and approval.	04/01/2015	04/16/2015	04/01/2015	04/16/2015	06/30/2015	DY1 Q1	
Task Appoint Sub-Committee members	Completed	Identify and appoint Finance and Sustainability (F&S) Sub-Committee members with financial leaders from PPS member organizations. Appoint SBH's CFO and a finance executive from Montefiore as the initial co-chairpersons.	04/01/2015	04/29/2015	04/01/2015	04/29/2015	06/30/2015	DY1 Q1	
Task Initiate Sub-Committee and report to EC	Completed	Conduct initial meeting of the F&S Sub-Committee meeting. Document Finance and Sustainability Sub-Committee actions and provide first report to Executive Committee.	05/01/2015	05/20/2015	05/01/2015	05/20/2015	06/30/2015	DY1 Q1	
Task Create PPS bank account	Completed	Set up a separate bank account and treasury function for PPS that is separate and distinct from SBH.	04/02/2015	06/30/2015	04/02/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Establish policies and procedures	Completed	Develop and finalize financial policies and procedures, reporting structure and roles and responsibilities for the PPS including CSO operation expenses, and expenses of PPS support services related to the DSRIP projects undertaken. Roles and responsibilities will be defined for CSO finance staff, SBH CFO in relationship to PPS, and role of PPS partners.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Obtain EC approval of financial framework	Completed	Obtain Executive Committee sign-off of PPS finance structure, policies and procedures.	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Perform network financial health current state	In Progress	This milestone must be completed by 3/31/2016. Network	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
assessment and develop financial sustainability strategy to address key issues.		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							
Task Conduct assessment of financial impact of DSRIP projects	In Progress	Assess financial impact of DSRIP projects on participating provider types based on revenue gains or losses associated with achieving required metrics. Present findings to the Finance and Sustainability Sub-Committee and Executive Committee.	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Conduct assessment of current state of financial health	Completed	Conduct financial health current state assessment utilizing assessment tool developed during the DSRIP planning phase for partners added since the first assessment was completed.	09/01/2015	11/15/2015	09/01/2015	11/15/2015	12/31/2015	DY1 Q3	
Task Analyze results of assessments	In Progress	Analyze results of financial health current state assessment and the financial impact of projects assessment, and, if applicable, identify financially frail partners. Review with Finance and Sustainability Sub-Committee and Executive Committee.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Establish reporting and monitoring processes	In Progress	Establish a process for identifying, monitoring and assisting financially frail partners. Define partner reporting requirements and the role of the CSO Provider Engagement Team and the Finance and Sustainability Sub-Committee. Present to the Executive Committee for review and approval.	11/15/2015	01/31/2016	11/15/2015	01/31/2016	03/31/2016	DY1 Q4	
Task Conduct first annual review	Not Started	Perform first annual review of the financial health current state assessment tool and revise as needed to capture key financial health and sustainability indicators. Present to the Executive Committee for review and approval.	01/15/2016	02/28/2016	01/15/2016	02/28/2016	03/31/2016	DY1 Q4	
Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Completed	This milestone must be completed by 12/31/2015. Finalized Compliance Plan (for PPS Lead).	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES

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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 Appoint Compliance Committee leadership	Completed	Appoint CSO lead as a member of the compliance committee. Appoint SBH's compliance officer as interim compliance officer for the PPS	04/01/2015	07/10/2015	04/01/2015	07/10/2015	09/30/2015	DY1 Q2	
Task Identify Compliance Officer	Completed	Identify a Compliance Officer who has an expertise in NYSSS Law 363-d.	07/01/2015	08/30/2015	07/01/2015	08/30/2015	09/30/2015	DY1 Q2	
Task Hire Compliance Officer	Completed	Hire or designate PPS Compliance Officer who will report to legal affairs department of SBH and its compliance officer. The Compliance Officer will conduct internal control and will develop a Compliance plan consistent with NYS SSL 363-d and OMIG requirements for DSRIP.	06/15/2015	07/31/2015	06/15/2015	07/31/2015	09/30/2015	DY1 Q2	
Task Establish compliance enforcement procedures	Completed	Establish PPS chain-of-command for compliance enforcement including relationship between the compliance function and the PPS governance structure.	07/15/2015	09/30/2015	07/15/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Establish compliance plan	Completed	Customize PPS lead's existing compliance plan and programs (e.g., HIPAA) for the PPS, consistent with NYS Social Services Law 363-d, OMIG requirements and present to the Executive Committee for approval.	07/15/2015	11/10/2015	07/15/2015	11/10/2015	12/31/2015	DY1 Q3	
Task Integrate compliance requirements into MSA	Completed	Incorporate compliance requirements into Master DSRIP Services Agreement as appropriate to ensure participant compliance with NYS Social Services Law 363-d.	07/15/2015	11/15/2015	07/15/2015	11/15/2015	12/31/2015	DY1 Q3	
Task Share compliance plan with partners	Completed	Publish PPS Compliance Plan (including standards of conduct, conflicts of interest, receipt of complaints/no retaliation policies, and monitoring procedures) and share with all partners and post to PPS website.	07/15/2015	11/30/2015	07/15/2015	11/30/2015	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	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task Identify subject matter experts for leadership positions	Completed	Recruit senior Medicaid MCO leadership to serve on Executive Committee. Identify and appoint HMO industry expert to F&S Sub-Committee.	04/01/2015	05/21/2015	04/01/2015	05/21/2015	06/30/2015	DY1 Q1	
Task Review VBP guidelines	Completed	Review final state value-based payment prototype and roadmap upon release.	07/01/2015	08/31/2015	07/01/2015	08/31/2015	09/30/2015	DY1 Q2	
Task Establish VBP payment assessment procedures	Completed	Develop value-based payment assessment and annual assessment process. Present to the Executive Committee for	08/01/2015	09/30/2015	08/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		review and approval.							
Task Assess current VBP arrangements	In Progress	Develop detailed analysis of PPS partners' existing value-based payment arrangements with Medicaid MCOs and other payers by reviewing claims-level data. A survey will be administered based on the defined VBP assessment procedures. Assessment will likely begin with larger organizations that already have significant VBP contracts and make up the majority of activity within the PPS and are actively participating in PPS leadership.	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Engage MCOs in VBP planning	Completed	Identify MCOs in BPHC PPS catchment area and actively engage them in developing value-based payment arrangements through a structured stakeholder engagement process.	09/01/2015	11/15/2015	09/01/2015	11/15/2015	12/31/2015	DY1 Q3	
Task Develop VBP education and engagement strategy	Completed	Develop provider education and engagement strategy through a structured stakeholder engagement process, which will facilitate participant understanding of and input to value-based payments and potential contracting arrangements.	08/15/2015	11/30/2015	08/15/2015	11/30/2015	12/31/2015	DY1 Q3	
Task Hold regular meetings with MCOs	Completed	Initiate monthly meetings with MCOs and engage in development of MCO strategy framework for BPHC PPS.	08/15/2015	11/30/2015	08/15/2015	11/30/2015	12/31/2015	DY1 Q3	
Task Engage PPS providers in VBP education and planning	In Progress	BPHC is working with Montefiore Hospital to leverage their experience and strategy to develop their VBP rates for the PPS. Montefiore Hospital is experienced with Value Based Purchasing contracts for Medicaid Managed Care and for their Accountable Care Organization (ACO) and will play a key role in the development of VBP rates.	12/01/2015	02/15/2016	12/01/2015	02/15/2016	03/31/2016	DY1 Q4	
Task Establish methodology for estimating revenue and determining value	In Progress	In coordination with Finance and Sustainability Committee, develop methodology for estimating revenue and determining value. Review and obtain sign-off from Executive Committee.	11/01/2015	01/31/2016	11/01/2015	01/31/2016	03/31/2016	DY1 Q4	
Task Conduct first annual assessment of VBP	In Progress	Perform the first annual assessment of the current state of value-based payment and associated revenue across all PPS partners.	11/01/2015	01/31/2016	11/01/2015	01/31/2016	03/31/2016	DY1 Q4	
Task Establish compensation and MCO strategy framework	In Progress	Develop preferred compensation and MCO strategy framework. Review and obtain sign-off with Executive Committee.	11/15/2015	01/31/2016	11/15/2015	01/31/2016	03/31/2016	DY1 Q4	
Task Establish methodology for PPS members to	Completed	In coordination with Finance and Sustainability Committee, develop plan to show how PPS members will demonstrate	09/01/2015	10/31/2015	09/01/2015	10/31/2015	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
demonstrate value		value to MCOs.							
Task Establish VBP sub working group within the F&S Subcommittee	Completed	Establish a sub working group of the F&S subcommittee. This sub working group will develop a plan for the best way to assess the current state of VBP that is compliant with BPHC Antitrust policies. Representatives will be able to represent the current state within their own organizations	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	In Progress	This milestone must be completed by 12/31/2016. Value-based payment plan, signed off by PPS board	07/15/2015	12/31/2016	07/15/2015	12/31/2016	12/31/2016	DY2 Q3	YES
Task Review VBP guidelines	Completed	Review final state value-based payment prototype and road map upon release.	07/15/2015	08/31/2015	07/15/2015	08/31/2015	09/30/2015	DY1 Q2	
Task Review baseline assessment of VBP current state	Not Started	Review baseline assessment of partners' value-based payment revenue to inform development of PPS value-based payment plan.	02/01/2016	04/30/2016	02/01/2016	04/30/2016	06/30/2016	DY2 Q1	
Task Conduct gap analysis	In Progress	Conduct gap assessment between PPS's current volume of value-based revenue and target of 90% across the PPS network.	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Engage MCOs in creation of transition plan	In Progress	Engage MCOs in development of value-based purchasing transition plan.	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Engage providers in creation of transition plan	In Progress	Engage PPS providers in development of the value-based purchasing transition plan, provider adoption strategy, reporting requirements and procedures.	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Establish reporting requirements and procedures	Not Started	Establish partner value-based payment reporting requirements and procedures to enable ongoing monitoring of PPS value-based payment revenue.	03/01/2016	05/31/2016	03/01/2016	05/31/2016	06/30/2016	DY2 Q1	
Task Determine organizational requirements for transition	Not Started	Define PPS organizational requirements necessary to support transition to value-based payment.	03/01/2016	04/30/2016	03/01/2016	04/30/2016	06/30/2016	DY2 Q1	
Task Establish VBP transition plan	Not Started	Finalize PPS value-based payment transition plan and provider adoption strategy in the timeframe required by DSRIP guidelines. Present to Executive Committee for approval.	06/01/2016	09/30/2016	06/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Finalize VBP reporting schedule	Not Started	Establish a monthly Executive Committee value based payment reporting schedule that will continue throughout	06/01/2016	09/30/2016	06/01/2016	09/30/2016	09/30/2016	DY2 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		DSRIP years.							
Task Begin expanding existing VBP arrangements	Not Started	SBH and MMC will expand the lives in their existing fully capitated arrangements starting in DY2	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Begin to pursue shared saving arrangements and risk-sharing	Not Started	Introduce partners to value-based contracting arrangements at a lower level of risk by pursuing shared savings arrangements, gradually converting to risk-sharing arrangements over time	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Expand VBP arrangements throughout PPS	Not Started	Expand the level of risk and capitation assumed by BPHC partners as the capabilities of PPS members increase	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Milestone #6 Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	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
Finalize PPS finance structure, including reporting structure	zstopak	Other	36_MDL0303_1_3_20160128095001_M1_BPHC_Finance_Structure.pdf	BPHC Finance Structure	01/28/2016 09:50 AM
	jpacesbh	Meeting Materials	36_MDL0303_1_3_20160126095357_M1_Finance_-_Meeting_Schedule_Template.xlsx	Finance & Sustainability Subcommittee Meeting Schedule Template	01/26/2016 09:53 AM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	jpacesbh	Documentation/Certification	36_MDL0303_1_3_20160126095324_M1_BPHC_Governance_Structure_-_Organizational_Chart.pdf	BPHC Governance Structure	01/26/2016 09:53 AM
	jpacesbh	Documentation/Certification	36_MDL0303_1_3_20160126095220_M1_EC_Approval_of_BPHC_Governance_Structure.pdf	Governance Structure Approval	01/26/2016 09:52 AM
	jpacesbh	Documentation/Certification	36_MDL0303_1_3_20160126095108_M1_BPHC_Finance_&_Sustainability_Subcommittee_Charter.pdf	BPHC Finance & Sustainability Subcommittee Charter	01/26/2016 09:51 AM
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	jpacesbh	Policies/Procedures	36_MDL0303_1_3_20160126095938_M3_BPHC_Code_of_Conduct_Final.pdf	BPHC Code of Conduct	01/26/2016 09:59 AM
	jpacesbh	Other	36_MDL0303_1_3_20160126095849_M3_BPHC_Compliance_Plan.pdf	BPHC Compliance Plan	01/26/2016 09:58 AM
	jpacesbh	Documentation/Certification	36_MDL0303_1_3_20160126095806_M3_BPHC_Compliance_Certification.pdf	BPHC Compliance Certification	01/26/2016 09:58 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize PPS finance structure, including reporting structure	The BPHC Finance & Sustainability Subcommittee has approved the PPS finance governance structure, as well as DY1 and DY2 Budgets. The finance team, which consists of a Senior Accountant and Director of Financial Planning, is charged with the following responsibilities: maintaining bank records, recording journal entries to general ledger, reconciliation of all funds flow and cash transactions, accounts payable and expense reimbursements, analysis of expenses, review payment structures for vendors and partner organizations, and all Finance related reporting. BPHC Finance reports monthly to Finance & Sustainability Subcommittee on all financial activities. The Finance & Sustainability Subcommittee monitors and makes recommendations to the Executive Committee on the distribution of project Partner implementation funds, the budget and PPS performance, finance structure and related policies and procedures, and the compliance plan for PPS partners.
Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	Update: The Finance & Sustainability Subcommittee reissued and is awaiting the results of a financial survey of its network providers. The deadline for the survey to complete is Jan 15 after which the data will be analyzed and decision made to evaluate the financially fragile providers. The organizations were asked to submit financial information from their latest audited financial statement. Following financial indicators were asked in the survey: Operating Revenue, Current Assets to Liability Ratio, EBITDA Margins, and Net Assets Fund Balance.
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	BPHC has hired a full-time Compliance Officer, Suzette Gordon, within the PPS Central Services Organization (CSO). BPHC has developed a Compliance Plan consistent with the requirements of the New York Social Services Law 363-d and Title 18 of the New York Codes Rules and Regulations, 18 NYCRR 521. The Compliance Plan has received approval from the Finance & Sustainability Subcommittee and the Executive Committee.
Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	Update: BPHC is partnering with the three MCOs to develop baseline revenue that will link to VBP. The Finance subcommittee chairs are working with MCOs to develop VBP strategies that reduce healthcare costs without compromising with overall health of PPS-attributed patients.
Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	Update: BPHC is working to establish a timeline that will initiate VBP in DY3 and DY4, and reach 90% penetration by DY 5. The Finance & Sustainability Subcommittee and the BPHC Executive Director are working with MCOs form partnerships and a workgroup that will help to establish a successful VBP plan.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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 & Complete	
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Complete	
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Ongoing	

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IPQR Module 3.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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.

(1) Provider Engagement: PPS must meaningfully engage and communicate individual PPS funding schedules at outset of DSRIP implementation to ensure partners and providers understand the process and project milestones tied to payment. As BPHC engages partners in clinical operational and project readiness planning, and introduces partners to the Master Services Agreement (MSA), it educates partners on DSRIP funds flow and funding schedules contained in the MSA. BPHC has developed a provider education and engagement strategy. (2) Availability of DSRIP Waiver Funds/Ability of PPS to Achieve and Draw Down Incentive Payments: PPS must achieve and report on state-established milestones and metrics to draw down incentive payments and subsequently distribute funds to partners. PPS has and will continue to engage in a thoughtful planning process to ensure it achieves DSRIP milestones and metrics efficiently and effectively. (3) Availability of Capital Funds: Timing and availability of capital funds will impact PPS project implementation and performance, as some projects require capital investments not covered by DSRIP waiver funds. Moreover, the timing of capital funds flows may create cash flow risks, especially for financially frail partners. PPS will work to identify additional sources of funding for capital-intensive projects. (4) Financial Frailty of Partners: Initial assessment of the financial health of its partner organizations showed the majority were "not immediately fragile." However, some key partners were identified as moderately. PPS, through its Finance and Sustainability Sub-Committee and CSO Provider Engagement Team, has been developing partner reporting requirements and a process for monitoring and assisting financially frail partners. (5) MCO Engagement: The transition to value-based payment (VBP) across the PPS will require engagement and willingness from Medicaid managed care organizations (MCOs) to transform existing contracts into DSRIP-aligned VBP contracts over 5 years. PPS will continue engaging MCOs through DSRIP implementation planning and monthly meetings to ensure MCOs are meaningfully engaged in developing transition plans and have time to prepare for the transition to VBP. (6) Social Services and CBOs: Several third-party groups will have a significant impact on patient outcomes and overall success of the PPS, but their existence depends on extraneous revenue streams. NYC-run social service agencies and CBOs are dependent on city and state funding and charitable support. While MCOs will be supported by NYS in this restructuring, local community and county agencies face a host of outside influences that could impair their ability to support the PPS in a meaningful way. (7) Federally Qualified Health Centers ("FQHC"): Reimbursement methodologies within the FQHC business paradigm may not be in sync as DSRIP initiatives evolve. Wraparound payments under the 1115 Waiver depend on legislation that expires during DSRIP period and the administrative costs/burdens and financial reporting that HRSA requires is inconsistent with population health scoring and financial review. FQHC have no margins and access to capital involves bureaucratic and public finance hurdles. (8) Ability to Access Data for Financial Reporting: For PPS to meet reporting requirements, PPS needs access to data for financial reporting. This requires that appropriate processes and mechanisms to allow providers to perform and provide timely information. PPS intends to create buy-in by engaging PPS participants to assist in the development and implementation of appropriate reporting requirements and structures. (9) Physician Engagement: PPS must effectively engage and educate physicians regarding DSRIP's incentive-based funding structure.

IPQR Module 3.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

• Performance Reporting: Identify point-of-contact in each partner organization for finance-related matters (e.g., reporting and policies/procedures); base partner reporting requirements on DSRIP reporting milestones/metrics; performance reporting infrastructure that supports provider, practice, and organization-level reporting and evaluation to drive DSRIP incentive payments (note: performance reporting and incentive payments will be detailed in each Participant's Master Services Agreement).
• Governance: The PPS governance structure must be capable of executing financial responsibilities; the PPS governance structure must evolve to incorporate Medicaid MCOs to support transition to value-based payment.
• IT: The PPS IT systems must support central finance and performance reporting to inform and track PPS and project-level budgets and funds flow; the PPS IT systems must support population health management to enable partners to improve patient outcomes that will drive the transition to value-based payment with Medicaid MCOs and other payers.
• Physician Engagement: The PPS must effectively engage and educate physicians regarding DSRIP's incentive-based funding structure, including contractual obligations associated with project-specific clinical interventions, Domain 1 requirements and their relationship to incentive payments.

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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
BPHC Executive Director	Irene Kaufmann	Overall financial sustainability plan
BPHC Director of Financial Planning	Ronald Sextus	Overall implementation of financial strategy and sustainability plan
SBH CFO	Todd Gorlewski	Oversight of the sustainability plan
BPHC Sr. Accountant	Janneth Gaona	Setting up GL and maintenance of all BPHC revenue and expense accounts. Reconciling and Managing BPHC Bank accounts.
BPHC Compliance Officer	Suzette Gordon	Oversight of the compliance strategy
BPHC External Independent Auditor	Ernst & Young	Independent auditor will audit annually and report to the Finance and Executive Committee that the recording of accounting are done according to GAAP and are in compliance.

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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		
BPHC CSO Business Staff	Accountable for integration and effective financial plan	Oversight and integration of finances into BPHC operations
BPHC Finance and Sustainability Sub-Committee	Governance for effective integration and use of IT, centrally and across partners	Oversight and integration of finance plan into BPHC operations
SBH Management/Leadership	Fiduciary oversight for effective financial plans	Oversight of BPHC financial operations
BPHC Executive Committee	Governance for effective and sustainable financial strategy	Governance structure with PPS-wide representation, makes policy decisions and provides direction for effective and sustainable financial strategy
BPHC Compliance Officer	Oversight and advice on the compliance plan and audits	Oversight and advice on financial compliance and audit
BPHC Senior Director of Quality Management and Analytics	Accountable for providing required quality data in a timely manner	Quality data support
SBH IT team	Support the financial functions with the existing IT infrastructure and data streams	Support with the technical infrastructure
BPHC member organizations	Work within financial models to ensure BPHC success	Provide services according to master contract requirements
External Stakeholders		
External Auditor - Ernyst & Young	Conduct the annual audit	Complete audit documentation and recommendation
Hudson Valley PPS	Align financial models for paying and incenting providers and provider organizations with those developed by BPHC	Financial models and master contract agreements
Bronx Chamber of Commerce	Coordinate with the BCC in order for local businesses to increase employment opportunities for the local community.	Participating in events geared towards employment opportunities that foster local community development.
Bronx Business Improvement Districts	Working with Bronx BIDs and local CBOs to increase their involvement in local economic empowerment of the community.	Meeting with Bronx BIDs such as Fordham BID, Belmont BID and others to identify programs and opportunities that the community can benefit from.
Community Boards	Community Boards will participate in identifying the local community needs and concerns.	BPHC will participate in Local Community Board Meeting, Educate them about DSRIP and learn from them about the community needs and how to improve them.
Bronx Elected Officials	Work with the various Bronx Elected Officials and CBOs to address social determinants of health to improve the overall health of Bronx residents.	Work with Bronx Elected Officials and CBOs to host forums in addressing how to improve the overall health and economics of the community.

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Medicaid Managed Care Health Plans	Monitor performance of financial models and use them to develop value-based contracting	Initiate development of value-based contracting with PPS hospitals and their providers

IPQR Module 3.7 - IT Expectations

Instructions :

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

The PPS will require appropriate IT systems to support central and PPS-wide reporting capabilities to support performance reporting, track PPS and project-level budgets and funds flow, and monitor financial sustainability. The systems will need to support PPS financial analysis reports, performance metrics reporting, and PPS-specific financial statements. When conducive, BPHC will leverage existing back-office systems within St. Barnabas Hospital and Montefiore. In terms of funds flow, treasury and general ledger, however, SBH has created a separate general ledger platform and banking arrangement to ensure that the restrictive nature and purpose of the intended funds are directed accurately with complete documentation for audit purposes. PPS-wide IT systems and health information exchanges that support care management and population health management will be required to enable partners to improve patient outcomes that will drive the transition to value-based payment with Medicaid MCOs and other payers.

IPQR Module 3.8 - Progress Reporting

Instructions :

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

The success of this workstream will be measured on the financial stability of the participants in the PPS, PPS adherence to a compliance plan consistent with NY State Social Services Law 363-d, and the migration from the current level of VBP across PPS provider participants to 90% of the total MCO-PPS payments captured in at least Level 1 VBPs, with more than 70% in Level 2 VBPs or higher.
The PPS has already done an initial assessment of the financial stability of its lead organization and its partners. It is currently expanding this initial assessment to new partners that have joined the PPS since the first assessment was completed. The assessment itself will be evaluated for potential updates and will be administered to all PPS participants annually. The Finance and Sustainability Sub-Committee will charged with updating the assessment as required, administering the evaluation and analyzing the results of the assessments. It will determine the need for potential interventions and initiate more robust monitoring of any financial fragile partners. The provider engagement team of the CSO and the Finance and Sustainability Sub-Committee will report findings from the assessment and monitoring activities regularly to the Executive Committee.

The PPS will publish its compliance plan and conduct quarterly compliance meetings. There will be quarterly and annual compliance reports as well as an annual review of the compliance plan itself to determine if additional changes are required.
The PPS has good visibility into the VBPs of its lead organization as well as some of the larger provider organizations participating in the PPS. It will develop an initial assessment to develop a complete baseline assessment of revenue linked to VBPs across all participants. The PPS will implement reporting requirements to monitor revenue linked to VBPs to regularly assess our performance against our plan to achieving 90% VBPs.

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Starting in DY1, Q3 the PPS began to engage MCOs and providers to develop the appropriate reporting requirements and procedures to meet the quarterly reporting requirements to the state.

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.	Completed	This milestone must be completed by 12/31/2015. Cultural competency / health literacy strategy signed off by PPS Board. The strategy should: -- Identify priority groups experiencing health disparities (based on your CNA and other analyses); -- Identify key factors to improve access to quality primary, behavioral health, and preventive health care -- Define plans for two-way communication with the population and community groups through specific community forums -- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors); and -- Identify community-based interventions to reduce health disparities and improve outcomes.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Initiate QCIS to support CC/HL strategy.	Completed	Establish and convene a Quality and Care Innovation Sub-Committee (QCIS) to support development of a PPS-wide cultural competency and health literacy strategy (CC/HL).	06/05/2015	06/30/2015	06/05/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Inventory existing CC/HL programs in PPS	Completed	Conduct an inventory of existing CC/HL programs across PPS members and identify assets and gaps that should be addressed in CC/HL strategy.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Identify priority populations and locations	Completed	Through CNA and PPS member surveys, identify priority populations and neighborhoods experiencing health disparities and having low literacy. Particular attention to be focused on immigrant populations and populations	05/18/2015	09/30/2015	05/18/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		experiencing food and/or housing insecurity. Furthermore the strategy should target neighborhoods designated as Medically Underserved Areas and populations residing along the corridor of concentrated preventable admissions, stretching from Fordham-Bronx Park, down the Grand Concourse, to the South Bronx.							
Task Identify best practices in interventions to reduce health disparities	Completed	Gather information from key stakeholders with expertise on CC/HL to identify PPS and community-based interventions to reduce health disparities and improve outcomes.	05/18/2015	09/30/2015	05/18/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop CC/HL strategy and action plan	Completed	Convene a CC/HL work group including co-chairs of the QCIS and CBO member leadership supported by the Director of Collaboration and the Director of Workforce Innovation. This group will utilize findings from CNA, inventory of providers, best practice experts and stakeholders to develop a CC/HL strategy and action plan. Strategy and action plan will include 1) specific initiatives such as remote simultaneous medical interpretation, 2) identified stigmatized populations such as the mentally ill and SUD, 3) standards for member organizations and 4) requirements and timing for training and re-training staff, in concert with implementation of the clinical projects.	05/18/2015	12/31/2015	05/18/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Partner with CBOs	Completed	In conjunction with the Director of Collaboration, seek partnerships with CBOs with experience and success in cultural competency and health literacy strategies (e.g. Health People, etc) to participate in the implementation of the CC/HL strategy.	05/18/2015	12/31/2015	05/18/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop an evaluation plan	Completed	Develop a plan for evaluating the effectiveness of the CC/HL strategy.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Obtain approval for CC/HL strategy and action plan	Completed	Present CC/HL plan to Quality and Care Innovation Sub-Committee then Executive Committee for approval	10/06/2015	12/17/2015	10/06/2015	12/17/2015	12/31/2015	DY1 Q3	
Milestone #2 Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	In Progress	This milestone must be completed by 6/30/2016. Cultural competency training strategy, signed off by PPS Board. The strategy should include: -- Training plans for clinicians, focused on available evidence-based research addressing health disparities for particular	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES

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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
		groups identified in your cultural competency strategy -- Training plans for other segments of your workforce (and others as appropriate) regarding specific population needs and effective patient engagement approaches							
Task Initiate development of health disparities training strategy	Completed	Convene Workforce Sub-Committee and QCIS to support development of health disparities training strategy.	05/22/2015	06/05/2015	05/22/2015	06/05/2015	06/30/2015	DY1 Q1	
Task Inventory training best practices	Completed	Perform inventory of existing training programs within the PPS and identify best practices to leverage (as part of strengths/gaps assessment in Milestone 1).	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Identify key features of training plans	In Progress	Based on inventory and research, identify key features of training plans, including scope of providers trained, mechanisms for delivering training services, and frequency of offerings (e.g., semiannual).	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Obtain approval for training plan	Not Started	Vet training plan through Workforce Sub-Committee, QCIS and Executive Committee.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Develop a reporting plan for training program	In Progress	Develop a plan for conducting ongoing quarterly reports on training program.	06/01/2015	03/31/2016	06/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Communicate training strategy to providers	Not Started	Present the training strategy to PPS providers through the rapid deployment collaboratives.	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
Finalize cultural competency / health literacy strategy.	6338	Other	36_MDL0403_1_3_20160127124020_M1_Cultural_Competency-Health_Literacy_Strategy_Final.docx	Cultural Competency - Health Literacy Strategy	01/27/2016 12:40 PM
	6338	Other	36_MDL0403_1_3_20160127123906_M1_Comm_Eng_Materials_-_BPHC_Newsletter.pdf	Community Engagement Materials - BPHC Newsletter	01/27/2016 12:39 PM
	6338	Other	36_MDL0403_1_3_20160127122933_M1_Comm_	Community Engagement Materials - BPHC	01/27/2016 12:29 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
			Eng_Materials_-_BPHC_Brochure.pdf	Brochure	
	6338	Other	36_MDL0403_1_3_20160127122725_M1_CC.HL_Q3_meeting_schedule.xlsx	Q3 Meeting Schedule	01/27/2016 12:27 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize cultural competency / health literacy strategy.	Update Q3: This milestone has been completed and the cultural competency/health literacy strategy has been approved by the Quality and Care Innovation Subcommittee and the Executive Committee. The Cultural Responsiveness Work Group will continue to hold regular meetings to further specify the plans, and implement and monitor the various programs and initiatives. This group will also serve to inform the Workforce Subcommittee regarding training needs linked to the implementation of clinical projects and community needs for health literacy support.
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	Besides implementing training for clinicians and other specific groups, it has been determined that cultural responsiveness and addressing the drivers of health disparities will be a component of every training program that is to be sponsored by the PPS. We have consulted with numerous subject matter experts including Dr. Marilyn Aquirre-Molina, the Director of the Center for Health Equities at Lehman College, Dr. Francesca Gany, the Executive Director of the Center for Immigrant Health and Cancer Disparities Service at Memorial Sloan Kettering Cancer Center, Dr. Roberto Lewis-Fernandez, director of the NY State Center of Excellence for Cultural Competency at the NY State Psychiatric Institute at Columbia University. We also have made plans for an RFI to go to CBOs within our PPS to assist with parts of this training strategy. This milestone is on track for completion.

Milestone Review Status

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

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IPQR Module 4.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

Extremely Diverse Linguistic Requirements and Low Literacy: The Bronx is one of the most diverse counties in NYS, and this rich diversity demands a culturally responsive system of care. However, CNA findings indicate that immigrant and limited English-speaking populations in the Bronx experience barriers to accessing health care, including low quality language services, lack of culturally and linguistically competent providers, low literacy, and distrust of the healthcare system. Such barriers are particularly challenging among smaller populations, including Albanian, Bengali, Chinese, Creole, Korean, Mandingo, and Russian speakers. Together, these issues could undermine the PPS's ability to engage patients in care. BPHC has developed mitigation strategies to address patient engagement, including plans to develop and disseminate plain-language, accessible, and culturally competent materials at 4th– to 6th-grade reading levels across the PPS; convene a work group to identify best practices on Patient Engagement led by an expert practitioner to develop, test, and promote health literacy standards and advise partner organizations on best practices; and develop culturally competent training materials that meet the needs of various subpopulations, such as age, language, and ethnic groups. PPS plans to deploy community health workers (CHWs) or health educators on site in provider offices. Recruiting and Workforce Challenges: Securing a culturally competent workforce is key to patient engagement and DSRIP's success more broadly. Yet hiring and recruiting locally-based, bilingual and/or otherwise culturally identifying frontline workers will be challenging, due both to the general shortage of qualified health workers and competition for similar workers among PPSs. BPHC has developed mitigation strategies to address recruiting and workforce issues, including working with local colleges to promote community-based English Speakers of Other Languages (ESOL) and GED training programs for new workers; working with 1199 TEF and PPS member organizations that have expertise recruiting local, peer-based, and other frontline staff; developing culturally competent training materials that address the health, cultural, and linguistic needs of various subpopulations; and recruiting community members to enroll in healthcare worker training courses. Recruitment of community members, particularly through CBOs, applies particularly to CHWs, critical to our cultural competency strategy. Provider Engagement: Clinical and administrative leadership within organizations may become overtaxed and resistant to adopting new protocols, which could in turn reduce providers' participation in and compliance with health literacy and cultural competency standards. In addition, some providers may have insufficient time and resources for training. BPHC will incorporate cultural competency and health literacy training and standards into the design of DSRIP projects and project-based trainings to minimize the number of trainings in which PPS providers must participate. BPHC's Director of Collaboration and Senior Director of Care Delivery and Practice Innovations will be responsible for conducting ongoing assessment of the PPS's cultural competency activities and will provide technical assistance to providers in need of additional resources and support.

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.)

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BPHC's cultural competency and health literacy strategy has interdependencies with the workforce, IT, and clinical project workstreams.

• Workforce Workstream Dependencies: The provision of culturally competent care will depend on the success of the PPS's Bronx-centric recruitment and training strategy. As discussed, the PPS will work with 1199 TEF, CUNY, and contracted CBOs to develop training curricula that meet cultural competency and health literacy standards and incorporate these trainings into all new hire orientations, refresher courses, and provider agreements.

• Practitioner Engagement Workstream Dependencies: Practitioners play a key role in providing culturally competent care to patients. The importance of providing culturally competent care and best practices for how to do so will be a key part of the practitioner communication and engagement plan, which will include regular webinars, in-person, peer-to-peer learning forums, and participation in project-specific and a Patient Engagement-focused Rapid Deployment Collaborative. It will also be included in the training/education plan targeting practitioners and other professional groups as part of educating them about the DSRIP program and the PPS-specific quality improvement agenda.

• IT and Population Health Management Workstream Dependencies: Connecting patients to culturally competent resources is critical to improving patient outcomes. BPHC's care management technology will include fields to record patients' linguistic and cultural needs so that patients are matched to care managers, providers, and community-based organizations that can appropriately serve them.

• Clinical Workstreams Dependencies: The PPS's success will be heavily reliant on the success of its clinical projects. The PPS's project referral protocols and resources must be able to address the social, linguistic, cultural, behavioral and physical needs of patients. The PPS will make available a Web-based PPS-wide directory of CBOs. These efforts will help to ensure PPS-wide tools and resources meet health literacy/cultural competency standards and address patients' social needs in a culturally competent manner.

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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
Co-Chairs, Quality and Care Innovation Sub-Committee (QCIS)	Debbie Pantin, SAED, VIP Community Services, Dr. David Collymore, Medical Director, Acacia	Development and implementation of cultural competency/health literacy ("CC/HL") strategy
Quality and Care Innovation Sub-Committee	QCIS has 15 members with clinical experience relative to the specific projects. Membership includes: David Collymore, MD Acacia Network Megan Fogarty BronxWorks Pablo Idez, LMSW The Institute for Family Health Kenneth Jones, MD Morris Heights Health Center Loredan Ladogana, MD UCP of NYC Frank Maselli, MD Bronx United IPA Anne Meara, RN Montefiore Medical Center Beverly Mosquera, MD Comunilife Chris Norwood Health People Todd Ostrow CenterLight Health Center Debbie Pantin, LMSW VIP Community Services Rona Shapiro 1199SEIU Ed Telzak, MD SBH Health System Lizica Troneci, MD SBH Health System Dharti Vaghela Essen Medical Associates, P.C. Committee will review recommendations made by CWG, and make final decisions about PPS strategy for cultural competency/health literacy	Strategy for CC/HL, Practitioner Communication & Education, EB practice guidelines/clinical practices & protocols
Senior Director, DSRIP Care Delivery & Practice Innovations, BPHC CSO	Dr. J. Robin Moon	Advisor to the development of the CC/HL strategy
Director of Collaboration, BPHC CSO	Albert Alvarez	Develop outreach to CBOs to identify CC/HL needs for specific sub populations, diseases and locations in the Bronx
Workforce Sub-Committee	Mary Morris, Co-Chair, SBH Health System Rosa Mejias, Co-Chair, 1199 TEF	Training strategy for CC/HL
Cultural Competency/Health Literacy Work Group	Includes key players listed above including: Debbie Pantin, SAED VIP Community Services (co-chair of QCIS), Charmaine Ruddock, Project Director, Bronx REACH, Barbara Hart, Executive Director, The Bronx Health Link, Albert Alvarez, BPHC Director of	CC/HL strategy and standards developed and signed off by Executive Committee

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
	Collaboration, Mary Morris, BPHC Director of Workforce Innovation and Rosa Mejias, TEF (co-chair of the Workforce Subcommittee)	
DSRIP Coordinator	Lawrence Robertson	Coordination of management analytics

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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		
Partner organization Providers and Staff	Participate and contribute to CC/HL PPS initiatives	Comply with identified standards
CBO partner liaisons that represent a range of socioeconomic, cultural and demographic backgrounds	Provide input and feedback to create CC/HL initiatives and strategy	Community stakeholder participation in meetings, town halls, focus groups and BPHC Cultural Competency/Health Literacy Work Group
Dr. Nicole Hollingsworth	Advisor	Best practice guidance
Arlene Allende, SBH	Advisor	Best practice guidance
Leanette Alvarado	Advisor	Best practice guidance
External Stakeholders		
BPHC patients	Provide feedback by participating in surveys and focus groups	Focus groups and patient satisfaction survey responses
Other Bronx PPSs	Potential collaboration in developing Bronx-wide CC/HL strategy	Bronx-wide CC/HL strategy
Bronx Community at large	Greater use of primary care providers, health self-management for chronic conditions & participation in educational programs sponsored by the PPS	Improved health outcomes, more jobs with "living wages"
TEF-Rosa Mejias, Co Chair, BPHC workforce Subcommittee	Best practice training research and programming	Support for training strategy for CC/HL

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.

Community health workers and other PPS care management staff will use a planned commercial care coordination management solution (CCMS) to support culturally competent outreach, education, care coordination referral, advocacy and other information provided to PPS patients. Based on protocols tailored to patient cultural cohorts, and on individual care plans where available, the CCMS will be used for such activities as:

- Running periodic reports to monitor cultural makeup and requirements of PPS patients, based on data collected in screenings, assessments, etc.
- Providing multilingual, multicultural care navigation and support
- Tracking and assisting patients with practice selection, active engagement in DSRIP programs, utilization tracking and pediatric-adult transitions
- Assisting patients with locating and accessing community resources, including for palliative care
- Supporting transitions and warm handoffs at discharge, with follow-up tracking
- Educating patients and families about wellness and care, and supporting patients in self-management and shared decision making related to their health needs
- Surveying patients and families regarding care experience.

Providers and staff in other workforce segments will be trained regarding specific population needs and effective patient engagement approaches.

IPQR Module 4.8 - Progress Reporting

Instructions :

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

BPHC will measure the success of our cultural competency/health literacy strategy through members' successful achievement of the Domain 1 CC/HL milestones as well as the milestones referenced above. BPHC will also measure progress through providers' participation in contracting agreements, which will incorporate the PPS's health literacy and cultural competency standards. The Senior Director for Quality Management and Analytics within the CSO will be responsible for conducting ongoing assessment of the PPS's cultural competency activities and related quality-improvement efforts.

Related to patient engagement and clinical improvement, BPHC's QCIS will be charged with overseeing implementation of clinical projects and holding providers and the PPS accountable for achieving targeted metrics and clinical outcomes. Further, because all BPHC projects were selected based on health disparities data within the CNA, achieving broader clinical targets will reflect favorably upon the PPS's success reducing health disparities and creating a culturally competent and linguistically appropriate system of care.

Additionally, BPHC will obtain feedback from providers on the effectiveness of cultural competency strategies and training programs. BPHC will also include cultural competency in BPHC patient satisfaction surveys in order to understand BPHC patient needs.

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).	Completed	Detailed IT current state assessment. Relevant QEs (RHIOs/HIEs) should be involved in performing this assessment.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task Assess central PPS IT capabilities	Completed	Complete an assessment of IT capabilities for central PPS functions related to data collection requirements, performed by CSO in consultation with IT Sub-Committee.	04/01/2015	06/15/2015	04/01/2015	06/15/2015	06/30/2015	DY1 Q1	
Task Assess partner IT readiness	Completed	Organize, review and assess partner IT readiness assessment data collected to date re: EHR and other HIT platforms, RHIO/HIE adoption, interoperability/interfaces and data analytics/measurement/reporting capabilities.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Develop partner IT assessment database	Completed	Design, create and populate partner database to store partner IT assessment data.	04/01/2015	06/25/2015	04/01/2015	06/25/2015	06/30/2015	DY1 Q1	
Task Additional partner IT assessment	Completed	Conduct further data collection through partner surveys and interviews to fill gaps in partner data.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Assess current state of IT readiness	Completed	Review partner data to assess current state readiness re: EHRs, HIE, PCMH and other use of HIT.	09/01/2015	10/15/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Share and validate findings	Completed	Communicate/validate findings and data-sharing requirement gaps with partners and Executive Committee.	10/15/2015	12/31/2015	12/15/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Document current state of IT readiness	Completed	Complete IT current state assessment supporting documentation for central PPS and partner IT.	10/15/2015	12/31/2015	10/15/2015	12/31/2015	12/31/2015	DY1 Q3	
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;	04/01/2015	03/18/2016	04/01/2015	03/18/2016	03/31/2016	DY1 Q4	NO

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 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							
Task Establish IT Sub-Committee	Completed	Establish IT Sub-Committee, reconstituted from IT & Analytics Planning Workgroup, incorporating new members according to governance nomination processes.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Document IT Sub-Committee Charter	Completed	Document IT Sub-Committee charter and processes including change management oversight.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Develop processes and protocols for partners	Completed	Create and update processes and protocols for adoption and use of IT that all partners must implement.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop communication and training for partners	Completed	Develop communication, education and training plans related to processes and protocols for adoption and use of IT.	08/30/2015	11/15/2015	08/30/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop impact and risk management strategy	Completed	Develop an impact and risk management strategy for IT change management.	11/02/2015	12/04/2015	11/02/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish workflows	In Progress	Develop and document workflows for IT change management. Workflows may include (but are not limited to): Accepting change requests from partners and PPS leadership; Prioritizing and classifying changes; Coordinating assessment of change impact; Coordinating change approval; Planning/scheduling changes; Coordinating implementation of changes; Conducting testing and post-implementation reviews; and Providing management information about changes and change management performance.	12/07/2015	01/22/2016	12/07/2015	01/22/2016	03/31/2016	DY1 Q4	
Task Establish tracking and reporting structure	Not Started	Develop approach for tracking and reporting on IT change management implementation.	01/11/2016	02/05/2016	01/11/2016	02/05/2016	03/31/2016	DY1 Q4	
Task Obtain EC approval of change management strategy	Not Started	Obtain Executive Committee approval of IT governance and change management processes and policy.	02/01/2016	03/18/2016	02/01/2016	03/18/2016	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: -- A governance framework with overarching rules of the road	04/01/2015	02/26/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	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
		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 Survey current state of interoperability	Completed	Survey current clinical data-sharing and interoperability systems across PPS network to understand needs and requirements for specific hardware and software	04/01/2015	09/25/2015	04/01/2015	09/25/2015	09/30/2015	DY1 Q2	
Task Develop data exchange strategy	Completed	Establish priorities and develop plan for establishing data exchange capabilities and agreements with and among partners and vendors.	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Establish strategy for Care Coordination Management Solution implementation	Completed	Select and plan implementation and method of payment for of Care Coordination Management Solution across member organizations.	06/01/2015	09/15/2015	06/01/2015	09/15/2015	09/30/2015	DY1 Q2	
Task Integrate standards into partner contracts	Completed	Incorporate standards for clinical connectivity and funds flow into partner contracts.	09/15/2015	11/15/2015	09/15/2015	12/29/2015	12/31/2015	DY1 Q3	
Task Establish compliance strategy	Completed	Develop approach and establish governance for determining priorities and methods for promoting and ensuring partner compliance with connectivity standards and requirements.	10/19/2015	11/13/2015	10/19/2015	12/29/2015	12/31/2015	DY1 Q3	
Task Finalize clinical connectivity roadmap	In Progress	Document clinical connectivity roadmap and obtain IT Sub-Committee approval.	11/02/2015	12/04/2015	11/02/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Share clinical connectivity plans with partners	In Progress	Establish and communicate connectivity standards, priorities, compliance plan and partner support resources, including training plan and assistance program to partners.	12/07/2015	01/08/2016	12/07/2015	01/08/2016	03/31/2016	DY1 Q4	
Task Integrate standards into vendor contracts	In Progress	Incorporate standards for clinical connectivity into vendor contracts and develop solutions where needed.	08/01/2015	10/15/2015	08/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Provide guidance on clinical data exchange	In Progress	Document and provide partner guidance for exchanging clinical data set, including data sharing policies and procedures.	10/01/2015	11/15/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Conduct training on clinical data sharing and	In Progress	Based on the systems implemented, in conjunction with workforce subcommittee, deploy training, i.e., on-site, in-	09/01/2015	12/15/2015	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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interoperability		person and web-based learning management system.							
Task Ensure tracking of changes to data sharing agreements	Not Started	Develop approach for tracking and reporting on changes to data sharing agreements.	01/11/2016	02/26/2016	01/11/2016	02/26/2016	03/31/2016	DY1 Q4	
Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	Completed	PPS plan for engaging attributed members in Qualifying Entities, signed off by PPS Board. The plan should include your approach to outreach into culturally and linguistically isolated communities.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task Match attributed members	Completed	Validate/match attributed members against QE RHIO consents on file to inform engagement strategy/plan and develop a GAP analysis	08/03/2015	12/31/2015	08/03/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Review QE processes and challenges	Completed	Review current consent processes and lessons learned/challenges with QE consent.	09/01/2015	09/20/2015	09/01/2015	09/20/2015	09/30/2015	DY1 Q2	
Task Finalize strategy for obtaining consent	Completed	Develop recommendations for outreach and education of members for partners, clinical, MCO, or CBO, to follow; obtain IT Sub-Committee review and Executive Committee approval.	08/24/2015	12/31/2015	08/24/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop subscription alert strategy	Completed	Plan to implement subscription alerts or triggers through member touchpoints.	08/01/2015	09/30/2015	08/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Establish QE engagement reporting strategy	Completed	Develop approach for tracking and reporting partners' opprotunity to engage members in QE, possibly using patient health registries and communicate results to partners.	10/05/2015	11/28/2015	10/05/2015	11/28/2015	12/31/2015	DY1 Q3	
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.	06/15/2015	12/31/2015	06/15/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Assess security risks and establish controls	Completed	Analyze information security risks, design controls and identify gaps that will include two factor authentication, data encryption requirements and data access.	06/15/2015	12/31/2015	06/15/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish CSO oversight for vendor security testing	Completed	Develop plan for ongoing CSO IT oversight - owned by Chief Security Information Officer - for vendor security testing, including multifactor authentication.	09/14/2015	10/30/2015	09/14/2015	10/30/2015	12/31/2015	DY1 Q3	
Task Finalize data security and confidentiality plan	Completed	Incorporate risk mitigation and security testing recommendations into data security and confidentiality plan and obtain IT Sub-Committee review and Executive Committee approval.	09/01/2015	11/01/2015	09/01/2015	11/01/2015	12/31/2015	DY1 Q3	

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Task Establish implementation tracking system	Completed	Develop an IT approach for tracking and reporting on implementation of plan.	09/01/2015	11/01/2015	09/01/2015	11/01/2015	12/31/2015	DY1 Q3	
Task Communicate plan to partners and conduct trainings	Completed	Communicate data security and confidentiality plan to partners using email, webinars and training and education learning management system.	11/01/2015	12/31/2015	11/01/2015	12/31/2015	12/31/2015	DY1 Q3	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
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).	vchibiso	Meeting Materials	36_MDL0503_1_3_20160125155515_1.0.2_Meeting_Schedule_IT_SubCom.xlsx	This is a meeting schedule for all IT Sub Committee meetings where IT Readiness Assessment was discussed monthly.	01/25/2016 03:55 PM
	vchibiso	Baseline or Performance Documentation	36_MDL0503_1_3_20160125155405_1.0.1_IT_Needs_Assessment.docx	This is a comprehensive IT Needs Assessment.	01/25/2016 03:54 PM
Develop a specific plan for engaging attributed members in Qualifying Entities	vchibiso	Implementation Plan & Periodic Updates	36_MDL0503_1_3_20160125163423_4.0_BPHC-Letterhead-QE_Consent_Engagement_Strategy.docx	QE Consent Engagement Strategy	01/25/2016 04:34 PM
Develop a data security and confidentiality plan.	vchibiso	Policies/Procedures	36_MDL0503_1_3_20160129090157_1-28-2016_SSP_Submission_for_PHI_Read-Only_Access.docx	Minimal SSP Submission for PHI Read-Only Access	01/29/2016 09:01 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).	A needs assessment document was compiled articulating the PPS's IT capabilities. It describes the central services organization (CSO), as well as individual member organizations. The information was collected from various sources (surveys, interviews, public profiles, SIM, NCQA, Salient Interactive Miner, NCQA, and SDOH), with much input from BronxRHIO, our QE. The information was discussed and vetted at the nearly monthly IT Subcommittee meetings. All the data are stored in the Salesforce database. Milestone is complete and will continue to be updated.

NYS Confidentiality – High

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop an IT Change Management Strategy.	IT subcommittee has provided guidance on creating strategies for IT adoption and implementation. A draft of an overarching policy for training/education and risk management have also been developed but are pending further review and context that will be provided when various large systems will come into full effect (e.g., care coordination management system, or CCMS, Bronx RHIO). So far, only few standalone systems have been implemented (e.g., Salesforce, which is our PPS network management tool, and DSRIP Tracker, which is our CSO project management tool) with limited IT Change Management implications. Milestone is on track for completion.
Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	Both CCMS and Bronx RHIO contracts have been delayed due to product due diligence, despite the aggressive effort initiated and thus has been the impediment of some of the tasks in this milestone. There is, however, a series of master services agreements (MSAs) signed by the seven largest primary care organizations in the PPS which are critical steps towards achieving clinical connectivity. We developed draft registries and business requirements for these registries for each of the 10 projects which will help inform our data transfer needs. Milestone is on track to for completion. Adjustment: Pending the finalization of the CCMS and Bronx RHIO contracts, tasks 3.10, 3.6, and 3.9 cannot be complete and thus will need to be delayed by a quarter. The contracts are in their final stages and this delay should not pose a risk to completing the milestone.
Develop a specific plan for engaging attributed members in Qualifying Entities	A plan for engaging attributed members in the QE that is approved by the IT Subcommittee is attached. The plan will be further refined as part of a cross-Bronx PPS collaboration effort between BronxLeb, HHC, Advocate PPS, and BPHC. Milestone is complete and will continue to be updated. Adjustment: The milestone is complete despite tasks 4.1 and 4.4 not being complete due to unforeseen regulatory barriers.
Develop a data security and confidentiality plan.	We are submitting the second section of the SSP this quarter. Milestone is on track for completion. Updates to the SSP workbooks, were not required for our remediation submission. Improvements will be made and included in the Q4 submission.

Milestone Review Status

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

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IPQR Module 5.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

Based on collaborative IT work to date, we feel well prepared to continue to manage the challenges in evolving BPHC's current multi-stakeholder IT governance into an operational IT change management framework. While we anticipate reluctance on the part of some partners to agree to certain elements of network IT governance and requirements, we will educate partners on the need and justification for all requirements, processes and IT change management governance and have incorporated compliance provisions into Master DSRIP Service Agreements (MSAs) to eliminate ambiguity and make compliance contractually obligated.

Partners may be challenged to comply with data sharing obligations, especially those that had not previously participated in data exchange or whose IT infrastructures may not meet certified EHR MU requirements. Again, we will educate all partners on the importance of data sharing and compliance with data security and confidentiality policies and incorporate data sharing agreements into their MSAs.

We will work with Bronx RHIO, our predominant QE and a close partner of SBH and Montefiore, among other BPHC participants, to understand gaps in patient engagement, as measured by consent, and to implement targeted strategies for obtaining consent from more attributed patients. Partners may be challenged, however, to participate in the Bronx RHIO, to interface their disparate IT systems for health information exchange or to acquire certified EHR solutions capable of interoperating. Failure to achieve connectivity and data sharing objectives will have particular impact on Project 2.a.i, since clinical interoperability is critical to development of an integrated delivery system. BPHC will establish programs to assist in these areas, including monitoring and direct assistance to partners in achieving these interoperability and data sharing objectives.

IPQR Module 5.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

The IT workstream is dependent on strategies and requirements developed in the Performance Reporting, Clinical Integration and Population Health Management workstreams primarily, and to a lesser extent in all other organizational workstreams to the extent they identify IT expectations (e.g., for financial system enhancements in the Financial Sustainability workstream, or for workforce training and enablement using the planned care coordination management solution). In addition, the IT workstream will be highly interdependent with General Project Implementation and in particular for Domain 2 & 3 project-specific strategies and their Domain 1 requirements. Elements of IT governance may be dependent on the Governance workstream since the IT Sub-Committee and other elements of IT governance will be integrated into overall BPHC governance. BPHC considers IT integral to all aspects of PPS performance.

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IPQR Module 5.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Chief Information Officer	Dr. Jitendra Barmecha, MD, MPH, FACP, Chief Information Officer, SVP—IT & Clinical Engineering, SBH	• BPHC IT strategy • Overall IT implementation • Data security and confidentiality planning and compliance • Partner and patient engagement technologies
Chief Information Security Officer	Sam Cooks - AVP-IT	• IT Infrastructure, • Data Security • Communication
IT Analyst for Information Security	Chris Delgado	Support the CSO on IT infrastructure/strategy, data security, communication
Senior Director, Quality Mgmt & Analytics, CSO	Janine Dimitrakakis	Overall delivery of QM and analytics reporting
Director of Partner Connectivity BxRHIO Partners	Greg Malloy, SBH IT Kathy Miller, Bronx RHIO Dr. Terri Elman, Bronx RHIO	• Partner connectivity strategy • Bronx RHIO and other QE relationships • Partner connectivity adoption, implementation and support
Director of Care Management Technologies	Zane Last, SBH IT	• Care management / population health management requirements definition • Care management / population health management IT implementation and support
Associate Director of HealthCare Data and Analytics	Jonathan Ong, SBH IT	IT infrastructure support and implementation
Montefiore Medical Center IT Liaison	Brian Hoch, MMC IT Chuck Anderson, MMC IT Jack Wolf, MMC IT	• Implementation, integration and support of critical IT systems and functions supporting BPHC
Key point person/project manager from provider organizations	Nicolette Guillou, Montefiore Akwasiba Rafaelin, Montefiore Twiggy Ramirez, Acacia Network Irene Borgen, SBH Health System Zena Nelson, Institute for Family Health (IFH) Fernando Alonso, Bronx United IPA Nieves Madrid, Morris Heights Dean Bertone, Union Community Health Center	• Connectivity adoption, implementation, integration and support at own organization (for participation in BPHC) • Data exchange support

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
IT Subcommittee	Nicole Atanasio, Lott, Inc. Jitendra Barmecha, SBH Health System Helen Dao, Union Community Health Center Brian Hoch, Montefiore Medical Center Jeeny Job, SBH Health System Tracie Jones, BronxWorks Vipul Khamar, Visiting Nurse Service of New York Elizabeth Lever, The Institute for Family Health Uday Madasu, Coordinated Behavioral Care IPA Mike Matteo, Centerlight Health System Kathy Miller, Bronx RHIO Edgardo Nieves, Morris Heights Health Center Anthony Ramirez, Acacia Network Sam Sarkissian, University Behavioral Associates Yvette Walker, AllMed Medical & Rehabilitation Centers Nicole Atanasio, Lott, Inc. Jitendra Barmecha, SBH Health System Helen Dao, Union Community Health Center Brian Hoch, Montefiore Medical Center Jeeny Job, SBH Health System	IT governance

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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		
Attributed Patients and Families/Caregivers	Recipient of care services delivered with support of effective IT	• Interaction sufficient to participate and take limited accountability for health and care-related activities
BPHC CSO Business Staff	Accountable for integration and effective use of IT in PPS services	• Oversight and integration of IT into BPHC operations
BPHC Governance Committee Members	Governance for effective integration and use of IT, centrally and across partners	• Oversight and integration of IT into BPHC operations
SBH Management/Leadership	Fiduciary oversight for effective integration and use of IT in BPHC operations	• Oversight and integration of IT into BPHC and SBH operations
SBH IT Leadership and Staff	Primary leadership, project management and support	• Coordinate, support and maintain coordinated BPHC (and SBH) IT solutions
Montefiore Management/Leadership	Accountable for integration of key Montefiore-supplied IT functionality for BPHC support	• Oversight and integration of Montefiore IT into BPHC operations
Montefiore CMO Staff	Effective use of BPHC IT to deliver care management services to patients	• Effective use of BPHC (and Montefiore) IT solutions
Montefiore Bronx Accountable Health Network Staff	Effective use of BPHC IT to deliver Health Home services to patients	• Effective use of BPHC (and Montefiore) IT solutions
Montefiore IT Leadership and Staff	Project management and support for integrated Montefiore IT	• Coordinate, support and maintain integrated Montefiore IT solutions
Partner Organization Providers and Staff	Integration, connectivity and effective use of BPHC IT solutions	• Adopt, implement use and support integrated BPHC IT solutions
External Stakeholders		
Bronx RHIO Management/Leadership and Staff	Accountable for integration of key Bronx RHIO-supplied IT functionality for BPHC support	• Oversight and integration of Bronx RHIO IT into BPHC operations
Bronx Community Advocates/Leaders/Elected Officials	Awareness of how IT is being used to effectively support BPHC and Bronx patients	• Consume stakeholder communication and participation in stakeholder events
Bronx Community Members/Public At-Large	Awareness of how IT is being used to effectively support BPHC and Bronx patients	• Consume stakeholder communication and participation in stakeholder events
Non-Partner Providers	Awareness of how IT is being used to effectively support Bronx patients and how they can participate in Bronx RHIO and other IT solutions related to BPHC	• Bronx RHIO or other QE participation as warranted to effectively treat patients
CBO partners with experience in MH/BH, I/DD and	Curriculum Development and/or training	Serve as subject matter experts to the vendor(s) or partner(s)

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
SAS (e.g., ACMH, Community Access, Communilife, Cardinal McCloskey Community Services, EAC, Inc., St. Ann's Corner of Harm Reduction)		involved in curriculum development and training.
Medicaid Managed Care Organizations (MCOs)	Awareness of how IT is/can be used to serve covered members	• Contribute data and participate in RHIO or other IT solutions as warranted to effectively serve members
NYCDOH	Awareness of how IT is being used by BPHC	• Offer solutions, participate in BPHC IT solutions in order to serve Bronx residents
NYSDOH	Provide guidance and tools, including MAPP/SIM, to support BPHC use of IT	• Guidance and tools to support BPHC IT use, including for efficient performance management and DOH reporting
Organized Labor	Awareness of how IT is being used by BPHC	• Member labor support for and training on BPHC IT solutions, as warranted
Other Bronx PPSs	Awareness of how IT is being used to effectively support Bronx patients and how multiple PPSs may be able to support each other's or share IT solutions	• Participation in joint IT planning and solution development as warranted

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IPQR Module 5.7 - Progress Reporting

Instructions :

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

IT workstream success will be measured according to the following:
• Governance – Multi-stakeholder representation and participation in IT Sub-Committee meetings, with timely decision-making for IT-related issues

• Strategy/Solution Development – Timely completion of current state assessment, IT connectivity roadmap, data sharing plan, etc.
• Strategy Monitoring – Progress against IT strategy objectives and milestones
• QE Adoption and Integration – Percentages of providers using Bronx RHIO and patients consenting to disclosure
• Partner IT Capabilities – Percentages of providers using certified EHR technology, Meaningful Use attestation, and PCMH 2014 recognition

• Patient Engagement – Progress against achieving patient engagement goals and documented use of IT in achieving goals

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 Establish reporting oversight responsibilities	Completed	Designate reporting oversight responsibilities to Executive Committee, Quality and Care Innovation Sub-Committee and Finance and Sustainability Sub-Committee. BPHC Senior Director for Quality Management and Analytics will be responsible for working with the Quality and Care Innovation Sub-Committee on performance reporting activities.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Develop reporting and communication requirements	Completed	Complete analysis of state guidance to develop comprehensive requirements related to reporting and communication across all workstreams and projects.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Define performance reporting categories	Completed	Define categories of reporting (beyond those that are state-mandated) necessary for PPS performance management and operations, including Rapid Cycle Evaluation and monitoring of overall performance of BPHC and its network partners.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Analyze reporting capacities across PPS	Completed	Assess existing reporting capabilities of BPHC and its network partners to identify gaps between requirements and current capabilities.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Analyze MCO data exchange capacity	Completed	Assess MCO capabilities for data exchange relative to requirements for performance metric submission.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task	Completed	Identify CSO staff and network partner staff (i.e., end-users)	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Develop and test reporting mechanisms		who will participate in developing and beta-testing the functionality and technical specifications for reports.							
Task Hire performance reporting support staff	Completed	Identify/recruit qualified staff to support BPHC performance reporting according to the structure in the approved strategy.	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop performance reporting strategy	Not Started	Develop a performance reporting strategy encompassing infrastructure, external and internal reporting (including CAHPS measures), quality and performance dashboard(s), approach to Rapid Cycle Evaluation and feedback, communication strategies, alignment with MCOs, and required staff capabilities and obtain Executive Committee approval.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
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.	06/01/2015	06/30/2016	06/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Establish PPS reporting goals	Completed	Define clinical quality and performance reporting goals for the PPS.	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Define staff categories for training	Completed	Identify specific categories of end-users (e.g., CSO staff, partner leadership, care managers, etc.) who will be trained.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish reporting responsibilities	Completed	Determine site-specific reporting responsibilities by role.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish reporting goals by role	Completed	Define goals for reporting by role, helping staff understand targets and responsibilities toward meeting targets.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Provide technical assistance on interpreting data and reports for performance reporting	In Progress	Assist staff by role how to use data and interpret reports (as appropriate for role)	09/01/2015	12/31/2015	09/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Contract with vendor to develop performance reporting training program	In Progress	Identify a training vendor to work with BPHC to develop a performance reporting training program, including a schedule of training events for specific categories of end-users. Include training on Continuous Quality Improvement (CQI).	09/01/2015	12/31/2015	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Include roles, methods and tools specifications in training program	In Progress	Ensure that training plan describes both reporting expectations by role and details methods and tools by which reports are generated.	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Further define the role of workgroups as clinical quality councils	Completed	Establish role of workgroups as project-specific clinical quality councils that can provide feedback to site-specific reporters/implementation teams/DSRIP managers and clinical leadership.	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
Task Obtain approval on training program	Not Started	Vet and finalize the initial training program with the Executive Committee.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Create training materials	Not Started	Develop draft training materials.	03/01/2016	06/30/2016	03/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Pilot the training materials	Not Started	Conduct set of initial trainings.	05/01/2016	06/30/2016	05/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Develop orientation and training timeline	Not Started	Develop new hire orientation program and annual training schedule.	03/01/2016	06/30/2016	03/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Establish feedback mechanism and conduct retraining as needed	Not Started	Develop and implement a feedback mechanism for organizations and individuals that includes mechanisms for retraining if needed, when performance reporting falls short of needs.	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

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish reporting structure for PPS-wide performance reporting and communication.	The PPS hired performance reporting support staff this quarter; Janine Dimitrakakis joined the PPS in October as Senior Director for Analytics. She has healthcare industry experience in background in data analysis, operations, EMR implementation, reporting and analytics. The PPS has begun defining the performance reporting strategy for the PPS to be able to conclude the milestone next quarter. Sources for performance data have been identified, including RHIO, SIM, CCMS, partner EMRs, and site-specific DSRIP Program Directors (collecting and reporting data for Rapid Cycle Evaluation metrics). A performance monitoring structure and feedback mechanism have been defined and will be presented to the Executive Committee in DY1, Q4. BPHC is in the process of determining the most effective location to host clinical quality and performance dashboards, including considerations of tools available in Performance Logic (BPHC's project management software) and Salesforce (BPHC's network management and communication tool). Milestone on track for completion.
Develop training program for organizations and individuals throughout the network, focused on clinical quality and	Update: The PPS identified reporting goals, responsibilities, and categories of staff who will need training. Reporting goals include provision of performance reports to BPHC partners using data obtained through Rapid Cycle Evaluation, proxy measures for state collected performance metrics, and project/registry

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
performance reporting.	metrics. Training will be provided to Medical Directors, Site-Specific DSRIP Program Directors, Nurse Care Management Supervisors and IT/Analytics staff on data collection and submission (where appropriate for measure and site), using software tools to generate reports via PPS systems, interpreting performance data, and continuous quality/performance improvement. BPHC further defined the role of the QCIS Implementation Work Groups (IWG) to provide oversight to clinical quality and performance reporting; these work groups have transformed from Transitional Work Groups (focused on process development) to Implementation Work Groups (acting as project-specific clinical quality councils). Due to system contracting delays, three tasks which require system tools and methods, will be deferred. Potential training vendors have been identified to develop CQI and performance reporting curriculum for the training program. Milestone on track for completion. Date change justification: As we have hit the ground running with these tasks, we are realizing that task 2.05 (technical assistance) is out of sequence. We now believe that tasks 2.06 and 2.07 (the planning and training) must occur before we can provide technical assistance to staff in a meaningful way. Two vendors have been tentatively identified for performance reporting training. Some end-user roles have been developed. System tools are not yet in place, so we feel that it would be cost-effective and time-saving to wait for their design and development to proceed before we can create plans and curricula for the specifics of the reporting training program. System tools are not yet in place, so we feel that it would be cost-effective and time-saving to wait for their design and development to proceed before we can create plans and curricula for the specifics regarding the methods and tools by which reports are generated.

Milestone Review Status

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

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IPQR Module 6.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

Please describe the key challenges or risks that you foresee in implementing these cross-cutting organizational strategies, including potential impacts on specific projects and, crucially, any risks that will undermine your ability to achieve outcome measure targets.
1. Partners have varying levels of reporting capacity as well as interoperability, making it challenging to exchange standardized data and reports within BPHC's PPS. BPHC's assessment of partners' reporting capabilities as well as activities in the IT workstream will identify gaps in capabilities and BPHC will work closely with partners to close such gaps in time to meet DSRIP goals.
2. Partners have varying levels of analytical capabilities and will need to be brought up to a standard level of functioning in order to understand how to interpret reports and use them to improve clinical and financial outcomes. BPHC's training program will educate key personnel within each network partner and ongoing trainings will be made available as new personnel join or existing personnel have questions or require support with respect to performance reporting. In addition, staff from the CSO will supplement formal trainings by providing "on the ground" support for data collection and quality control while partner staff ramp up their reporting and interpretation skills.
3. It will be important to define and communicate the PPS's priorities and performance expectations throughout the CSO and between the CSO and network partners. Lack of understanding of the goals of BPHC and/or lack of understanding of how the day-to-day work of staff connects to those goals will lead to wasted and ineffective effort and will negatively affect the pace at which the goals of DSRIP are met. Because performance reporting and accountabilities are connected to every aspect of DSRIP implementation, there is a great need for an overarching vision for data analytics that serves the goals of the BPHC PPS. This vision must include clearly defined and articulated performance standards and expectations as well as a performance improvement strategy that articulates a feedback process between network partners and the CSO.
4. Because the PPSs will evolve and be a "learning entity," it will be challenging for the CSO to maintain focus on those goals and to orient new staff to the culture shift. BPHC is in the process of developing a PPS-wide communication plan that will address performance reporting expectations and processes. The communication plan will be continuously evaluated and updated to ensure BPHC is effectively reaching its partners through a range of methods (e.g., in-person meetings and webinars, newsletters and e-blasts, website updates, desk-side training and mentorship, etc.).

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.)

A clinical quality and performance reporting program will touch every aspect of the PPS. The PPS goals and performance standards, which will influence the structure of reporting, will be developed and approved by the committee structure implemented under the governance workstream. System improvements will be planned, deployed and monitored through the IT workstream. To be effective, the clinical quality and performance reporting program must be developed in tandem with the clinicians' engagement strategy because the reporting tools developed must be

championed by clinicians in order for the culture of change to take root. BPHC's approach to care management and population health management will inform the content of the dashboards and reports and the capabilities of the IT infrastructure will influence the types and timing of data available to be reported and analyzed. The program must also be developed with an eye towards the evolution of the PPS's workforce and serve the defined financial sustainability goals.

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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
Executive Director, CSO	Irene Kaufmann	BPHC overall performance management
Chief Financial Officer, CSO	Todd Gorlewski	Oversee financial metrics and outcome accountability
Senior Director, Quality Mgmt & Analytics, CSO	Dr. Amanda Ascher, CMO BPHC	Overall delivery of QM and analytics reporting
Senior Director, Care Delivery & Practice Innovations, CSO	Dr. J. Robin Moon	Seamless connecting with and strategy for the QM and clinical projects
Associate Director, Information Services, SBH (IT)	Jonathan Ong	IT infrastructure support and implementation
Key point person/project manager from provider organizations	Nicolette Guillou, Montefiore (ambulatory) Akwasiba Rafaelin (ED and IP) Twiggy Rodriguez, Acacia Network Irene Borgen, SBH Health System Zena Nelson, Institute for Family Health (IFH) Fernando Alonso, Bronx United IPA Nieves Madrid, Morris Heights Health Center (MHHC) Dean Bertone, Union Community Health Center (UCHC)	Integration and support of the reporting functions, reporting requirement adoption, implementation and communication with BPHC

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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		
Executive Committee: Eric Appelbaum, SBH; Maxine Golub, IFH; Marianne Kennedy, VNSNY; Pamela Mattel, Acacia; Fernando Oliver, Bronx United; Tosan Orwariye, MHHC; Amanda Parsons, MMC; Paul Rosenfield, Centerlight; Stephen Rosenthal MMC; Charles Scaglione, Bronx RHIO; Eileen Torres, BronxWorks; Len Walsch, SBH; Pat Wang, HealthFirst; Gladys Wrenwick, 1199; Douglas York, UCHC	Leadership on all performance reporting areas	Overall oversight of reporting process, including IT infrastructure, clinical quality metrics and financial issues
IT Sub-Committee members Nicole Atanasio, Lott Residence; Jitendra Barmecha, SBH; Helen Dao, UCHC; Brian Hoch, MMC; Jeeny Job, SBH; Tracie Jones, BronxWorks; Kate Nixon, VNSNY; Elizabeth Lever, IFH; Uday Madasu, Jewish Board; Michael Matteo, CenterLight; Kathy Miller, Bronx RHIO; Edgardo Nieves, MHHC; Anthony Ramirez, Acaia; Sam sarkissian, UBA	Leadership on tech decisions around the reporting process	Oversight and integration of the reporting infrastructure for BPHC PPS
Quality and Care Innovation Sub-Committee members Todd Ostrow, CenterLight; Kenneth Jones, MHHC; Dharti Vaghela, Essen; Frank Maseli, Bronx United; Chris Norwood, HealthPeople; Megan Fogarty, BronxWorks; Michele Quigley, United Cerebral Palsy Assoc; Debbie Pantin, VIP; Pablo Idez, IFH; Anne Meara, MMC; David Collymore, Acacia; Ed Telzak, DBH; Beverly Mosquera, Communilife; Rona Shapiro, 1199; Lizica Troneci, SBH	Leadership over the QA team at BPHC CSO	Oversight of defining quality report requirement and logistics

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Finance and Sustainability Sub-Committee members Carol Bouton, IFH; Carol Cassell, ArchCare; Tomas Del Rio, Acacia; Max Francios, Bronx United; Marcus Freeman, MHHC; Donna Friedman, RMHA; Todd Gorlewski, SBH; Mary Hartnett, UCHC; Josephine Incorvaia, CenterLight; David Koschitzki, MJHS; David Menashy, MMC; Kity Khudkar, Schevier Nursing; Denise Nunez, Divino Nino;l Ravi Ramaswamy, Families on the Move	Leadership on financial metrics	Oversight of financial reporting issues
Montefiore leadership Amanda Parsons, Stephen Rosenthal, Anne Meara	Accountable for integrating Montefiore quality measures with BPHC	Oversight and coordination of quality reporting to BPHC PPS
BPHC CSO clinical team staff Amanda Ascher, Janine Dimitrikakis, J Robin Moon	Accountable for timely communication and coordination with the QM team	Oversight and integration of the reporting into the QM
BPHC Executive Committee members Eric Appelbaum, SBH; Maxine Golub, IFH; Marianne Kennedy, VNSNY; Pamela Mattel, Acacia; Fernando Oliver, Bronx United; Tosan Orwariye, MHHC; Amanda Parsons, MMC; Paul Rosenfield, Centerlight; Stephen Rosenthal MMC; Charles Scaglione, Bronx RHIO; Eileen Torres, BronxWorks; Len Walsch, SBH; Pat Wang, HealthFirst; Gladys Wrenwick, 1199; Douglas York, UCHC	Leadership for and oversight of BPHC performance	Oversight of quality reporting into BPHC
Partner organization providers and staff, including DSRIP Program Managers/Directors	Accountable for meeting the PPS partnership requirement	Delivery of quality reporting requirements to BPHC
External Stakeholders		
Bronx RHIO Leadership and staff Charles Scaglione, Kathy Miller, Nance Shatkin, Keela Shatkin	Accountable for integration of key Bronx RHIO-supplied IT functionality for BPHC support	Oversight and integration of Bronx RHIO IT into BPHC operations
Other PPSs in NYC: Bronx Lebanon, OneCity, Staten Island, Advocate, Mount Sinai (initial idea exchange)	Exchange of ideas and plans utilized and potentially share solutions	Participation in joint planning, requirement development and mitigation strategies
1199SEIU TEF (Training vendor)	Accountable for training partners for reporting requirement and compliance	Fully developed training program. Train all partners.

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IPQR Module 6.7 - IT Expectations

Instructions :

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

BPHC intends to leverage shared data management and analytics infrastructure already present in the PPS, from Bronx RHIO. St. Barnabas Health System (SBH) has a close working and governance relationship with Bronx RHIO, as do Montefiore and Bronx Lebanon Hospital Center. Together, these organizations and others in the Bronx are already contributing data to Bronx RHIO, which manages the data for health information exchange and analytics, the latter under an ongoing Health Care Innovation Award from CMS. In either instance, the NYSDOH MAPP and Salient Interactive Miner (SIM) also contribute data utilized by BPHC's analytics team.

IPQR Module 6.8 - Progress Reporting

Instructions :

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

The success of this organizational workstream will be measured as follows:
Metric Submission – Successful and timely submission to DOH of performance measures and metrics that accurately reflect the progress of BPHC.
Rapid Cycle Evaluation – Effectiveness of clinical quality and performance dashboard tools in enabling BPHC to monitor progress and identify areas of strength and areas for improvement.
Analytics Staff Engagement and Communication – Training analytics staff to use the tools, to understand the goals of clinicians and leadership, and to communicate results to effectively translate metrics and measures into improved outcomes. This includes training on performance improvement and continuous quality improvement so that teams can take data that reflects poor or less-than-ideal performace and translate that into a PI project that will result in improved outcomes. As data reflects improved (or static) outcomes, continuous quality improvement strategies resule in further PI projects.
Staff and Leadership Engagement – Participation of clinicians and leadership in using clinical quality and performance measurement dashboards developed to improve care delivery and financial outcomes.
Informed Decision-Making – Integration of performance reporting into decision-making through the governance process to drive improvements, deploy resources, and assess progress against overall program goals.
Project level quality reporting--Successful and timely reporting to DOH of project level processes, outcomes, measures and metrics that accurately reflect the progress of each project.

IPQR Module 6.9 - IA Monitoring

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Instructions :

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Section 07 – Practitioner Engagement

IPQR Module 7.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop Practitioners communication and engagement plan.	In Progress	Practitioner communication and engagement plan. This should include: -- Your plans for creating PPS-wide professional groups / communities and their role in the PPS structure -- The development of standard performance reports to professional groups --The identification of profession / peer-group representatives for relevant governing bodies, including (but not limited to) Clinical Quality Committee	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Select QCIS members	Completed	Work with key PPS organizations and community-based organizations to select thought leaders from among the major practitioner groups/CBOs (including primary care physicians, subspecialists, nurses, mental health professionals, social workers, and peers) who will participate in the Quality and Care Innovation Sub-Committee.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Create QCIS meeting schedule and agenda	Completed	Establish a regular meeting schedule for convening the Quality and Care Innovation Sub-Committee, which will include review of standard performance reports as a standing agenda item.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Select work group members	Completed	Work with key PPS organizations and CBOs to select thought leaders from among the major practitioner groups/CBOs (including primary care physicians, subspecialists, nurses, mental health professionals, social workers, and peers) who will form rapid deployment collaboratives that will develop engagement strategies specific to the PPS quality improvement agenda and DSRIP projects. These	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		collaboratives will also serve as project clinical quality councils.							
Task Produce a plan for practitioner communication and engagement	Completed	Document practitioner communication/engagement plan including composition and role of the RDCs, schedule for regular webinars, and an approach for in-person, peer-to-peer learning forums. Include methods to monitor provider engagement levels.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish web-based practitioner communication tool	Completed	Establish an online practitioner communication tool.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Finalize plan for practitioner communication and engagement	Completed	Submit practitioner communication and engagement plan to Quality & Care Innovation Sub-Committee for review and approval.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Create RDC meeting schedule	Completed	Establish regular meeting schedule for convening the rapid deployment collaboratives.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Produce standard reporting tools	Not Started	Develop initial drafts of the content, format, frequency of standard performance reports (including rapid cycle evaluation and other reporting) addressing project-specific DSRIP metrics.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Create standard RDC meeting agenda	Not Started	Establish standard agenda for the RDC meetings including (1) implementation strategies and tactics, and (2) review of the rapid cycle evaluation reports and other performance reports.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
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.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Categorize practitioners for training purposes	Completed	Review PPS practitioner listing and organize the list into provider specific types for DSRIP project training purposes.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop training curriculum	Completed	Contract with vendors and/or partners with curriculum development and/or training capabilities geared to DSRIP project and practitioner type. Include Subject Matter Experts from our PPS partners in MH/BH, I/DD, and SAS in the curriculum development process.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Obtain approval of curriculum	Completed	Quality and Care Innovation Sub-Committee reviews/approves curriculum.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Develop training timeline	Completed	Develop training schedule and logistics to maximize participation by practitioners and arrange CME credit (free to PPS members) if feasible.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop plan for continuous quality improvement mechanisms	Not Started	Develop continuous quality improvement agenda and process and make recommendations to the Quality and Care Innovation Sub-Committee for approval.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Establish curriculum review process for quality improvement	Not Started	Work with the Quality and Care Innovation Sub-Committee and the RDCs to establish a process for curriculum content reviews/updates for general and provider type-specific education programs to address issues of special relevance including culture change, BPHC's quality agenda and the impact of quality improvement on practitioner incentives.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Develop post-training tests	Completed	Develop CME-type post-training testing/evaluation for practitioners to measure success of training.	04/01/2016	06/30/2016	11/02/2015	12/31/2015	12/31/2015	DY1 Q3	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop Practitioners communication and engagement plan.	Update: BPHC partner representatives, including senior clinical leadership and clinical practitioners, participate in our governance structure, made up of the Executive committee and four subcommittees: Quality and Care Innovation Subcommittee (QCIS), IT, Finance & Sustainability, and Workforce. QCIS reviews various reports produced by the CSO clinical team, and reviews and approves clinical elements (including evidence-based guidelines for clinical practice) of the Clinical Operations Plans developed in project-specific workgroups. These workgroups also have clinical practitioner engagement and these practitioners and newly engaged practitioners have formed Implementation Work Groups, or IWGs ("rapid deployment collaboratives"), to serve as project-specific clinical quality

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	councils that are overseen by the QCIS. The Practitioner Communications and Engagement Plan is near completion, and the milestone on track for timely completion.
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.	Update: Agreements have been developed with project-specific vendor/partners (The Institute for Family Health, Montefiore's Care Management Organization [CMO], a.i.r. nyc, and Health People) to conduct trainings based on the Clinical Operations Plans (COPs) developed by project-specific workgroups (described in Milestone 1 narrative). Chief Medical Officer achieved CME credit in January 2016 for practitioner trainings. We are working with a vendor to create a Performance Reporting Training that will also be provided to our practitioners. Milestone is on track for completion.

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.

BPHC has included both primary care and subspecialist clinicians from key partners throughout the planning and implementation process. A sample of clinicians participating include:

• Cardiovascular, diabetes, and asthma projects: Dr. Eric Appelbaum, Associate Medical Director at SBH Health System; Dr. David Collymore, Chief Medical Officer at Acacia Network; and Dr. Vanessa Pratomo, Associate Medical Director of Montefiore's Care Management Organization

• Primary care/behavioral health integration project: Dr. Brian Wong, Director of Adult Behavioral Health Services for the Montefiore Medical Group and Dr. Thomas Betzler, Executive Clinical Director, Montefiore Behavioral Health Center

• Care transitions, emergency department triage, and Health Home at-risk projects: Alex Alvarez, BSN, Senior Director, Network Care Management of Montefiore's Care Management Organization; Neil Pessin, Ph.D. of psychology, Vice President, Community Mental Health Services at Community Care Management Partners; Wanda Kelly, Director of Case Management, SBH Health System; and Donna Friedman, Ph.D. of psychology and LCSW, Deputy Executive Director of the Riverdale Mental Health Association

Overall, the range of practitioner types represented includes nurses, social workers, health educators, mental health professionals, and substance abuse professionals.

The PPS has held numerous "all member" webinars to educate practitioners about the transformative nature and resources that DSRIP will bring to the Bronx health care delivery system. We are expanding the number and types of practitioners included in the implementation planning process to include a broader group that has more physicians, nurses, social workers, care managers and behavioral health professionals.

The biggest risk to achieving the milestones is that practitioners will not feel able to take the time from their practice to participate in the Quality and Care Innovation Sub-Committee and/or to attend the educational and training sessions provided for each of the projects in which they have committed to participate. This is especially a risk for primary care practitioners (PCP) and their care team members to whom much of the training will be directed; virtually all of the DSRIP projects BPHC has selected impact PCPs in some way. BPHC hopes to mitigate this risk by offering trainings at various times and by potentially compensating practitioners who may be impacted by loss of income related to the training or participation in governing Committees, Sub-Committees, and/or Rapid Deployment Collaboratives. Provider turnover during the DSRIP period could also pose a risk to achieving DSRIP performance goals. We will implement a practitioner tracking system and provide regularly repeated orientations and briefings on the complexities of project implementation, which will be accompanied by a comprehensive implementation manual for new practitioners to use as a guide.

Another risk is that many BPHC practitioners will be participating in multiple clinical projects within our PPS and may also be participating in projects run by other PPSs. The sheer number of new projects to implement may be overwhelming for practitioners. To mitigate this risk, BPHC has conducted joint clinical planning efforts with other Bronx PPSs to align projects and project interventions. We plan to continue joint planning discussions over the course of DY1.

IPQR Module 7.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

It is difficult to point to a DSRIP workstream for which practitioner engagement is not interdependent. For example, IT use is fundamental to: practitioners adopting population health management, the CSO tracking quality metrics, practitioners monitoring patient activity between visits, and practitioners receiving alerts that enable quick follow up and communication when patients are in the hospital or emergency department. All of these capabilities advance BPHC's abilities to improve quality of care and patient outcomes that ultimately lead to cost reductions and financial sustainability. The long term success of clinical improvement projects in Domain 3 depends on practitioner willingness across the PPS network to adopt standardized clinical guidelines, processes and protocols proven to result in lower costs and better outcomes. Funds flow also is crucial for all practitioners' implementation of clinical projects, both for project operationalization and as a mechanism to reward practitioners for their commitment to the DSRIP projects. Finally, practitioners are a fundamental portion of the DSRIP workforce, and practitioner engagement is crucial to practitioner recruitment and retention efforts.

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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
BPHC CMO	Dr. Amanda Ascher	Provide oversight in the areas of the provider engagement and clinical/delivery strategy
Senior Director, Care Delivery and Practice Innovations	Dr. J. Robin Moon	Develop communication and support plans that are project-specific
BPHC Workforce Sub-Committee Co-Chairs	Mary Morris, Co-Chair, SBH Health System Rosa Mejias, Co-Chair, 1199 TEF	• Develop curriculum to support the quality agenda • Develop training materials that are project specific
Implementation Workgroups	Chairs of the IWGs	Solicit feedback from provider community on curriculum and quality agenda
Montefiore provider engagement liaison	Laura DeMaria	Assist in development and implementation of the communication and engagement plan
Bronx United IPA	Frank Maselli	Assist in development and implementation of the communication and engagement plan
NYSNA	Lourdes Blanco	Assist in development and implementation of the communication and engagement plan

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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		
Provider partners	Recipients of training and education in BPHC's quality goals	Participate in the training sessions and demonstrate practice change in support of BPHC's quality agenda
CBO partners with experience in MH/BH, I/DD and SAS (e.g., ACMH, Community Access, Communilife, Cardinal McCloskey Community Services, EAC, Inc., St. Ann's Corner of Harm Reduction)	Curriculum Development and/or training	Serve as subject matter experts to the vendor(s) or partner(s) involved in curriculum development and training.
BPHC training vendors (including 1199 TEF), Montefiore CMO, Institute for Family Health, a.i.r. NYC	Training and retraining of the work force	• Develop curriculum to support the quality agenda • Develop training materials that are project specific
Provider partners: Amanda Parsons, Montefiore Medical Group; Frank Maselli, Bronx United IPA; David Collymore, Acacia; Erica Gayle, IFH; Nelson Eng, UCHC; Dr. Tosan Oruwariye, MHHC	Management staff of these key providers will lead organization efforts to engage practitioners in critical trainings	Practitioners participate in the training sessions and demonstrate practice change in support of BPHC's quality agenda
Quality and Care Innovation Sub-Committee members Chairs: Dr. David Collymore, Acacia; Debbie Pantin, VIP Community Services	Provide quality standards and strategy	Approve the strategy and content for communication and engagement plan
External Stakeholders		
Other PPSs Damara Gutnick, MHV PPS; Kallanna Manjunath, Albany PPS; Anna Flatteau, OneCity Health	Sharing best practices	Regular communication stream
GNYHA--Mary-Ann Etiebet	Convener of all PPS CMO/Medical Directors' meetings	Regular communication stream
Bronx Medical Society	Provide discussion and feedback on clinical changes.	Help to engage provider partners in transformation (PCMH)

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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.

BPHC will implement and utilize a commercial customer relationship management (CRM) system such as from Salesforce.com to manage our physician network, including support for physician communication and engagement.
BPHC will demo and otherwise build awareness among physicians of the capabilities of the planned commercial care coordination management solution (CCMS), focusing on how the infrastructure will be used to provide better service and outcomes to their patients and make their practices more efficient, allowing them to deliver higher quality patient care, along with:
• Providing multi-lingual, multi-cultural care navigation and support
• Tracking and assisting patients with practice selection, active engagement in DSRIP programs, utilization tracking and pediatric-adult transitions

• Assisting patients with locating and accessing community resources
• Support transitions and warm handoffs at discharge, with follow-up tracking
• Educating patients and families about wellness and care, and supporting patients in self-management and shared decision making related to their health needs
• Surveying patients and families regarding care experience
In addition, physician training in evidence-based medicine, care coordination, population health management and other topics pertinent to BPHC and DSRIP will be scheduled, delivered and tracked using a learning management system (LMS) administered by the BPHC CSO.

IPQR Module 7.8 - Progress Reporting

Instructions :

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

The PPS will measure the success of this workstream in four ways. First, at the most basic level, we will monitor attendance at education and training sessions, all-member webinars, and other learning forums provided by the CSO. We will track attendance at clinical governance meetings, including our implementation and quality workgroups. Second, we have developed CME-type post-training testing for practitioners to measure the success and effects of the training. Third, to track long-term success of the practitioner engagement trainings, the CSO will be tracking practitioner performance on each project through rapid cycle evaluation (RCE) and auditing adherence to evidence-based guidelines and processes and protocols on a periodic basis. (e.g. Behavioral Health Integration into Primary Care, Care Management referrals, Diabetic Outcomes, etc.) Fourth, we will periodically bring RCE results to the Rapid Deployment Collaboratives (Implementation Work Groups acting as clinical quality councils and reporting to the Quality and Care Innovations Subcommittee) to gain knowledge about provider experiences and concerns regarding DSRIP project implementation and impact on them and their patients.

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IPQR Module 7.9 - IA Monitoring

Instructions :

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Section 08 – Population Health Management

IPQR Module 8.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop population health management roadmap.	In Progress	Population health roadmap, signed off by PPS Board, including: -- The IT infrastructure required to support a population health management approach -- Your overarching plans for achieving PCMH 2014 Level 3 certification in relevant provider organizations --Defined priority target populations and define plans for addressing their health disparities.	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4	NO
Task Envision PHM for PPS future state	Completed	Develop a population health management (PHM) vision	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Conduct gap analysis	Completed	Conduct gap analysis between current state and future vision, including assessing the gaps and barriers to achieving the PHM vision	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop Site-Specific Implementation Teams	Completed	Identify clinical champions and operational leaders in each primary care provider organization to develop and lead each of their providers/sites along the path to PCMH recognition. These facility-based champions/leaders form the Site-Specific Implementation Teams.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop technical assistance mechanisms for PCMH recognition	In Progress	Develop centralized technical assistance programs to assist primary care practices in achieving NCQA Level 3 PCMH recognition	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Develop PHM roadmap	In Progress	Draft PHM roadmap informed by gap analysis and assessment of PHM capabilities throughout the PPS	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Analyze current PHM capacity	In Progress	Assess current PHM capabilities throughout the PPS with a special focus on primary care and behavioral health practice organizations; assessment will include their readiness for	12/01/2015	03/31/2016	12/01/2015	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
		embedding PHM practices and workflows that support PCMH Level 3 and their staffing infrastructure to support PHM							
Task Partner with Bronx RHIO	In Progress	Establish partnership with RHIO that covers all PPS partners that need to receive and/or contribute patient data	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Obtain member buy-in for PHM roadmap	Not Started	Review PHM roadmap with IT Sub-Committee and Executive Committee	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Develop PHM registries	In Progress	Develop, with RHIO, PPS-wide PHM registries, for both PPS wide metrics as well as facility-level PHM capabilities.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Develop training methodology for registry and care plan systems	Not Started	Develop methodology for training on registry use and Care Plans Systems use as well as accountability for PHM outcomes, and evaluation, feedback and Continuous Quality Improvement for Site-Specific Implementation Teams.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Achieve PPS-wide PCMH recognition	In Progress	Move all primary care practices to NCQA Level 3 2014 PCMH recognition by end of DY3	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4	
Milestone #2 Finalize PPS-wide bed reduction plan.	In Progress	PPS Bed Reduction plan, signed off by PPS Board. This should set out your plan for bed reductions across your network, including behavioral health units/facilities, in line with planned reductions in avoidable admissions and the shift of activity from inpatient to outpatient settings.	08/01/2015	12/31/2018	08/01/2015	12/31/2018	12/31/2018	DY4 Q3	NO
Task Engage members in bed reduction strategy	In Progress	Convene Executive Committee to discuss bed reduction plan	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Analyze hospital utilization patterns	In Progress	Assess current inpatient hospital utilization rate trends in the Bronx	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Analyze hospital physical plants	Not Started	Assess long term viability, deferred maintenance, and efficiency of hospital physical plants	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Create bed-need projection strategy	Not Started	Develop methodology to project future bed need based on analysis of secular trends and impact of DSRIP interventions on inpatient utilization by hospital	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Refine bed-need projection strategy	Not Started	Test methodology to project future bed need, refine as needed and apply to PPS hospital providers to estimate bed reductions	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Engage SDOH in bed reduction strategy	Not Started	Work with SDOH to develop options to accomplish bed reductions and sustain and build capacity to provide a wide range of ambulatory services	01/01/2017	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1	
Task Project financial implications of bed reduction strategy	Not Started	Incorporate options under consideration into financial sustainability plan	07/01/2017	09/30/2017	07/01/2017	09/30/2017	09/30/2017	DY3 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Obtain approval for bed reduction strategy	Not Started	Present bed reduction plan to Executive Committee for review and approval	01/01/2018	03/31/2018	01/01/2018	03/31/2018	03/31/2018	DY3 Q4	
Task Monitor utilization and quality trends	Not Started	Track changes in occupancy, utilization rates overall, and discharges for PPRs, PQIs, and PDIs	04/01/2018	12/31/2018	04/01/2018	12/31/2018	12/31/2018	DY4 Q3	
Task Refine bed reduction projections and plans	Not Started	Reforecast bed reduction projections annually and update bed reduction plan accordingly	04/01/2018	12/31/2018	04/01/2018	12/31/2018	12/31/2018	DY4 Q3	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop population health management roadmap.	Update: This quarter BPHC conducted a population health management (PHM) vision gap analysis across system capabilities across key PPS systems, such as the BronxRHIO and CCMS for typical population health management functionality. The PHM gap analysis reviewed functions such as patient stratification, registries or cohorts to track / trigger events to manage care, referral management, data repository and ability to measure cost/outcomes/effectiveness, patient engagement, and care planning. BPHC also developed Site Specific Implementation Teams comprised of front line staff engaged in program roll out. Milestone on track for completion.
Finalize PPS-wide bed reduction plan.	Update: BPHC remains in the planning phase. PPS leadership is working to determine the most effective manner in which to engage partners in the development of a Bed Reduction Plan strategy. Analysis of hospital utilization patterns will be initiated in the coming months. Milestone on track for completion.

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

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.

BPHC anticipates it will have to manage a number of risks while instituting population health management strategies.
(1) Many primary care providers and community-based organizations lack an understanding of how to achieve population health management. While achieving NCQA Level 3 PCMH recognition significantly moves practices towards full population health management, it does not completely achieve this goal. This lack of understanding among providers may impede provider acceptance of the need to adopt new technologies and workflows to support population health management. To mitigate this risk, the CSO will implement a communications and education strategy to enhance providers' understanding and acceptance of population health management. The CSO will also develop and centralize resources and technologies to support providers' transition to population health management.
(2) Providers' adoption of new technology will be slow and will require significant resources devoted to training and oversight to ensure optimization. Slow uptake of technology could result in delays in meeting DSRIP speed and scale targets for patient engagement and achievement of Domain 1 project requirements. To mitigate these risks, BPHC will be prepared to use a variety of training methods to reach providers, including in-person, web-based, and call-in technical support, to provide training and technical assistance during off-hours to meet provider needs. Further, challenges with RHIO and patient engagement are outlined in our IT workstream and overcoming these barriers as outlined there will be key to success of our PHM registries.
(3) There is a risk that not all primary care provider sites will achieve NCQA PCMH Level 3 recognition by the end of DY3. The process for achieving 2014 NCQA PCMH Level 3 recognition is time consuming and requires strong support from leadership. Many primary care practice organizations have small numbers of personnel in leadership and administrative positions, creating a risk that they will not be able to devote sufficient attention to the process for attaining PCMH recognition. Some of the smaller practices may not have adequate staffing to meet all of the NCQA Level 3 2014 requirements. To mitigate these risks, BPHC will provide technical assistance to and invest resources in practices to ensure that there is sufficient internal and external leadership support and basic staff resources to meet the NCQA 2014 PCMH goal within the DSRIP-required time period.

IPQR Module 8.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

Population health management has the following major interdependencies with other workstreams.
Dependency #1: While IT systems alone will not yield a highly functioning population health management-based primary care practice, they are a necessary component of the change that will need to occur if population health management is to be successfully embedded into the daily

workflows of a primary care practice. Close alignment of IT architecture and its components with population health management goals must be central to planning. The selection of IT applications and phasing in of new technologies, along with training capabilities, are key to success in population health management.
Dependency #2: Clinical integration and the PCMH roadmap intersect with the population health management roadmap in multiple areas, specifically regarding conducting readiness assessments and the identification of data needs. For example, these workstreams require BPHC to integrate data from social service organizations, supportive housing providers and other community-based organizations into care planning and registry tools.
Dependency #3: BPHC's ability to achieve its vision of population health management will depend on its success at engaging and educating practitioners on how to use data effectively in improving outcomes and in implementing common protocols and processes to achieve DSRIP goals. In addition, BPHC must be successful in its performance reporting efforts.
Dependency #4: Timely implementation of our population health management roadmap is heavily dependent on our workforce strategy. For example, moving all primary care practices to NCQA Level 3 PCMH recognition by the end of DY3 will require adequate healthcare worker capacity in primary care sites and training to ensure that staff are functioning as a care team as envisioned by NCQA. In addition, the BPHC workforce will be heavily involved in planning efforts regarding PPS bed reduction. Finally, successful implementation of cultural competency and health literacy training and recruitment of culturally competent staff will be critical to patient engagement.
Dependency #5: The development of care coordination and care management programs as part of our clinical project implementation will be critical to the success of our primary care providers attaining Level 3 PCMH recognition and our PPS's success in moving to an integrated delivery system.

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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
Quality and Care Innovation Sub-Committee	Sub-Committee members	Develop strategy for deploying effective population health for BPHC attributed patients and the communities it serves
Central Services Organization (CSO)	All CSO staff	Conduct assessment and gap analysis of BPHC provider capabilities in implementing population health strategies
CIO, BPHC	Dr. Jitendra Barmecha, CIO, SBH	Develop architecture of IT applications that can automate PHM functions, and integrate care management software with provider IT technologies
Senior Director, Quality Management and Analytics	Dr. Amanda Ascher, CMO BPHC	Produce patient cohorts that will be targeted for population health interventions including tactics surrounding predictive modeling and risk stratification
Senior Director, Care Delivery & Practice Innovations	Dr. J. Robin Moon	Deploy evidence-based tools and care management functions that support patient engagement and activation
IT Sub-Committee	Dr. Jitendra Barmecha, Chair, SBH Health System	Assist in selecting PHM related applications, developing phase in implementation schedule
Executive Committee	Len Walsh, Chair	Develop a bed reduction plan for BPHC member hospitals
Partner IT Liaisons	Nicole Atansasio, Lott, Inc; Helen Dao, Union; Brian Hoch, Montefiore; Jeeny Job, SBH; Tracie Jones, BronxWorks; Vipul Khamar, VNSNY; Elizabeth Lever, The Institute for Family Health; Uday Madasu, CBC IPA; Mike Matteo, Centerlight; Kathy Miller, Bronx RHIO; Edgardo Nieves, Morris Heights; Anthony Ramirez, Acacia; Sam Sarkissian, UBA; Uvette Walker, Allmed	Implement, adopt and integrate with BPHC population health tools

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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		
Attributed patients	Recipients of services	Participate in care management
Providers in BPHC	Identify patients for care management	Participate in training on clinical and billing documentation to enable appropriate population identification and selection for PHM. Participate in technical assistance and project management for PCMH NCQA certification.
Care managers at partner organizations, including BAHN, CCMP and CBC	Manage risk reduction in identified populations	Create care plans and manage populations to reduce adverse outcomes including reductions in disease burden
CBOs	Promote health by actively engaging patient on social determinants	Intervene on patients identified with social determinants
External Stakeholders		
NYCDOHMH	Coordinating Domain 4 goal achievement	Coordinates and collaborates with NYC PPSs in developing strategies to improve MHSA infrastructure and retention in HIV care
State DOH	Oversees state DSRIP implementation and effectiveness	Creates timelines and deliverables for DSRIP program
Other PPSs participating in the same Domain 4 projects: OneCity, Community Care Brooklyn, Bronx Health Access, Mount Sinai, Brooklyn Bridges, NewYork Hospital Queens	Collaboration, information exchange, shared workforce development	Key deliverables/resps: Collaborate on shared projects and organizational initiatives, strategize on information exchange, and collaborate on shared workforce development

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.

Current population health management IT capabilities in place in BPHC include Montefiore CMO's comprehensive care management system which is being used by 400 care management employees to coordinate care for more than 300,000 individuals across employer-sponsored coverage and Medicare and Medicaid managed care. In addition, care management agencies supporting our partner Health Home populations are using smaller scale care management solutions, while other partners are using homegrown analytics to track patients across settings and within condition cohorts. Finally, the Bronx RHIO has developed the Bronx Regional Analytics Database (BRAD) under a multi-year grant from the CMS Center for Medicare and Medicaid Innovation.

A primary BPHC objective is to develop a standardized approach to population health management on behalf of our attributed population across all PPS participants based on a new IT infrastructure – portions of which are being selected in collaboration with Montefiore CMO and Montefiore's Hudson Valley PPS and portions of which build on existing capabilities. Our plans for leveraging and developing a new and integrated IT infrastructure for population health management are based on the following:

• Central data management and analytics through the Bronx RHIO.
• Patient and provider matching and master data management through Bronx RHIO to provide a single integrated view of each patient and a unified, standard and navigable view of participating partners to each other.
• A common commercial care coordination management solution (CCMS) selected from among three finalist vendors being assessed by a cross-functional team of Montefiore and BPHC clinical, operational and technology subject matter experts.
• Health information exchange through Bronx RHIO to achieve required data sharing between electronic medical records and the CCMS, across BPHC and potentially with other PPSs.
• Performance management and metrics (analytics) for internal analysis and reporting and NYSDOH reporting, based on Bronx RHIO and Montefiore Enterprise Data Warehouse capabilities.
• Assessment, monitoring and support programs and resources to help partners implement certified EHRs, adopt and integrate with RHIO services and, if eligible, use the combined IT infrastructure to achieve PCMH 2014 recognition.
• A digital health strategy for patient engagement, including telehealth, remote monitoring, a patient portal and personal health record sharing and digital health apps that are culturally competent.

IPQR Module 8.8 - Progress Reporting

Instructions :

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

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BPHC will measure the success of the population health management workstream using the following metrics:
• The number of primary care practice team members who have begun training on population health management applications
• The number of primary care practice team members who have completed training on population health management applications
• The number of providers (primary care team, behavioral health teams and others) that actively use electronic medical records, care planning tools, and patient registries
• The number of primary care practices that have submitted to the CSO work plans and timelines for attaining NCQA 2014 PCMH recognition

• The number of primary care practices that have begun the process per their work plan for achieving NCQA Level 1, 2 or 3 PCMH recognition

• The number of primary practices that achieved NCQA Level 1, 2 or 3 PCMH recognition
• The approval of a bed reduction plan by the Executive Committee
• DSRIP project-specific metrics such as PQIs, PDIs, PPRs, PPVs, and HEDIS metrics such as hemoglobin A1c, LDL, flu shots, and others

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'.	Completed	Clinical integration 'needs assessment' document, signed off by the Clinical Quality Committee, including: -- Mapping the providers in the network and their requirements for clinical integration (including clinical providers, care management and other providers impacting on social determinants of health) -- Identifying key data points for shared access and the key interfaces that will have an impact on clinical integration -- Identify other potential mechanisms to be used for driving clinical integration	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task Envision clinical integration end-state	Completed	Define end-state clinical integration model, aligned with requirements for Project 2.a.i and IT Systems & Processes.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Identify care protocols for clinical integration	Completed	Determine which project-specific care protocols require clinical integration. Protocols will be determined as outlined in second milestone "Developing a Clinical Integration Strategy."	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Investigate gaps and needs across PPS related to clinical integration	Completed	Conduct data collection with partners to complete assessment of key DSRIP project requirements, clinical service gaps, workforce and process gaps, data sharing and interface needs, etc.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish definition of clinical integration for partners	Completed	Define clinical integration for our Provider Partners as the need for PPS-wide standardization and alignment with high-value treatment protocols that various provider partners can implement in their practices; this includes, but is not limited to, promoting effective care transitions.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Analyze data on gaps and needs across PPS	Completed	Complete analysis of data collected to identify clinical integration needs, potential strategies/programs and priorities,	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
related to clinical integration		based on project, partner and PPS management goals.							
Task Report findings on gaps and needs across PPS related to clinical integration	Completed	Document assessment findings and recommendations, with prioritized clinical integration activities.	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Develop a Clinical Integration strategy.	In Progress	Clinical Integration Strategy, signed off by Clinical Quality Committee, including: -- Clinical and other info for sharing -- Data sharing systems and interoperability -- A specific Care Transitions Strategy, including: hospital admission and discharge coordination; and care transitions and coordination and communication among primary care, mental health and substance use providers -- Training for providers across settings (inc. ED, inpatient, outpatient) regarding clinical integration, tools and communication for coordination -- Training for operations staff on care coordination and communication tools	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Create project-based work groups to develop clinical guidelines	Completed	Form project-based workgroups to recommend, for clinical use across the PPS, high value treatment protocols and evidence based guidelines and clinical recommendations.	06/15/2015	09/30/2015	06/15/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Identify overlaps between project and PCMH requirements	Completed	Develop cross-walks for the project specific metrics with PCMH 2014 level 3 requirements.	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Identify overlaps between clinical project requirements	Completed	Develop crosswalks across all selected projects to assure clinical integration across projects and to avoid siloed implementation and integration plans.	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Create mechanism for approval of workgroup recommendations by QCIS	Completed	Establish methodology for workgroup recommendations to be vetted and approved by QCIS	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop PPS clinical integration strategy	Completed	Develop strategy for clinical integration, based on needs assessment findings and recommendations, in consultation with the Quality and Care Innovation Sub-Committee and the Executive Committee.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop data sharing and clinical interoperability implementation plan	In Progress	Identify and document data sharing and clinical interoperability implementation plan, including standardized workflow and protocols, staff and partner role definitions, and strategies such as event notification, clinical messaging and	08/01/2015	12/31/2015	08/01/2015	03/31/2016	03/31/2016	DY1 Q4	

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		other protocols specific to supporting care transitions across settings.							
Task Foster two-way communications for transfer of clinical information	Completed	Establish expectations for two-way communication with multidisciplinary care teams that interact with and treat patients, ensuring seamless clinical information transfer.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish site-specific implementation teams	Completed	Identify Provider-based Implementation Teams	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop dissemination strategy for implementation tools and procedures	Completed	Develop strategy for dissemination of recommendations, training on guidelines/protocols/implementation strategies	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Further define the role of workgroups as clinical quality councils	Completed	Develop methodologies for project-based workgroups to serve as project quality councils.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish feedback mechanisms	Completed	Develop feedback mechanisms for accountability and Continuous Quality Improvement	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Implement communications strategy to engage partners in clinical interoperability planning	In Progress	Communicate clinical interoperability implementation plan to partners using email, webinars and formal training and education designed to engage providers/partners in clinical integration efforts.	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Create care transitions strategy	Completed	Work with vendor to develop care transitions strategy across patient and provider types, including impementation plan. Care transition planning steps will include but not be limited to: Stakeholder Identification, finalizing workplan, curriculum development, staffing plan development, workflow for PCP appointment scheduling, evaluate IT needs including ENS, staff recruitment and training, site-specific support during and post-implementation.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop care coordination training strategy	In Progress	Identify and decide on options for staff training on care coordination skills, patient centered communication skills and the use of care coordination tools.	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Identify training curricula	In Progress	Identify training curricula for providers on behavioral health assessments to identify unmet needs of patients.	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Establish regular review of and updates to evidence based guidelines	In Progress	Develop mechanisms for regular review of project-selected Evidence Based Guidelines (by project quality councils) to assure our PPS is utilizing the most up-to-date tools and that those upadated guidelines/protocols continue to be clinically integrated across the PPS.	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 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
Perform a clinical integration 'needs assessment'.	zstopak	Documentation/Certification	36_MDL0903_1_3_20160129092307_M1_Clinical_Integration_Meeting_Schedule_DY1Q3_-_FINAL.xlsx	Clinical Integration Meeting Schedule Template	01/29/2016 09:23 AM
	lrobsbh	Other	36_MDL0903_1_3_20160121132742_DSRIP_Transformational_Requirements_11.5.15.docx	Transformation requirements	01/21/2016 01:27 PM
	lrobsbh	Other	36_MDL0903_1_3_20160121132631_BPHC_Start up_Funds_Request_for_Information_for_Clinical_Integration_10.31.15.xlsx	Start up funds RFI	01/21/2016 01:26 PM
	lrobsbh	Other	36_MDL0903_1_3_20160121132559_BPHC_Provider_List_for_Clinical_Integration_via_PCMH_Engagement.xlsx	Provider list for clinical integration	01/21/2016 01:25 PM
	lrobsbh	Other	36_MDL0903_1_3_20160121132522_BPHC_Partner_Startup_RFI_for_Clinical_Integration_Background.docx	Partner startup RFI for clinical integration background.	01/21/2016 01:25 PM
	lrobsbh	Other	36_MDL0903_1_3_20160121132441_BPHC_Clinical_Integration_Planning_Document.12.8.15.pptx	Clinical integration planning document.	01/21/2016 01:24 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform a clinical integration 'needs assessment'.	BPHC has completed this milestone. The attached documentation demonstrates our close attention to the clinical integration needs across our PPS. The documents show the network providers (by type and grouping) to be integrated and the key interfaces and supports needed to achieve clinical integration. A separate list of providers by organization and individual provider name is attached to show how these providers have already been or are being integrated through PCMH transformation process. As our data connectivity is enabled, we will be able to show updated lists of providers who have been further integrated. The meeting schedule attached shows the development of the Clinical Integration Planning Document, the Needs Assessment Tool, which we call the Request for Information for Clinical Integration ("RFI") and the review process.
Develop a Clinical Integration strategy.	Update: BPHC is on track toward timely milestone completion. We have a Care Transitions design team and a Care Coordination Management Systems (CCMS) Solutions Workgroup addressing the specific data-sharing systems and interoperability requirements for a PPS-wide Care Transitions Strategy, and we are creating training curricula for providers of all types regarding clinical integration, communications tools and care coordination. It is our plan to coordinately seamlessly with the Workforce counterparts to ensure such incorporation in training. We also continue to vet IT platforms for data-sharing and interoperability, including Bronx RHIO, Acupera as a care coordination management system, Healthify as referral management system, and Salesforce as network management

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	system, as we near agreements for their PPS-wide utilization. Date change justification: The finalization of the data sharing and clinical interoperability implementation plan will be completed in DY1, Q4 to better align with overall milestone progress.

Milestone Review Status

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

Due to the cooperative nature of our partner relationship, we expect that network participants will embrace collaborative clinical integration assessment and strategy activities, and that they are eager to engage in greater clinical integration. We recognize, however, that our partners often already feel stretched thin by the operating requirements of their existing organizations and that creating and managing an effective integrated workflow across a high number of partners may present a challenge. The greatest risk will be to attempt to "boil the ocean" regarding clinical integration. We will mitigate against this risk by basing integration goals on specific project and organizational requirements identified in other workstreams, and on measures specified in program terms and conditions that can be measured to provide quantitative evidence of integration improving patient outcomes. We will also seek to define common and standardized workflows and protocols that make clinical integration achievable for all partners, without creating a substantial additional burden.
Additional risks may arise from disparate technology and data sets and an inadequate workforce and resources. We will mitigate these risks by thoroughly assessing and analyzing partner interoperability and staff capabilities and readiness, as described in the IT Systems & Processes workstream, and providing formal PPS program support for achieving EHR implementation and integration, QE participation and PCMH recognition.

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.)

The strategies developed in the Clinical Integration workstream are closely related to requirements and strategies that will be identified in the Workforce Strategy, IT Systems and Processes, Performance Reporting, Physician Engagement and Population Health Management workstreams. In addition, the Clinical Integration workstream will be highly interdependent with General Project Implementation and in particular for Domain 2 & 3 project-specific strategies and their Domain 1 requirements, including primary care providers attaining 2014 Level 3 PCMH recognition. Many of the goals and requirements of project 2.a.i are closely related to clinical integration. Finally, physician engagement will be a core component and prerequisite for establishing a clinically integrated network.

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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
Senior Director, Care Delivery & Practice Innovations	Dr. J. Robin Moon	• Oversight of project management and clinical integration • Clinical integration strategy
Clinical Project Directors, CSO	Vitaly Chibisov, Benny Turner, Caitlin Verrilli, Monica Chierici	• Completed and analyzed provider and CBO surveys • Clinical Integration strategy
Executive Committee, BPHC	Len Walsh, Chair	• Oversight of clinical integration
QCI Subcommittee	Co-chairs: Dr. David Collymore, Acacia Debbie Pantin, VIP Community Services	• Oversight of performance reporting structure and plan
Workforce Subcommittee	Mary Morris, Co-Chair, SBH Health System Rosa Mejias, Co-Chair, 1199 TEF	• Provider training plan and tools
Key Point Person/DSRIP Project Managers	Nicolette Guillou, Montefiore (ambulatory) Akwasiba Rafaelin (ED and in patient) Twiggy Rodriguez, Acacia Network Irene Borgen, SBH Health System Zena Nelson, Institute for Family Health (IFH) Fernando Alonso, Bronx United IPA Nieves Madrid, Morris Heights Health Center (MHHC) Dean Bertone, Union Community Health Center (UCHC)	• Regular communication • Timely reporting on pertinent data • Feedback on the integration process
Clinical Liaisons	Site-Specific Medical Directors/Designees	• Regular communication • Timely reporting on pertinent data • Feedback on the integration process
Montefiore CMO Liaisons	Anne Meara, Associate Vice President, Network Care Management, Montefiore Care Management Organization Alex Alvarez, Director, Care Management Resource Unit	• Regular communication • Timely reporting on pertinent data • Feedback on the integration process
IT team, CSO	SBH IT Team led by Dr. Jitendra Barmecha, CIO	• IT infrastructure to support the data integration
Mental Health Liasions	Virna Little, IFH Dr. Lizica Troneci, Chair Psychiatry, SBH	BH clinical integration
Substance Use Liaisons	Debbie Pantin, SAED, VIP Pam Mattel, CEO, Acacia,	Substance Use clinical integration

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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		
Bronx RHIO leadership: Kathryn Miller, Charles Scaglione	Health information exchange provider	Support in analyzing current state of IT interoperability and developing strategies to support, broaden and enhance future clinical integration with data exchange
IT team, SBH: Dr. Jitendra Barmecho, CIO, Jonathan Ong, Zane Last, Gregg Malloy	Provide data exchange, IT interoperability and systems integration strategy and support	Alignment with IT systems and processes related to clinical integration; input into data sharing and interoperability strategies, including IT interfaces and messaging to support clinical integration
Montefiore CMO: Anne Meara, Alex Alvarez, Peggy Czinger, John Willeford	Provide clinical integration experience and expertise from ongoing care	Lessons learned from and input into future team-based care management, care coordination and organizational supports (e.g., staffing, IT, contact center, etc.)
External Stakeholders		
NYC DOHMH	Support for the Domain 3 project's planning and execution	Domain 3 projects planning process
Other Bronx PPSs: Advocate PPS OneCity Health PPS Bronx Lebanon PPS	Accountability and sharing of best practices	Regular communication stream
OASAS	Support for PC/BH Integration and MHSA	Support with review of clinical guidelines to align with best practices.

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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.

Nearly all components of BPHC's shared IT infrastructure will support and are critical to clinical integration:
• Central data management and analytics through the Bronx RHIO will provide common data and outcomes measurement to bind together partners and help them track common integration results in a standardized way.
• Patient and provider matching and master data management through Bronx RHIO will provide a single integrated view of each patient and a unified, standard and navigable view of participating partners to each other.
• A common care coordination management solution (CCMS) will further present an integrated view of the patient and provide a common tool for interacting with patients and with other partners
• Data sharing and interoperability standards and protocols embedded in partner contracts will support transitions and care management and promote an integrated and longitudinal view of the patient through secure messaging, event notification and potential aggregated portal data sets and other patient- and provider-facing applications.

IPQR Module 9.8 - Progress Reporting

Instructions :

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

Clinical integration will be measured by: evidence of high value treatment protocols implemented by providers across the PPS; improvements in clinical outcomes (e.g., improved rates of LDL and HTN control in CVD patients, improved A1C rates in Diabetics, improved depression screening and improving PHQ9 scores in patients receiving care in a BH integrated model.) Clinical integration success will also be measured by the level of Provider based engagement in Continuous Quality improvement, as measured by our workgroups which serve as project-specific quality councils.

IPQR Module 9.9 - IA Monitoring:

Instructions :

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Section 10 – General Project Reporting

IPQR Module 10.1 - Overall approach to implementation

Instructions :

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

BPHC is committed to establishing a care delivery model with mutually reinforcing resources and capabilities across the PPS. These aim to measurably improve patient satisfaction, improve outcomes, lower costs and enable the transition from volume to value-based care. To this end: 1) BPHC is establishing a population health management-driven HIT architecture to allow electronic data sharing across providers and access to patient-level information. This will facilitate rapid treatment and care management decisions among collaborating providers and beneficiaries about physical, behavioral, and social problems that impact beneficiaries' lives and support attainment of PCMH Level 3 2014 standards. 2) BPHC is creating an analytics capability for access to timely performance reports, to help accountable parties measure and track the impact of their actions on both a patient and population level and identify areas for improvement. The analytics team monitors the PPS and partners' progress towards meeting project targets. 3) BPHC is developing a workforce recruitment and retention strategy including career paths, higher education incentives, and excellent training and competitive salaries for a culturally and linguistically competent care management staff to engage, educate, and support individuals in need of assistance in managing both medical and social chronic conditions. 4) BPHC is leveraging the clinical and administrative leadership within each PPS partner and will ensure they have adequate dedicated time to drive overall DSRIP implementation. Partners' clinical and administrative leadership will: educate and motivate staff to embrace evidence-based practices; use technology to help improve patient outcomes; ensure that staff engage in DSRIP project-related training; provide quality oversight; and oversee the achievement of PCMH NCQA Level 3 2014 recognition. 5) BPHC has established a Quality and Care Innovation Sub-Committee (QCIS) to act as BPHC's clinical governance body. The QCIS draws from key partners and include diverse, well-informed, activist practitioner thought leaders, ranging from PCPs, subspecialists, nurses, mental health professionals, and social workers. The QCIS analytics support team will acquire and present data to rapidly and decisively direct attention to high performers for best practices and to low performers for remediation. The clinical governance body will: provide clear direction and a strong voice in defining and implementing change at the provider level to create a culture of quality and accountability; advocate for clinical integration to improve care; and seize opportunities to collaborate with other PPSs. 6) BPHC is developing a financial sustainability plan that begins with a transparent and coordinated inter-project budgeting system that: supports DSRIP central services; accurately reflects needed investments in PPS provider staffing and IT infrastructure; accounts for overlapping project personnel and training curricula; and moves in phases to a total cost of care model that expands upon the risk-based model now in place for some PPS providers via Healthfirst and other MCO contracts. 7) BPHC is actively collaborating with other Bronx PPSs, including the HHC and Bronx-Lebanon-led PPSs and the Advocate Community Providers PPS, on multiple areas including clinical planning, workforce development, community engagement, and information sharing. 8) BPHC has established a Central Services Organization (CSO) to provide a range of services to PPS partners, including clinical supervision, information technology, financial, training, analytics, administrative, and care management/care coordination infrastructure services. The CSO will also ensure partners' compliance with project requirements and track the project implementation and patient engagement speed commitments across all projects.

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

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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.

BPHC sees its DSRIP projects as a suite of programs that enable one another and magnify the impact of individual projects and workstreams. Some of the major dependencies include the following: Population health management and IT systems & processes: Attaining PCMH Level 3 recognition is widely viewed among clinicians who have been involved in DSRIP planning as the "master DSRIP project milestone" off of which virtually all other DSRIP projects and elements are built, including patient engagement and follow up. The BPHC HIT architecture is geared to providing IT capabilities that support work flows and protocols used by high-functioning Level 3 PCMHs to transition to population health management, such as electronic medical records, best practice alerts, care planning systems, patient registries, and tracking and stratification tools. Underlying these capabilities are a central data storage and management plan, robust data governance, and RHIO connectivity. Project implementation, IT systems & processes, and financial sustainability: Clinical improvement projects focused on cardiovascular disease, diabetes, asthma, and behavioral health will be built upon the chronic care management foundation provided by a high functioning Level 3 PCMH. Key PCMH features that promote effective chronic care management include use of evidence-based guidelines selected by consensus of the clinical governance body and data sharing that enables practitioners and embedded care managers to assess and develop effective care plans for the target populations. Ultimately, the establishment of Level 3 PCMHs across the PPS will be the impetus for moving to value-based payments that build a sustainable delivery system. Implementation of clinical improvement projects will be designed to build upon IT, workflows and clinical training used in the NCQA PCMH recognition process. Performance reporting, clinical integration and practitioner engagement: Practitioner accountability will be built on performance reporting that provides provider-specific and comparative performance data on the patient, practice and population level. Performance reporting is a key provider engagement tactic. Workforce strategy: A robust and well-trained workforce, rooted in the diverse communities of the Bronx, and engaged in the transformative change required under DSRIP will be central to the success of DSRIP project implementation. BPHC has identified a four-part workforce strategy that will be fleshed out based on the needs of our clinical projects. Our strategy includes: (1) redeployment of workers to respond to shifting staffing needs and ensure any displaced workers are connected to new employment; (2) training and education to address the needs for both retraining of existing staff and onboarding those newly hired under DSRIP; (3) robust recruitment to attract new workers; and (4) active engagement of labor and frontline staff.

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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
Executive Director, CSO	Irene Kaufmann	• Oversee all of the PPS work and CSO activities to accomplish all of the projects' implementation. • Communicate with the Executive Committee, and represent the CSO to all of the Sub-Committees. • Project monitoring and performance reporting. • Support and report to BPHC governance. • Act as liaison to NYSDOH and other PPSs.
Chief Medical Officer, CSO	Dr. Amanda Ascher	• Oversee project-specific provider engagement and clinical/delivery strategies and monitoring of performance/ outcomes. • Collaborate with BPHC members' CMOs. • Liaison with other PPSs on evidence-based practice implementation.
Senior Director, Care Delivery & Practice Innovations, CSO	Dr. J. Robin Moon	• Oversee all of the clinical projects implementation (Domains 1-4), including monitoring and reporting. • Work closely with the Quality Management team. • Monitor speed and scale • Identify and promote care delivery and practice innovations.
Senior Director, Quality Management & Informatics, CSO	Janine Dimitrakakis	• Oversee the development of quality metrics, and monitoring and reporting of them. • Work closely with the clinical projects team and the SBH IT team.
BPHC Workforce Liaison	Mary Morris	• Work with project participants to implement workforce implementation plans to meet participants' recruitment, training and worker retention needs. • Collect and analyze workforce data and report on training effectiveness.
BPHC Director of Financial Planning	Ronald Sextus	• Conduct financial evaluation of each project. • Develop, implement and manage funds distribution methodologies.

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		• Develop value-based payment models. • Produce quarterly reports for Executive Director and governance.
BPHC Chief Technology Officer	Jitandra Barmecha	• Work with project participants to develop and implement IT components of project plans. • Advise governance, Executive Director and Director of Finance of resource gaps that may impede IT implementation. • Liaison with Bronx RHIO and other PPSs.
BPHC Compliance Officer	Suzette Gordon	• Monitor and develop corrective action plans as needed to ensure member compliance with rules and regulations of regulatory agencies and with BPHC's by-laws and policies & procedures. • Disseminate current, revised and new policies and procedures.
BPHC Director of Collaboration	Albert Alvarez	• Manage BPHC member engagement and outreach to CBOs and community stakeholders. • Manage website, social media and communications for and within BPHC.
BPHC Executive Committee Chair	Leonard Walsh	• Governance: Oversight of and support for all aspects of deployment of DSRIP projects.
BPHC Partners' Project Liaisons	Akwasiba Rafaelin, Montefiore (ED and IP) Nicolette Guillou, Montefiore (ambulatory) Irene Borgen, SBH Health System Twiggy Rodriguez, Acacia Network Nieves Madrid, Morris Heights Health Center (MHHC) Dean Bertone, Union Community Health Center (UCHC) Zena Nelson, Institute for Family Health (IFH) Fernando Alonso, Bronx United IPA	• Coordinate with project transitional work groups and CSO project directors to oversee implementation activities at participating sites.

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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		
SBH Health System Leonard Walsh Eric Appelbaum	Lead Applicant	Fiduciary for DSRIP; Chair of Executive Committee for BPHC
Montefiore Medical Center Steven Rosenthal Amanda Parsons	Largest provider in BPHC	Member of Executive Committee of BPHC; contractor to provide key technical assistance on projects 2.b.iii and 2.b.iv; committed provider in all DSRIP projects
Institute for Family Health Maxine Golub	FQHC providing primary care services in several high-need areas of the Bronx	Member of Executive Committee of BPHC; contractor to provide technical assistance on project 3.a.i; committed provider in DSRIP projects 2.a.i, 2.a.iii, 3.a.i, 3.b.i, 3.c.i, 3.d.ii
Acacia Network Pam Mattel	FQHC providing primary care services in several high-need areas of the Bronx; behavioral health provider, SNF and respite housing provider	Member of Executive Committee of BPHC; contractor to provide technical assistance on project 3.a.i; committed provider in DSRIP projects 2.a.i, 2.a.iii, 3.b.i, 3.c.i, 3.d.ii
Union Community Health Center Doug York	FQHC providing primary care services in several high-need areas of the Bronx	Member of Executive Committee of BPHC; contractor to provide technical assistance on project 3.a.i; committed provider in DSRIP projects 2.a.i, 2.a.iii, 3.b.i, 3.c.i, 3.d.ii
Bronx United IPA Fernando Oliver	IPA group providing primary care services in several high-need areas of the Bronx	Member of Executive Committee of BPHC; contractor to provide technical assistance on project 3.a.i; committed provider in DSRIP projects 2.a.i, 2.a.iii, 2.b.iv, 3.b.i, 3.c.i, 3.d.ii
Morris Heights Health Center Tosan Oruwariye	FQHC providing primary care services in several high-need areas of the Bronx	Member of Executive Committee of BPHC; contractor to provide technical assistance on project 3.a.i; committed provider in DSRIP projects 2.a.i, 2.a.iii, 2.b.iii, 3.b.i, 3.c.i, 3.d.ii
Health People Chris Norwood	CBO providing evidence-based education to patients in the Bronx with chronic illnesses	Member of DSRIP Quality and Care Innovation Sub-Committee and clinical work group; contractor for delivering Stanford Model program to target groups for projects 3.b.i and 3.c.i
VNSNY Marianne Kennedy	Home care provider and MLTC provider	Member of the BPHC Executive Committee; committed partner in project 2.b.iv
Bronx Works Eileen Torres	CBO that provides numerous support and social services	Member of the BPHC Executive Committee
Bronx RHIO Charles Scaglione	Non-profit organization that provides health information exchange, shared data management and supporting data analytics, and	Member of the BPHC Executive Committee

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
	performance monitoring	
CenterLight Paul Rosenfeld	Home care and MLTC provider	Member of the BPHC Executive Committee; committed partner in projects 2.a.iii and 2.b.iv
1199 TEF	Workforce vendor that will support execution of workforce planning and training related activities including participation on the Sub-Committee, best practices, information from other PPSs, helping to screen candidates for new hires, assessment, remediation and culture change, preparation of reports to the State and dispute resolution.	Member of BPHC Executive Committee; committed to being primary vendor for implementing BPHC workforce strategy including training, re-training, education programs and re-deployment support
Healthfirst Pat Wang	Managed care organization providing coverage to a majority of patients attributed to BPHC	Member of Executive Committee of BPHC; will work with PPS on movement to full risk-based contracting
External Stakeholders		
1199 TEF	Workforce vendor that will support execution of workforce planning and training related activities including participation on the Sub-Committee, best practices, information from other PPSs, helping to screen candidates for new hires, assessment, remediation and culture change, preparation of reports to the State and dispute resolution.	Committed to being primary vendor for implementing BPHC workforce strategy including training, re-training, education programs and re-deployment support

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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.

In order to support its projects and to act as an effective integrated performing provider system, BPHC will require and implement the following IT infrastructure: Care coordination & management: Collaboratively with the Montefiore CMO and the Montefiore-sponsored Hudson Valley PPS, BPHC is in the process of evaluating and procuring a care coordination management solution (CCMS) for population stratification, patient engagement, patient assessment, care planning, clinical and social service navigation, care transition management, patient registries and care management workflow, capacity and task management. Health information exchange (HIE): BPHC will build on the close governance and working relationship that SBH and key PPS partners have with Bronx RHIO to achieve project milestones related to health information exchange and data sharing. Bronx RHIO enjoys significant penetration with Bronx providers, including BPHC members. BPHC is working with Bronx RHIO to perform due diligence on its HIE capacity and capabilities and has undertaken further assessment of PPS partners' current level of integration with the RHIO and their readiness to achieve the level of integration required by BPHC projects. In addition, BPHC and Bronx RHIO are working on arrangements for cross-PPS/QE collaboration and will co-develop interfaces to the CCMS. Connections to the SHIN-NY are also being explored. Central data management: The Bronx RHIO will provide data governance, data specification and acquisition capabilities, data normalization/quality, patient and provider matching, master data management (MDM), central data storage and authorized access in an operational data store, and bi-directional data sharing with BPHC partners. Performance management and metrics (analytics): While much NYSDOH DSRIP metric reporting will be claims-based, and will be performed by the DOH in the Salient MAPP system, BPHC will need to identify its own required level of detail for performance monitoring. Assessment, monitoring and support programs and resources: Based on a current state assessment of PPS partner capabilities against BPHC and DOH requirements, the BPHC CSO will establish program management services for monitoring or assisting PPS partners as required with acquiring EHRs certified for Meaningful Use attestation, achieving PCMH 2014 recognition and participating and integrating with the Bronx RHIO for health information exchange. Digital health strategy for patient engagement: Beyond the IT discussed above, BPHC is developing strategies for implementing patient engagement and activation mechanisms to promote patient self-management in PPS/IDS programs. This may in the future include developing a comprehensive strategy for telehealth, remote monitoring and patient engagement through digital health apps that are culturally competent and sensitive to patient circumstances and needs. In addition, BPHC is exploring opportunities for connecting community-based organizations to the PPS's IT infrastructure to facilitate patient engagement, provider communication, and closed loop referral tracking.

IPQR Module 10.6 - Performance Monitoring

Instructions :

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

The PPS's CSO analytics and IT staff, BPHC Chief Medical Officer, the CSO's Senior Director of Quality Management & Informatics, and the Quality & Care Innovation Sub-Committee (QCI) will work together closely to design reporting formats for three audiences—providers, CSO clinical

project team members and QCI Sub-Committee members—that integrate Domain 1 process metrics, Domain 2 and 3 quality and outcome metrics, and other internal PPS reporting metrics selected by the QCI into its performance reporting dashboard and resulting performance reports to be shared with PPS members. The rapid cycle evaluation process will be the basic method used to monitor progress and identify providers that appear to be at risk of missing performance targets. We will also work with our partners at the provider level to ensure that they have a continuous quality improvement process in place to detect and address operational problems in each of the projects they participate in on an ongoing basis. Under the leadership of the BPHC CMO and Senior Director of Quality Management & Informatics, the CSO will organize and support a continuous quality improvement process to be carried out both centrally and internally by participants. The continuous quality improvement process will include identifying areas for both partner-specific and cross-partner improvement strategies and tactics, monitoring progress against improvement targets, assisting with root cause analysis, and convening cross-PPS work groups on special topics that emerge from reporting via the analytics team.

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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.

Throughout implementation, BPHC will continue to encourage and insist upon extensive community involvement, which includes representation from a diverse group of Bronx provider & community-based organizations (CBOs) in its project advisory committee. BPHC has hired a multilingual Director of Collaboration with deep roots in the community, responsible for managing outreach to community stakeholders & CBOs. Our community engagement efforts provide bidirectional dialogue to ensure project implementation is achieving results & allow for course correction & innovation. These efforts aim to develop capacity within the community to ensure sustainability. We are creating new connections & resources through sharing of information, skills & tools, & collaboration with other Bronx PPSs. In addition, we are creating job opportunities & career pathways for community members. BPHC is undertaking the following steps to ensure that the Bronx community continues to be deeply involved: PPS has conducted a survey to enhance our knowledge of the services offered by & capacity of CBOs in our PPS, which will provide the basis for a web-based CBO service directory to facilitate direct referrals to support services. BPHC met regularly with CBOs to gain input & build a community engagement strategy. Through Community-based Discussion Sessions, members of the organizations defined aim-focused, common issues among licensed & grant-funded CBOs & organizations providing community-based services & to express participation needs & questions. Targeted participants included CBOs providing senior care, food pantries, social services, home health, legal, farmers markets, housing, education, behavioral health, developmental disabilities, & family & children services. Minutes & common themes from the sessions were distributed to participants, followed by an invitation to join the Community Engagement Plan Workgroup. The Workgroup identified the need for 3 additional groups: Communications Strategies (to create efficient & effective methods of communication from CBO to CBO & from CBO to PPS constituent, with additional focus on consumer involvement & patient engagement); Outreach & Engagement (conduct networking events, define level of CBO participation, & build proactive relationships on behalf of the PPS with new & existing CBOs); & Interconnectivity (continue to work on connecting CBO resources via available technology). All CBOs are invited to join the community engagement process. To engage the community stakeholders further, BPHC will encourage & solicit feedback through its website, presentations, publications, social media platforms, & public fora. BPHC produces & publishes a biweekly bulletin & a quarterly newsletter & will continue to host all-Member webinars. BPHC has begun contracting with CBOs that will be major contributors to the success of our DSRIP projects. BPHC is contracting with Health People: Community Preventive Health Institute (CBO specializing in evidence-based patient education for chronic disease management) & a.i.r. nyc (a CBO providing home-based services to families with asthma). In the Bronx, the biggest risk associated with community engagement is that the level of need for community resources, such as behavioral health & social support services, exceeds the resources available. Other risks may include insufficient infrastructure to manage the number of CBOs & people engaged, address the complexity associated with serving a diverse population in culturally meaningful ways, ensure rapid response to community need & suggestions, & support communication at the community level via information technology. However, DSRIP provides a unique opportunity to increase the reach & impact of existing resources & improve & build new infrastructure to engage our community in efforts to improve health in the Bronx.

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 :

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

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IPQR Module 11.2 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Define target workforce state (in line with DSRIP program's goals).	In Progress	Finalized PPS target workforce state, signed off by PPS workforce governance body.	07/01/2015	03/31/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Establish and convene Workforce Project Team	Completed	Establish and convene Workforce Project Team (including Workforce Sub-Committee, Workforce Workgroups, workforce liaison and other supportive staff from the CSO, 1199 SEIU Training and Employment Funds (TEF), subject matter experts and stakeholders) responsible for implementing, executing and overseeing workforce activities.	07/01/2015	07/01/2015	07/01/2015	07/01/2015	09/30/2015	DY1 Q2	
Task Identify the requirements for each DSRIP project	In Progress	Identify the requirements for each DSRIP project and the new services that will be delivered, in conjunction with the Quality and Care Innovation Sub-Committee.	07/17/2015	03/31/2016	07/17/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Identify types and numbers of workers needed for each DSRIP project	In Progress	Identify the types and numbers of workers needed for each DSRIP project.	07/17/2015	03/31/2016	07/17/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Identify competencies, skills, training and roles required for each DSRIP project	In Progress	Identify the competencies, skills, training and roles required for each DSRIP project, with particular attention to developing common standards and definitions for care management roles.	07/31/2015	03/31/2016	07/31/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Consolidate project-by-project analysis	Not Started	Consolidate project-by-project analysis to develop a comprehensive view of the workforce needs to support all DSRIP projects.	08/10/2015	03/31/2016	04/30/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Finalize target workforce state	Not Started	Finalize target workforce state and receive signoff from Workforce Sub-Committee and Executive Committee.	11/01/2015	03/31/2016	04/30/2016	06/30/2016	06/30/2016	DY2 Q1	
Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	In Progress	Completed workforce transition roadmap, signed off by PPS workforce governance body.	07/01/2015	03/31/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Convene Workforce Sub-Committee	Completed	Convene Workforce Sub-Committee to provide input on the approach for developing the workforce transition roadmap.	07/01/2015	09/09/2015	07/01/2015	09/09/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Provide PPS member organizations with individualized survey data to determine their current workforce state	Not Started	Working with the Center for Health Workforce Studies (CHWS), provide PPS member organizations with individualized survey data to determine their current workforce state.	10/15/2015	03/31/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Draft a workforce transition roadmap template	Not Started	Based on current workforce state and future targeted workforce state (as defined in the milestone above and below), work with TEF to draft a workforce transition plan template that addresses workforce volume including hiring, training, deploying staff as well as the timeline for the changes and the related dependencies to assist PPS member organizations in developing individualized workforce transition roadmaps.	10/15/2015	03/31/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Obtain approval of transition plan template	Not Started	Obtain approval of transition plan template by Workforce Sub-Committee and Executive Committee to assist PPS member organizations in achieving future target workforce state.	10/01/2015	03/31/2016	08/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	In Progress	Current state assessment report & gap analysis, signed off by PPS workforce governance body.	11/01/2015	03/31/2016	11/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Gather baseline information on current workforce state	In Progress	Work with CHWS to gather baseline information on current workforce state through member surveys and available workforce data. Baseline information will include an assessment of staff volume, staff titles/types, competencies and credentials related to implementing each DSRIP project	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Identify overall change in numbers, FTEs, salary, and benefits, by organization and in the aggregate as well as identify causes of potential workforce changes	Not Started	Work with CHWS and TEF to identify overall change in numbers, FTEs, salary, and benefits, by organization and in the aggregate as well as identify if the potential workforce changes are a result of: retraining, redeployment, new hires, or attrition.	11/01/2015	03/31/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Apply training costs and training strategies to the retraining of health workforce staff and identify any other training costs	Not Started	Work with TEF to apply training costs and training strategies to the retraining of health workforce staff and identify any other training costs (i.e. CBOS w/o new staff, but may need training to understand DSRIP and the process).	11/01/2015	03/31/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Link training strategies and training costs to PPS DSRIP projects	In Progress	Work with TEF to link training strategies and training costs to PPS DSRIP projects.	11/01/2015	03/31/2016	11/01/2015	09/30/2016	09/30/2016	DY2 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Identify staff who could be redeployed into future state roles to implement DSRIP projects	Not Started	Work with PPS partners, including unions, to identify staff who could be redeployed into future state roles to implement DSRIP projects. Workforce Advisory Work Group will be available to facilitate.	11/01/2015	03/31/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Conduct a job analysis of at-risk positions and a skill transferability analysis to create job transition maps and career ladders within the PPS	Not Started	Work with TEF and other members of the Workforce Sub-Committee to conduct a job analysis of at-risk positions and a skill transferability analysis to create job transition maps and career ladders within the PPS.	11/01/2015	03/31/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Identify new hire needs to implement DSRIP projects	Not Started	Identify new hire needs to implement DSRIP projects	11/01/2015	03/31/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Perform workforce budget analysis for each DSRIP project over the duration of the projects	Not Started	Perform workforce budget analysis for each DSRIP project over the duration of the projects, taking into consideration overlap of training needs in projects.	11/01/2015	03/31/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Obtain sign-off on current state assessment report and gap analysis	Not Started	Obtain sign-off on current state assessment report and gap analysis from Workforce Sub-Committee and Executive Committee.	11/01/2015	03/31/2016	05/15/2016	09/30/2016	09/30/2016	DY2 Q2	
Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	In Progress	Compensation and benefit analysis report, signed off by PPS workforce governance body.	11/01/2015	08/31/2016	11/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES
Task Identify compensation and benefits ranges for current staff critical to implementation of DSRIP projects	In Progress	As part of gathering baseline information from CHWS in the milestone above through member surveys and available workforce data, work with partners and stakeholders (including unions) to identify compensation and benefits ranges for current staff critical to implementation of DSRIP projects, including care managers.	11/01/2015	08/31/2016	11/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Develop impact analysis on staff needing to be retrained and redeployed across PPS member organization	In Progress	Working with TEF, build on analysis of at risk positions to develop impact analysis on staff needing to be retrained and redeployed across PPS member organizations.	11/01/2015	08/31/2016	11/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Develop compensation and benefit range targets for staff positions, including new hires, critical to DSRIP implementation	In Progress	Work with PPS members and targeted stakeholders to develop compensation and benefit range targets for staff positions, including new hires, critical to DSRIP implementation to inform PPS budgeting and workforce	11/01/2015	08/31/2016	11/01/2015	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
		impact analysis.							
Task Calculate the number of partially and fully placed staff and develop a tracking system	In Progress	Work with TEF to calculate the number of partially and fully placed staff and develop a tracking system	11/01/2015	08/31/2016	11/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Determine impacts to partial placement staff and potential contingencies and develop and incorporate policies for staff who face partial placement and for staff who refuse retraining or redeployment	Not Started	Convene the Workforce Advisory Work Group to determine impacts to partial placement staff and potential contingencies and develop and incorporate policies for staff who face partial placement and for staff who refuse retraining or redeployment, taking into consideration Collective Bargaining Agreements and HR policies at Partner organizations.	11/01/2015	08/31/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Draft comprehensive compensation and benefit analysis report	Not Started	Draft comprehensive compensation and benefit analysis report.	11/01/2015	08/31/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Review and approval of compensation and benefit analysis report	Not Started	Review and approval of compensation and benefit analysis report by Workforce Sub-Committee and Executive Committee.	11/01/2015	08/31/2016	05/01/2016	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.	11/01/2015	03/31/2016	11/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Provide training, as well as case management, counseling, job search assistance, employment workshops and tracking systems for impacted workers	In Progress	Contract with 1199 Training and Employment Fund to provide training, as well as case management, counseling, job search assistance, employment workshops and tracking systems for impacted workers.	11/01/2015	03/31/2016	11/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Provide specialized training for specific DSRIP projects	In Progress	Contract with other organizations (CBOs) to provide specialized training for specific DSRIP projects, including training on cultural competency and health literacy strategies, as needed.	11/01/2015	03/31/2016	11/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Create an inventory of needed training to implement each DSRIP project	In Progress	In concert with the Workforce Sub-Committee, Quality and Care Innovation Sub-Committee and workforce vendors and through member surveys and stakeholder input, create an inventory of needed training to implement each DSRIP project, including specific skills, certifications and competencies.	11/01/2015	03/31/2016	11/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Identify existing staff and new hires that will need to be retrained, and the competencies and skills they will need in the future to implement DSRIP projects	In Progress	As part of the inventory effort and the above milestones, work with TEF to identify existing staff and new hires that will need to be retrained, and the competencies and skills they will need in the future to implement DSRIP projects.	11/01/2015	03/31/2016	11/01/2015	09/30/2016	09/30/2016	DY2 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Develop vision, goals and objectives for training strategy and draft detailed training strategy	Not Started	Work with TEF to develop vision, goals and objectives for training strategy and draft detailed training strategy, including plans and process to develop training curricula in concert with training vendors and the associated timeline.	11/01/2015	03/31/2016	01/29/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Develop mechanism to measure effectiveness of training in relation to training goals to implement DSRIP projects	Not Started	Work with partner organization HR leads to develop a mechanism to measure effectiveness of training in relation to training goals to implement DSRIP projects	11/01/2015	03/31/2016	01/29/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Finalize, review and approve training strategy	Not Started	Finalize, review and approve training strategy by Workforce Sub-Committee and Executive Committee.	11/01/2015	03/31/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Define target workforce state (in line with DSRIP program's goals).	Given the changes made by the NY State DOH in workforce reporting deadlines for AV-driving milestones and the associated suggested deadlines for the non-AV-driving milestones, BPHC will follow all of the guidance for all workforce deliverables deadlines. Therefore, the "defined workforce state" in line with DSRIP's Program goals will be completed by DY2Q1 (June 30, 2016). This also provides additional time for the BPHC PPS to work with its vendor and the workforce consortium that has been created between BPHC, One City Health, Community Care of Brooklyn and NYU/Lutheran PPS. It was determined that only the Workforce Subcommittee will be required to approve the target workforce state.
Create a workforce transition roadmap for achieving defined target workforce state.	Given the changes made by the NY State DOH in workforce reporting deadlines for AV-driving milestones and the associated suggested deadlines for the non-AV-driving milestones, BPHC will follow all of the guidance for all workforce deliverables deadlines. Therefore, the workforce transition roadmap will be completed by DY2Q2 (September 30, 2016). This also provides additional time for the BPHC PPS to work with its vendor and the workforce consortium that has been created between BPHC, One City Health, Community Care of Brooklyn and NYU/Lutheran PPS. It has been determined that only the Workforce Subcommittee will be required to approve the transition roadmap.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform detailed gap analysis between current state assessment of workforce and projected future state.	Given the changes made by the NY State DOH in workforce reporting deadlines for AV-driving milestones and the associated suggested deadlines for the non-AV-driving milestones, BPHC will follow all of the guidance for all workforce deliverables deadlines. Therefore, the detailed gap analysis between Current and future state will be completed by DY2Q2 (September 30, 2016). The PPS has been diligently working on the survey of the current state with its consortium partners to document the current staffing configuration and compensation and benefits for all organizations in the BPHC PPS (and overlapping consortium PPSs) to help inform this milestone. It was determined that only the Workforce Subcommittee will be required to approve the gap analysis. .
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.	Given the changes made by the NY State DOH in workforce reporting deadlines for AV-driving milestones and the associated suggested deadlines for the non-AV-driving milestones, BPHC will follow all of the guidance for all workforce deliverables deadlines. Therefore, the compensation and benefit analysis, an AV-driving milestone, will be completed by DY2Q1 (June 30, 2016). The BPHC PPS has been diligently working on the survey as part of the cross-PPS effort – along with consortium PPSs – of the current state including compensation and benefits information to be sent and analyzed directly by a third party, our workforce vendor to avoid anti-trust concerns. This survey will also be completed in DY3 and DY5. It was determined that only the Workforce Subcommittee will be required to approve the analysis.
Develop training strategy.	Given the changes made by the NY State DOH in workforce reporting deadlines for AV-driving milestones and the associated suggested deadlines for the no-AV-driving milestones, BPHC will follow all of the guidance for all workforce deliverables deadlines. Therefore, the BPHC training strategy will be completed by DY2Q2 (September 30, 2016). BPHC has already begun work with our workforce vendor, 1199 TEF on the training strategy. It was determined that only the Workforce Subcommittee will be required to approve the 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.

A robust & well-trained workforce, rooted in the diverse communities of the Bronx & engaged in the transformative change required under DSRIP is central to the success of BPHC. There will be 3 major workforce challenges to address: 1) BPHC has a diverse, largely unionized workforce of approximately 35,000. Partner orgs have unique cultures, policies & collective bargaining agreements. These factors make engaging the workforce a challenge. The greatest risk to workforce strategy deployment is potential lack of buy-in from staff. The PPS will provide ongoing communication specifically geared to the workforce & continued opportunities for input & resolution of disputes with unions, employee groups & individuals. For unionized partners, staff engagement will be closely coordinated with union leadership, within the context of collective bargaining agreements. In addition to the Workforce Sub-Committee (made up of union, workforce experts including TEF, HR & training representatives from member orgs & frontline staff), three additional work groups have been formed to work with and be monitored by the sub-committee: the Workforce Communication Workgroup for development & implementation of communication/engagement strategies – including regular bulletins, new media campaigns, speakers at labor-management & town hall meetings and the Workforce Planning Work Group which meets regularly to analyze internal and external recruitment and training strategies for recommendations to the Workforce subcommittee. A third group, the Advisory Group (facilitated by the TEF Labor-Management Project) will provide a forum for input, dispute resolution & problem solving as needed. 2) BPHC has intense retraining and training needs. We anticipate 5,000-10,000 existing staff will need retraining to implement the PPS' clinical projects. BPHC also anticipates up to 750 new jobs created within the PPS, all of which will require training. To address the needs for both retraining of existing staff & onboarding new hires, BPHC will undertake a large-scale training initiative addressing care coordination, patient engagement, motivational interviewing, cultural competence, inter-disciplinary team care planning, chronic disease management, virtual & cross-sector communications & use of health information technology, as well as protocols associated with specific project interventions. Some training will result in certification/licensing for existing employees. 3) There is difficulty in recruitment & hiring. BPHC will need to recruit & hire staff for new positions. Historically, the Bronx has had difficulty recruiting healthcare professionals. The Bronx is the least healthy county in NYS & ranks worst in social & economic factors. These factors make Bronx residents an especially challenging population to treat, hindering recruitment efforts. In addition, compensation for Bronx health providers is reported to be less than surrounding counties in NY & NJ, so qualified candidates are lost to other locales. BPHC plans to develop common templates for job descriptions & postings for use by partners, create a job board on its website, provide technical assistance to partners on sourcing, recruiting, onboarding & retention strategies, & partner with local colleges, CBOs (e.g. Phipps Neighborhood & Bronx-Westchester Area Health Education Center), local high schools, & TEF to develop new & sustainable workforce talent pools. Because workforce challenges are consistent throughout the Bronx, BPHC also intends to collaborate with the other PPSs in the Bronx to develop & implement joint workforce strategies to the maximum extent possible. The Workforce Sub-Committee will be charged with monitoring the comprehensive workforce strategy to ensure BPHC retains, trains, & hires the staff necessary to support successful implementation of DSRIP projects & to mitigate associated risks.

IPQR Module 11.5 - Major Dependencies on Organizational Workstreams

Instructions :

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

BPHC's workforce strategy has interdependencies with many workstreams, including clinical project implementation, cultural competency, IT systems and processes, and finance and budgeting.

• Project Implementation Interdependencies: The number and types of staff that must be retrained or redeployed and the number and type of staff that needs to be newly hired depend on the needs and services of the clinical projects. As the implementation of the clinical projects evolves, it will be important to closely monitor any changes that could impact workforce needs.

• Cultural Competency Workstream Interdependencies: The success of the PPS' recruitment and training strategy will impact the provision of culturally competent care. The PPS will work with 1199 TEF, CUNY, and contracted CBOs to develop training curricula that meet cultural competency and health literacy standards and incorporate these trainings into all new hire orientations, refresher courses, and provider agreements.

• IT Systems & Processes: To support a robust IT infrastructure, BPHC is planning to implement an electronic care planning tool across the PPS. The success of this tool is heavily dependent on the ability of the healthcare workforce to use this platform to track and manage care. BPHC's CSO will institute extensive training for the care management workforce on the use of the care planning tool.

• Finance and Budgeting: BPHC anticipates that partners will require funding to hire and deploy additional staff and potentially to adjust compensation for existing staff critical to successful implementation of the DSRIP projects.

• Governance: Establishment of the Workforce Sub-committee will be critical to engaging workers and thus ensuring the success of each DSRIP project.

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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
Director of Workforce Innovation, BPHC	Mary Morris	Responsible for the development and implementation of all workforce implementation plans including providing leadership and advisement to the Workforce Sub-Committee, reporting to the Executive Committee.
Director of Collaboration, BPHC	Albert Alvarez	Responsible for obtaining input from the community on workforce needs.
Workforce Sub-Committee	The WSC has 12-15 voting members including representation from unions, HR, workforce experts, frontline staff (for all names, please see Membership Template in Governance workstream).	Responsible for implementing the workforce strategy, including Workforce Communication and Workforce Advisory facilitated by the 1199 Labor Management staff to ensure workforce input and identify concerns and structural barriers for collaborative decision making.
Workforce Training Vendor	1199 Training and Employment Funds (Rosa Mejias)	TEF will support execution of workforce training related activities including participation on the Sub-Committee, providing research on training vendors, best practices, information from other PPSs, helping to screen candidates for new hires, assessment, remediation and case management for candidates, culture change, preparation of reports to the State and dispute resolution.
Labor Representatives	Representatives from 1199 SEIU, NYSNA and CIR (Tom Cloutier, Teresa Pica, Gladys Wrenick, Rosa Mejias, and others)	Provide expertise on CBAs, and insight in retraining, redeployment and hiring needs.

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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		
Linda Reid, Annie Wiseman, Susan Roti	Training Leads in Partner Organizations	Provide best practice training approaches and guidance in program implementation
Erlinda Girado, Victoria Izaylevsky, Katrina Jones, Marc Wolf, Gloria Kenny	HR Leads in Partner Organizations	Support data collection for staff FTEs, comp and benefits, CBO information, hiring needs
Patricia Belair	SVP, Ambulatory Services and Strategy, SBH Health System	Advisor on ambulatory care competencies/jobs
External Stakeholders		
1199 SEIU, NYSNA, CIR	Labor Union Representatives	Facilitate worker engagement
Curtis Dann-Messier	CUNY liaison	Coordinate curriculum development, supply talent
Marilyn Aquirre-Molina, Executive Director, CUNY Institute for Health Equity	Connection to Bronx Borough President Ruben Diaz's Not 62 Campaign	Input for curriculum development. Provide action-research on the social determinants of health that contribute to the high rates of morbidity and mortality in the Bronx, and technical support for training curriculum to enable us to better address health equity.
Swawna Trager, Executive Director of the NY Alliance for Health Careers	Provide talent pool of new staff for CHWs and other "peer" roles.	Potential training funding source-city and federal funding including stipends for training, tuition reimbursement, wrap arounds and paid internships, Curriculum development consultation.
Jessica Hill, Director Bronx-Westchester AHEC	Provides Bronx resident talent pipelines for various PPS staff positions.	Creates community-based health professional training opportunities and public health programs. Strengthens community networks to increase minority representation in all healthcare professions.
GNYHA	Provide training on key areas of care coordination teams and cultural competency.	Provide research findings on NYC health issues.

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 development of shared IT infrastructure across the PPS will be important in storing information, tracking progress on workforce transitions, and delivering and tracking training to ensure success of the DSRIP clinical projects. Shared IT infrastructure will be especially important given the high volume of training, redeployment and new hires that needs to take place in order to implement the DSRIP projects.
1) Storing Information. BPHC will need to document information from all of the PPS Partners regarding their current workforce state, including volume, competencies and skills. It will be important to have an IT platform that will store this large volume of information in an organized way.
2) Tracking. BPHC anticipates that there will be extensive movement and changes in the workforce that will need to be tracked over time in order to ensure that BPHC reaches the future targeted workforce state. It will be crucial to track these changes across the PPS. The IT infrastructure will be key in reporting workforce process measures in the quarterly reports.
3) Training. Providers and staff will be trained regarding specific population needs and effective patient engagement approaches. Training will be scheduled, delivered and tracked using a learning management system (LMS) administered by the BPHC CSO.
4) Job Listings. BPHC will also use the IT infrastructure to post job openings on the "job board" across the PPS in order to recruit and hire qualified staff.

IPQR Module 11.9 - Progress Reporting

Instructions :

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

BPHC will measure the success of its workforce strategy through the milestones listed above. BPHC will focus on monitoring key workforce measures, such as the number and type of staff who are retrained or redeployed as well as new hires. The Workforce Sub-Committee will be charged with monitoring the comprehensive workforce strategy to ensure that BPHC retains, trains, and hires the staff necessary to support successful implementation of DSRIP projects. The Workforce Sub-Committee will be supported by two workgroups: 1) Workforce Communications Workgroup and 2) Workforce Advisory Workgroup that will support workforce efforts.

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IPQR Module 11.10 - Staff Impact

Instructions :

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

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

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

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

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

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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.

Providers & BPHC may not agree on contract terms due to uncertainty around DSRIP. Potential Impact (PI): Providers cannot fully engage in BPHC; PPS cannot reach provider participation goal. Mitigation (M): BPHC works to understand provider capabilities & sets clear expectations. Providers enter into a standard pro forma Master Services Agreement early, deferring agreement on detailed requirements until they are known & incorporated in rolling Statement of Works addenda.
Payers/social service agencies not yet identified may need to participate in BPHC. PI: BPHC will not achieve its fullest potential in meeting IDS goals. M: BPHC collaborates with Coalition of NYS Public Health Plans to explore payer participation, undertakes/documents formal processes to identify & pursue payers/social service agencies for inclusion in PPS.
ACO/HHs may not have IT capabilities to implement IDS strategy. PI: ACO/HHs cannot fully participate in the IDS. M: BPHC assesses population health management (PHM) systems & capabilities of each attested ACO/HH, offering its own systems as needed.
Patients do not engage sufficiently to benefit from care delivery improvements. PI: BPHC may not achieve DSRIP health improvement goals for the community. M: BPHC offers focused, culturally relevant, evidence-based, easy-to-understand education to patients, integrates relevant materials into care management (CM) staff training. PCP team members, CBOs, patient educators, CHWs engage patients.
Providers do not fully embrace CM or PHM. PI: PCPs continue to provide patients non-coordinated care encouraged by fee-for-service system. M: BPHC provides training, support, tools for CM & PHM.
Providers/BPHC do not fully achieve DSRIP & PPS goals. PI: BPHC/State do not achieve performance goals, jeopardizing DSRIP funding & health system transformation. M: BPHC and partners select and vet evidence-based protocols via appropriate governance structures. Implementation of same protocols contractually required. PPS provides training, follow-up to ensure effective protocols deployment.

Providers do not implement EHR systems that meet MU & PCMH Level 3 standards &/or do not achieve PCMH 2014 Level 3 recognition by DY3Q4. PI: Providers cannot fully participate in planned interventions, CM, PHM across the IDS. M: BPHC uses gap analysis to develop a program to monitor & deploy assistance to providers at risk. BPHC supports practices; deploys internal community, external consulting resources; provides customized technical assistance, coaching, & care team training modules.
BxRHIO fails to develop services/satisfy partner demand for secure messaging, alerts & patient record look up, or Providers do not integrate & use secure messaging, alerts & patient record look up by DY3Q4. PI: Providers cannot fully participate in planned interventions, CM & PHM across the IDS; BPHC may fail/be delayed in achieving this IDS goal & state may fail to achieve a full return on its investment in RHIO development. M: BPHC completes due diligence regarding BxRHIO HIE capabilities & contracts to develop/deliver at risk services. Partner contracts with BPHC will include terms obliging them to integrate/adopt BxRHIO services. CSO monitors, assists PPS partners to participate/integrate with BxRHIO for HIE.
BPHC will not attract/train sufficient management/workforce talent. PI: BPHC may fail/be delayed in reaching care transformation goals. M: BPHC coordinates with community colleges, 1199 Job Security Fund, Montefiore CMO, & NYSNA to identify and attract a braod pool of capable workers & use alternative employment tactics. Regulatory barriers may impede planned activities. PI: Care transformation goals are not met. M: BPHC

applied for regulatory relief in various areas and included potential alternatives in its Organizational Application. Continue to monitor potential barriers in regulation/DSRIP guidance.

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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	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Define pro forma role of all PPS providers in BPHC's network model of care (prioritized programs/projects, target patient populations, interventions, accountabilities, use of care plans, funds flow, etc.) to establish BPHC-wide expectations, building on clinical planning to date and planned population health management, clinical integration and IT assessment and planning detailed in those work streams	Project		In Progress	08/01/2015	06/15/2016	08/01/2015	06/15/2016	06/30/2016	DY2 Q1
Task Draft Master Services Agreement (MSA) and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure	Project		Completed	04/01/2015	05/21/2015	04/01/2015	05/21/2015	06/30/2015	DY1 Q1
Task Solicit comments on MSA from partners through distribution to members, opportunity to submit written comments, and review in Committee and Sub-Committee meetings.	Project		Completed	05/21/2015	06/08/2015	05/21/2015	06/08/2015	06/30/2015	DY1 Q1
Task Finalize MSA agreement	Project		Completed	07/01/2015	07/23/2015	07/01/2015	07/23/2015	09/30/2015	DY1 Q2
Task	Project		Completed	06/01/2015	12/31/2015	06/01/2015	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
Develop and finalize project schedules in concert with Clinical Operations Plans (COPs)									
Task Review and negotiate project schedules with partner organizations. The order in which project schedules will be negotiated will be based on prioritization of partner organizations developed by SBH	Project		Completed	08/15/2015	12/31/2015	08/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task Complete first round of contracting with all PPS partners	Project		In Progress	08/15/2015	03/20/2016	08/15/2015	03/20/2016	03/31/2016	DY1 Q4
Task Identify payers and social service organizations required to support IDS strategy that are not already identified as PPS member partners; schedule, conduct and document regular meetings to discuss formal mechanisms for them to participate in BPHC	Project		Not Started	03/20/2016	06/30/2016	03/20/2016	06/30/2016	06/30/2016	DY2 Q1
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	08/30/2015	03/31/2016	08/30/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS produces a list of participating HHs and ACOs.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.	Project		In Progress	08/30/2015	03/31/2016	08/30/2015	03/31/2016	03/31/2016	DY1 Q4
Task Define contracting, coordination and assessment strategy for Montefiore BAHN ACO, and care model expectations, coordination and contracting strategies related to BAHN, CBC and CCMP partner Health Homes, based on requirement frameworks developed to date and those that will result from planned assessment and planning activities in other work streams	Project		In Progress	09/10/2015	03/31/2016	09/10/2015	03/31/2016	03/31/2016	DY1 Q4
Task Assess HH and ACO population health management capabilities to determine if the skills and experience of the ACO and other	Project		In Progress	08/30/2015	03/31/2016	08/30/2015	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
organizations can be leveraged by BPHC, based on strategies and expectations; incorporate into BPHC operational strategy/plan									
Task Develop and implement effective referral strategy to the HH/ACO, including referral tracking	Project		In Progress	10/30/2015	02/25/2016	10/30/2015	02/25/2016	03/31/2016	DY1 Q4
Task Integrate HHs and ACOs into the IT infrastructure	Project		In Progress	09/30/2015	03/31/2016	09/30/2015	03/31/2016	03/31/2016	DY1 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	08/15/2015	03/31/2017	08/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	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		Not Started	01/01/2017	03/31/2017	01/01/2017	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		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task PPS trains staff on IDS protocols and processes.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Identify and document required clinical and care management protocols for priority programs, projects and interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data	Project		Completed	08/15/2015	12/31/2015	08/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations for how interventions will be logged, tracked and reported.	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Deploy systems to improve and promote effective care transitions, include protocols for tracking and follow-up	Project		Not Started	01/15/2016	02/28/2016	01/15/2016	02/28/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Operationalize partner and workforce roles by providing gap analysis and appropriate training to clinicians and care management staff (including licensed care managers, care coordinators, patient navigators/community health workers, medical assistants and front-office staff).	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Establish data collection, survey and reporting mechanisms to enable BPHC monitoring to ensure that patients are receiving appropriate health care and community support in priority projects, based on needs identified in prior planning activities	Project		Not Started	02/01/2016	06/15/2016	02/01/2016	06/15/2016	06/30/2016	DY2 Q1
Task Review process for rapid cycle evaluation and continuous improvement of data collection, survey and reporting methods based on priority project experience and modify process as needed to ensure patients receive appropriate health care and community support	Project		Not Started	08/01/2016	09/01/2016	08/01/2016	09/01/2016	09/30/2016	DY2 Q2
Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Hospital	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Mental Health	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY	Provider	Safety Net Nursing Home	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
requirements.									
Task PPS uses alerts and secure messaging functionality.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Identify safety net provider data sharing requirements and assess partner and QE data sharing capabilities and current HIE participation	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Coordinate with Bronx RHIO to develop comprehensive HIE adoption program to encourage and support partner participation and integration	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Begin coordinated interface and service development with Bronx RHIO	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish BPHC program to manage support for safety net providers to ensure that all are actively sharing health information, coordinating with Bronx RHIO to encourage, track and support partner participation and integration/data sharing	Project		Not Started	03/01/2016	04/25/2016	03/01/2016	04/25/2016	06/30/2016	DY2 Q1
Task Track status and manage support to ensure that all PPS safety net providers are actively sharing health information through Bronx RHIO or alternative health information exchange	Project		Not Started	03/01/2016	03/31/2018	03/01/2016	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	06/30/2015	03/31/2018	06/30/2015	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		Not Started	03/31/2018	03/31/2018	03/31/2018	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)	Not Started	03/31/2018	03/31/2018	03/31/2018	03/31/2018	03/31/2018	DY3 Q4
Task Assess eligible participating partner EHR use relative to Meaningful Use and PCMH 2014 Level 3 standards	Project		Completed	06/30/2015	12/31/2015	06/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish BPHC program to educate, encourage, track and	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
support eligible safety net providers in acquiring/implementing certified EHR systems, including potential use of incentive-based payments for implementation									
Task Recruit or contract for EHR implementation resources as needed	Project		In Progress	11/01/2015	06/30/2016	11/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner EHR implementation and progress towards Meaningful Use and PCMH standards	Project		Not Started	08/01/2016	12/31/2016	08/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Track status and manage support to ensure all eligible safety net providers are using certified EHR systems that meet Meaningful Use and PCMH 2014 Level 3 standards	Project		In Progress	10/15/2015	03/15/2018	10/15/2015	03/15/2018	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	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform gap analysis and identify priories to achieving integration of patient record.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.	Project		Completed	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task	Project		Not Started	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
Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.									
Task Create budget to build registry and acquire necessary resources	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 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	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)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
of DY 3.									
Task Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.	Project		Not Started	01/01/2018	03/31/2018	01/01/2018	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	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		Not Started	01/01/2018	03/31/2018	01/01/2018	03/31/2018	03/31/2018	DY3 Q4
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recruit or contract for PCMH practice certification resources as needed	Project		Completed	05/01/2015	12/31/2015	05/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition	Project		In Progress	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Perform gap analysis by practice and identify key priorities.	Project		In Progress	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.	Project		In Progress	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition	Project		Not Started	01/01/2016	11/30/2016	01/01/2016	11/30/2016	12/31/2016	DY2 Q3
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
needed.									
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	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Medicaid Managed Care contract(s) are in place that include value-based payments.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Review final State value-based payment roadmap and PPS value-based payment plan	Project		Completed	07/01/2015	08/04/2015	07/01/2015	08/04/2015	09/30/2015	DY1 Q2
Task Identify Medicaid MCOs engaged with our attributed patients and actively engage them in developing new and strengthening existing value-based payment arrangements through a structured stakeholder engagement process.	Project		In Progress	09/01/2015	11/15/2015	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish partner value-based payment reporting requirements and procedures to enable ongoing monitoring of PPS value-based payment revenue in accordance with State roadmap goals	Project		Not Started	03/01/2016	05/31/2016	03/01/2016	05/31/2016	06/30/2016	DY2 Q1
Task Develop detailed analysis of PPS partners' existing value-based payment arrangements with Medicaid MCOs and other payers by reviewing claims-level data	Project		Not Started	09/30/2015	12/31/2015	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Engage MCOs in defining PPS MCO contracting strategy and organizational requirements necessary to support the development of contracts with Medicaid MCOs	Project		Not Started	09/15/2015	12/01/2015	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Engage PPS partners to assist in defining PPS MCO contracting strategy and organizational requirements necessary to support the development of contracts with Medicaid MCOs	Project		In Progress	11/15/2015	02/01/2016	11/15/2015	02/01/2016	03/31/2016	DY1 Q4
Task Develop or contract with an organizational structure (e.g. IPA, ACO, etc.) or multiple organizational structures to support contracting with Medicaid MCOs and other payers as an integrated system	Project		In Progress	11/15/2015	02/15/2016	11/15/2015	02/15/2016	03/31/2016	DY1 Q4
Task	Project		Not Started	02/15/2016	03/31/2016	02/15/2016	03/31/2016	03/31/2016	DY1 Q4

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DSRIP Implementation Plan Project

SBH Health System (PPS ID:36)

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 value-based payment arrangements for presentation to Medicaid MCOs and other payers									
Task Develop PPS plan, overseen by Finance and Sustainability Sub-committee, to achieve 90% value based payments by DY5 and present to the Executive Committee for review and signoff	Project		In Progress	07/15/2015	12/31/2016	07/15/2015	12/31/2016	12/31/2016	DY2 Q3
Task Produce quarterly report to Executive Committee on transition to value-based payment, based on plan developed and approved in earlier steps	Project		Not Started	11/01/2016	11/30/2016	11/01/2016	11/30/2016	12/31/2016	DY2 Q3
Task Complete annual process to initiate new and assess and refine existing PPS value-based payment arrangements, based on reporting and ongoing monitoring procedures, options analysis and plans/strategies established in earlier steps	Project		Not Started	02/01/2017	03/31/2017	02/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Recruit senior Medicaid MCO leadership to serve on Executive Committee. Identify and appoint HMO industry expert to F&S Sub-Committee.	Project		Completed	04/01/2015	05/21/2015	04/01/2015	05/21/2015	06/30/2015	DY1 Q1
Task Develop provider education and engagement strategy through a structured stakeholder engagement process, which will facilitate participant understanding of and input to value-based payments and potential contracting arrangements.	Project		In Progress	08/15/2015	11/30/2015	12/07/2015	03/31/2016	03/31/2016	DY1 Q4
Task Assess PPS progress in meeting State roadmap value-based payment goals for DY 3 and DY 4	Project		Not Started	02/01/2017	03/31/2017	02/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	Project	N/A	In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Review final State value-based payment roadmap and PPS value-based payment plan	Project		Completed	07/01/2015	08/04/2015	07/01/2015	08/04/2015	09/30/2015	DY1 Q2
Task Identify Medicaid MCOs and other payers that serve PPS	Project		In Progress	10/01/2015	04/15/2016	10/01/2015	04/15/2016	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
service area and obtain key DSRIP contact at each Medicaid MCO for participation in PPS activities									
Task Establish reporting mechanisms to collect and analyze Medicaid MCO and PPS partner data relative to utilization, performance, and payment reform	Project		In Progress	10/01/2015	11/15/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Convene first monthly meeting of Medicaid MCO workgroup; membership will be a subset of the Finance and Sustainability Sub-committee with the potential to add members from PPS providers and MCO representatives	Project		Not Started	08/15/2015	11/30/2015	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Collect and analyze PPS data and prepare framework for reports to Medicaid MCOs	Project		Not Started	01/15/2016	03/31/2016	01/15/2016	03/31/2016	03/31/2016	DY1 Q4
Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	Project	N/A	In Progress	08/15/2015	03/31/2017	08/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Establish reporting mechanisms and framework for collecting and analyzing data on patient outcomes by PPS partners and providers	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Develop provider education and engagement strategy through a structured stakeholder engagement process, which will facilitate participant understanding of and input to value-based payments and potential contracting arrangements.	Project		In Progress	08/15/2015	11/30/2015	08/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Collect and analyze data on patient outcomes by PPS partners and providers	Project		Not Started	01/15/2016	03/31/2016	01/15/2016	03/31/2016	03/31/2016	DY1 Q4
Task Develop recommendation for allocation of internal PPS provider bonus payments to reflect PPS partner and provider performance relative to patient outcomes	Project		Not Started	03/01/2016	05/30/2016	03/01/2016	05/30/2016	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 Present recommendation for allocation of internal PPS provider bonus payments to Executive Committee	Project		Not Started	05/30/2016	06/30/2016	05/30/2016	06/30/2016	06/30/2016	DY2 Q1
Task Engage MCO workgroup and participating MCO organizations to reconcile and align PPS and MCO activities related to provider compensation associated with patient outcome	Project		Not Started	05/30/2016	06/30/2016	05/30/2016	06/30/2016	06/30/2016	DY2 Q1
Task Issue first internal PPS provider bonus payments for high-performing partners exceeding outcome and quality thresholds	Project		Not Started	08/01/2016	09/30/2016	08/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Complete first quarterly report to Executive Committee on progress toward aligning provider compensation with patient outcomes.	Project		Not Started	08/01/2016	09/30/2016	08/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Develop provider value-based compensation framework through the Finance and Sustainability Sub-Committee, Medicaid MCO workgroup and the Executive Committee.	Project		Not Started	09/01/2016	12/31/2016	09/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Complete first annual evaluation of PPS value-based payment plan and recommend changes, if needed	Project		In Progress	11/01/2015	01/31/2016	11/01/2015	01/31/2016	03/31/2016	DY1 Q4
Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	Project	N/A	In Progress	04/01/2015	11/30/2016	04/01/2015	11/30/2016	12/31/2016	DY2 Q3
Task Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.	Project		Not Started	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Identify community based services relevant to the community, and identify organizations that provide them, to gain an understanding of their willingness in and capability to expand their services and to contractually engage with BPHC to engage patients in their care through outreach activities, peforming patient screening and assessment, helping patients navigate service providers (including engagement and activation with primary care) and providing patient education and self-management assistance	Project		Completed	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 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
Task Identify CBOs to contract with in DY1, via: 1) project-specific work groups identifying CBOs to target and engage based on the services they provide and how those services address the predominant social determinants of health in the Bronx by primary condition (diabetes, CVD, asthma, etc), based on the initial Bronx CNA (November 2014); 2) CSO implement a survey of current CBO members of our PPS to profile their services and their interest and capacity to participate as partner organizations in our DSRIP projects; 3) hosting weekly forums with groups of CBOs designed to inform them about the CBO role as member organizations and to facilitate their participation in our DSRIP projects.	Project		Completed	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Draft Master Services Agreement (MSA) and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure.	Project		Completed	04/01/2015	05/21/2015	04/01/2015	05/21/2015	06/30/2015	DY1 Q1
Task Solicit comments on MSA from PPS members through distribution to members, opportunity for submission of written comments, and review in Committee and Sub-Committee meetings.	Project		Completed	05/21/2015	06/08/2015	05/21/2015	06/08/2015	06/30/2015	DY1 Q1
Task Finalize MSA.	Project		Completed	07/01/2015	07/23/2015	07/01/2015	07/23/2015	09/30/2015	DY1 Q2
Task Develop and finalize CBO project schedules in concert with Clinical Operational Plans.	Project		In Progress	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Review and negotiate project schedules with CBOs.	Project		In Progress	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Execute agreements and project schedules for CBOs.	Project		In Progress	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Develop patient engagement and activation protocols for priority projects, target subpopulations or interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Begin patient outreach, engagement, screening/assessment,	Project		Not Started	10/15/2016	11/30/2016	10/15/2016	11/30/2016	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
navigation activation and education for high priority projects and population									
Task Define patient engagement and patient engagement metrics. Define mechanisms for evaluation, feedback and continuous quality improvement.	Project		In Progress	07/22/2015	06/30/2016	07/22/2015	06/30/2016	06/30/2016	DY2 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 Define pro forma role of all PPS providers in BPHC's network model of care (prioritized programs/projects, target patient populations, interventions, accountabilities, use of care plans, funds flow, etc.) to establish BPHC-wide expectations, building on clinical planning to date and planned population health management, clinical integration and IT assessment and planning detailed in those work streams										
Task Draft Master Services Agreement (MSA) and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure										
Task Solicit comments on MSA from partners through distribution to members, opportunity to submit written comments, and review in Committee and Sub-Committee meetings.										
Task Finalize MSA agreement										
Task Develop and finalize project schedules in concert with Clinical Operations Plans (COPs)										

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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 Review and negotiate project schedules with partner organizations. The order in which project schedules will be negotiated will be based on prioritization of partner organizations developed by SBH										
Task Complete first round of contracting with all PPS partners										
Task Identify payers and social service organizations required to support IDS strategy that are not already identified as PPS member partners; schedule, conduct and document regular meetings to discuss formal mechanisms for them to participate in BPHC										
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 Define contracting, coordination and assessment strategy for Montefiore BAHN ACO, and care model expectations, coordination and contracting strategies related to BAHN, CBC and CCMP partner Health Homes, based on requirement frameworks developed to date and those that will result from planned assessment and planning activities in other work streams										
Task Assess HH and ACO population health management capabilities to determine if the skills and experience of the ACO and other organizations can be leveraged by BPHC, based on strategies and expectations; incorporate into BPHC operational strategy/plan										
Task Develop and implement effective referral strategy to the HH/ACO, including referral tracking										
Task Integrate HHs and ACOs into the IT infrastructure										

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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 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 Identify and document required clinical and care management protocols for priority programs, projects and interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data										
Task Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations for how interventions will be logged, tracked and reported.										
Task Deploy systems to improve and promote effective care transitions, include protocols for tracking and follow-up										
Task Operationalize partner and workforce roles by providing gap analysis and appropriate training to clinicians and care management staff (including licensed care managers, care coordinators, patient navigators/community health workers, medical assistants and front-office staff).										
Task Establish data collection, survey and reporting mechanisms to enable BPHC monitoring to ensure that patients are receiving appropriate health care and community support in priority projects, based on needs identified in prior planning activities										
Task Review process for rapid cycle evaluation and continuous improvement of data collection, survey and reporting methods										

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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 priority project experience and modify process as needed to ensure patients receive appropriate health care and community support										
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	0	0	0	0	0	0
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	165
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	1
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	3
Task PPS uses alerts and secure messaging functionality.										
Task Identify safety net provider data sharing requirements and assess partner and QE data sharing capabilities and current HIE participation										
Task Coordinate with Bronx RHIO to develop comprehensive HIE adoption program to encourage and support partner participation and integration										
Task Begin coordinated interface and service development with Bronx RHIO										
Task Establish BPHC program to manage support for safety net providers to ensure that all are actively sharing health information, coordinating with Bronx RHIO to encourage, track and support partner participation and integration/data sharing										
Task Track status and manage support to ensure that all PPS safety										

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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
net providers are actively sharing health information through Bronx RHIO or alternative health information exchange										
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	0	0	0	0	0	0	0	0	0
Task Assess eligible participating partner EHR use relative to Meaningful Use and PCMH 2014 Level 3 standards										
Task Establish BPHC program to educate, encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, including potential use of incentive-based payments for implementation										
Task Recruit or contract for EHR implementation resources as needed										
Task Begin actively encouraging, tracking and supporting partner EHR implementation and progress towards Meaningful Use and PCMH standards										
Task Track status and manage support to ensure all eligible safety net providers are using certified EHR systems that meet Meaningful Use and PCMH 2014 Level 3 standards										
Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff										
Task Perform current state assessment of E.H.R. capabilities.										

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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 Perform gap analysis and identify priories to achieving integration of patient record.										
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.										
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)										
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.										
Task Create budget to build registry and acquire necessary resources										
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries										
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data										
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care										
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.										
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.										
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.										

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Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.										
Task Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.										
Task All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.	0	0	0	0	0	0	0	0	0	0
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 Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices										
Task Recruit or contract for PCMH practice certification resources as needed										
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition										
Task Perform gap analysis by practice and identify key priorities.										
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.										
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition										
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed.										
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.										

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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 Review final State value-based payment roadmap and PPS value-based payment plan										
Task Identify Medicaid MCOs engaged with our attributed patients and actively engage them in developing new and strengthening existing value-based payment arrangements through a structured stakeholder engagement process.										
Task Establish partner value-based payment reporting requirements and procedures to enable ongoing monitoring of PPS value-based payment revenue in accordance with State roadmap goals										
Task Develop detailed analysis of PPS partners' existing value-based payment arrangements with Medicaid MCOs and other payers by reviewing claims-level data										
Task Engage MCOs in defining PPS MCO contracting strategy and organizational requirements necessary to support the development of contracts with Medicaid MCOs										
Task Engage PPS partners to assist in defining PPS MCO contracting strategy and organizational requirements necessary to support the development of contracts with Medicaid MCOs										
Task Develop or contract with an organizational structure (e.g. IPA, ACO, etc.) or multiple organizational structures to support contracting with Medicaid MCOs and other payers as an integrated system										
Task Develop value-based payment arrangements for presentation to Medicaid MCOs and other payers										
Task Develop PPS plan, overseen by Finance and Sustainability Sub-committee, to achieve 90% value based payments by DY5 and present to the Executive Committee for review and signoff										
Task Produce quarterly report to Executive Committee on transition to										

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value-based payment, based on plan developed and approved in earlier steps										
Task Complete annual process to initiate new and assess and refine existing PPS value-based payment arrangements, based on reporting and ongoing monitoring procedures, options analysis and plans/strategies established in earlier steps										
Task Recruit senior Medicaid MCO leadership to serve on Executive Committee. Identify and appoint HMO industry expert to F&S Sub-Committee.										
Task Develop provider education and engagement strategy through a structured stakeholder engagement process, which will facilitate participant understanding of and input to value-based payments and potential contracting arrangements.										
Task Assess PPS progress in meeting State roadmap value-based payment goals for DY 3 and DY 4										
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 Review final State value-based payment roadmap and PPS value-based payment plan										
Task Identify Medicaid MCOs and other payers that serve PPS service area and obtain key DSRIP contact at each Medicaid MCO for participation in PPS activities										
Task Establish reporting mechanisms to collect and analyze Medicaid MCO and PPS partner data relative to utilization, performance, and payment reform										
Task Convene first monthly meeting of Medicaid MCO workgroup; membership will be a subset of the Finance and Sustainability Sub-committee with the potential to add members from PPS providers and MCO representatives										
Task Collect and analyze PPS data and prepare framework for reports to Medicaid MCOs										

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

SBH Health System (PPS ID:36)

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 #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 Establish reporting mechanisms and framework for collecting and analyzing data on patient outcomes by PPS partners and providers										
Task Develop provider education and engagement strategy through a structured stakeholder engagement process, which will facilitate participant understanding of and input to value-based payments and potential contracting arrangements.										
Task Collect and analyze data on patient outcomes by PPS partners and providers										
Task Develop recommendation for allocation of internal PPS provider bonus payments to reflect PPS partner and provider performance relative to patient outcomes										
Task Present recommendation for allocation of internal PPS provider bonus payments to Executive Committee										
Task Engage MCO workgroup and participating MCO organizations to reconcile and align PPS and MCO activities related to provider compensation associated with patient outcome										
Task Issue first internal PPS provider bonus payments for high-performing partners exceeding outcome and quality thresholds										
Task Complete first quarterly report to Executive Committee on progress toward aligning provider compensation with patient outcomes.										
Task Develop provider value-based compensation framework through the Finance and Sustainability Sub-Committee, Medicaid MCO workgroup and the Executive Committee.										
Task Complete first annual evaluation of PPS value-based payment										

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

SBH Health System (PPS ID:36)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
plan and recommend changes, if needed										
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 Identify community based services relevant to the community, and identify organizations that provide them, to gain an understanding of their willingness in and capability to expand their services and to contractually engage with BPHC to engage patients in their care through outreach activities, peforming patient screening and assessment, helping patients navigate service providers (including engagement and activation with primary care) and providing patient education and self-management assistance										
Task Identify CBOs to contract with in DY1, via: 1) project-specific work groups identifying CBOs to target and engage based on the services they provide and how those services address the predominant social determinants of health in the Bronx by primary condition (diabetes, CVD, asthma, etc), based on the initial Bronx CNA (November 2014); 2) CSO implement a survey of current CBO members of our PPS to profile their services and their interest and capacity to participate as partner organizations in our DSRIP projects; 3) hosting weekly forums with groups of CBOs designed to inform them about the CBO role as member organizations and to facilitate their participation in our DSRIP projects.										
Task Draft Master Services Agreement (MSA) and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure.										
Task Solicit comments on MSA from PPS members through distribution to members, opportunity for submission of written comments, and review in Committee and Sub-Committee meetings.										
Task Finalize MSA.										

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SBH Health System (PPS ID:36)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Develop and finalize CBO project schedules in concert with Clinical Operational Plans.										
Task Review and negotiate project schedules with CBOs.										
Task Execute agreements and project schedules for CBOs.										
Task Develop patient engagement and activation protocols for priority projects, target subpopulations or interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data										
Task Begin patient outreach, engagement, screening/assessment, navigation activation and education for high priority projects and population										
Task Define patient engagement and patient engagement metrics. Define mechanisms for evaluation, feedback and continuous quality improvement.										

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 Define pro forma role of all PPS providers in BPHC's network model of care (prioritized programs/projects, target patient populations, interventions, accountabilities, use of care plans, funds flow, etc.) to establish BPHC-wide expectations, building on clinical planning to date and planned population health management, clinical integration and IT assessment and planning detailed in those work streams										

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SBH Health System (PPS ID:36)

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 Draft Master Services Agreement (MSA) and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure										
Task Solicit comments on MSA from partners through distribution to members, opportunity to submit written comments, and review in Committee and Sub-Committee meetings.										
Task Finalize MSA agreement										
Task Develop and finalize project schedules in concert with Clinical Operations Plans (COPs)										
Task Review and negotiate project schedules with partner organizations. The order in which project schedules will be negotiated will be based on prioritization of partner organizations developed by SBH										
Task Complete first round of contracting with all PPS partners										
Task Identify payers and social service organizations required to support IDS strategy that are not already identified as PPS member partners; schedule, conduct and document regular meetings to discuss formal mechanisms for them to participate in BPHC										
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 Define contracting, coordination and assessment strategy for Montefiore BAHN ACO, and care model expectations, coordination and contracting strategies related to BAHN, CBC and CCMP partner Health Homes, based on requirement frameworks developed to date and those that will result from										

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SBH Health System (PPS ID:36)

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
planned assessment and planning activities in other work streams										
Task Assess HH and ACO population health management capabilities to determine if the skills and experience of the ACO and other organizations can be leveraged by BPHC, based on strategies and expectations; incorporate into BPHC operational strategy/plan										
Task Develop and implement effective referral strategy to the HH/ACO, including referral tracking										
Task Integrate HHs and ACOs into the IT infrastructure										
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 Identify and document required clinical and care management protocols for priority programs, projects and interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data										
Task Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations for how interventions will be logged, tracked and reported.										
Task Deploy systems to improve and promote effective care transitions, include protocols for tracking and follow-up										

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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 Operationalize partner and workforce roles by providing gap analysis and appropriate training to clinicians and care management staff (including licensed care managers, care coordinators, patient navigators/community health workers, medical assistants and front-office staff).										
Task Establish data collection, survey and reporting mechanisms to enable BPHC monitoring to ensure that patients are receiving appropriate health care and community support in priority projects, based on needs identified in prior planning activities										
Task Review process for rapid cycle evaluation and continuous improvement of data collection, survey and reporting methods based on priority project experience and modify process as needed to ensure patients receive appropriate health care and community support										
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	187	936	936	936	936	936
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	330	495	825	1,320	1,977	3,295	3,295	3,295	3,295	3,295
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	2	3	4	7	12	12	12	12	12	12
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	65	325	325	325	325	325
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	6	11	17	27	44	44	44	44	44	44
Task PPS uses alerts and secure messaging functionality.										
Task Identify safety net provider data sharing requirements and assess partner and QE data sharing capabilities and current HIE participation										

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SBH Health System (PPS ID:36)

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 Coordinate with Bronx RHIO to develop comprehensive HIE adoption program to encourage and support partner participation and integration										
Task Begin coordinated interface and service development with Bronx RHIO										
Task Establish BPHC program to manage support for safety net providers to ensure that all are actively sharing health information, coordinating with Bronx RHIO to encourage, track and support partner participation and integration/data sharing										
Task Track status and manage support to ensure that all PPS safety net providers are actively sharing health information through Bronx RHIO or alternative health information exchange										
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	0	0	0	0	422	422	422	422	422
Task Assess eligible participating partner EHR use relative to Meaningful Use and PCMH 2014 Level 3 standards										
Task Establish BPHC program to educate, encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, including potential use of incentive-based payments for implementation										
Task Recruit or contract for EHR implementation resources as needed										
Task Begin actively encouraging, tracking and supporting partner EHR implementation and progress towards Meaningful Use and PCMH standards										
Task Track status and manage support to ensure all eligible safety net providers are using certified EHR systems that meet Meaningful Use and PCMH 2014 Level 3 standards										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #6 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 Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff										
Task Perform current state assessment of E.H.R. capabilities.										
Task Perform gap analysis and identify priories to achieving integration of patient record.										
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.										
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)										
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.										
Task Create budget to build registry and acquire necessary resources										
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries										
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data										
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary 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
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.										
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.										
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.										
Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.										
Task Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.										
Task All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.	0	0	0	0	187	936	936	936	936	936
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 Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices										
Task Recruit or contract for PCMH practice certification resources as needed										
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition										

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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 Perform gap analysis by practice and identify key priorities.										
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.										
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition										
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed.										
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.										
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 Review final State value-based payment roadmap and PPS value-based payment plan										
Task Identify Medicaid MCOs engaged with our attributed patients and actively engage them in developing new and strengthening existing value-based payment arrangements through a structured stakeholder engagement process.										
Task Establish partner value-based payment reporting requirements and procedures to enable ongoing monitoring of PPS value-based payment revenue in accordance with State roadmap goals										
Task Develop detailed analysis of PPS partners' existing value-based payment arrangements with Medicaid MCOs and other payers by reviewing claims-level data										
Task Engage MCOs in defining PPS MCO contracting strategy and organizational requirements necessary to support the development of contracts with Medicaid MCOs										
Task Engage PPS partners to assist in defining PPS MCO contracting										

SBH Health System (PPS ID:36)

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
strategy and organizational requirements necessary to support the development of contracts with Medicaid MCOs										
Task Develop or contract with an organizational structure (e.g. IPA, ACO, etc.) or multiple organizational structures to support contracting with Medicaid MCOs and other payers as an integrated system										
Task Develop value-based payment arrangements for presentation to Medicaid MCOs and other payers										
Task Develop PPS plan, overseen by Finance and Sustainability Sub-committee, to achieve 90% value based payments by DY5 and present to the Executive Committee for review and signoff										
Task Produce quarterly report to Executive Committee on transition to value-based payment, based on plan developed and approved in earlier steps										
Task Complete annual process to initiate new and assess and refine existing PPS value-based payment arrangements, based on reporting and ongoing monitoring procedures, options analysis and plans/strategies established in earlier steps										
Task Recruit senior Medicaid MCO leadership to serve on Executive Committee. Identify and appoint HMO industry expert to F&S Sub-Committee.										
Task Develop provider education and engagement strategy through a structured stakeholder engagement process, which will facilitate participant understanding of and input to value-based payments and potential contracting arrangements.										
Task Assess PPS progress in meeting State roadmap value-based payment goals for DY 3 and DY 4										
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 Review final State value-based payment roadmap and PPS value-based payment plan										

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SBH Health System (PPS ID:36)

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 Identify Medicaid MCOs and other payers that serve PPS service area and obtain key DSRIP contact at each Medicaid MCO for participation in PPS activities										
Task Establish reporting mechanisms to collect and analyze Medicaid MCO and PPS partner data relative to utilization, performance, and payment reform										
Task Convene first monthly meeting of Medicaid MCO workgroup; membership will be a subset of the Finance and Sustainability Sub-committee with the potential to add members from PPS providers and MCO representatives										
Task Collect and analyze PPS data and prepare framework for reports to Medicaid MCOs										
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 Establish reporting mechanisms and framework for collecting and analyzing data on patient outcomes by PPS partners and providers										
Task Develop provider education and engagement strategy through a structured stakeholder engagement process, which will facilitate participant understanding of and input to value-based payments and potential contracting arrangements.										
Task Collect and analyze data on patient outcomes by PPS partners and providers										
Task Develop recommendation for allocation of internal PPS provider bonus payments to reflect PPS partner and provider performance relative to patient outcomes										
Task Present recommendation for allocation of internal PPS provider bonus payments to Executive Committee										

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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 Engage MCO workgroup and participating MCO organizations to reconcile and align PPS and MCO activities related to provider compensation associated with patient outcome										
Task Issue first internal PPS provider bonus payments for high-performing partners exceeding outcome and quality thresholds										
Task Complete first quarterly report to Executive Committee on progress toward aligning provider compensation with patient outcomes.										
Task Develop provider value-based compensation framework through the Finance and Sustainability Sub-Committee, Medicaid MCO workgroup and the Executive Committee.										
Task Complete first annual evaluation of PPS value-based payment plan and recommend changes, if needed										
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 Identify community based services relevant to the community, and identify organizations that provide them, to gain an understanding of their willingness in and capability to expand their services and to contractually engage with BPHC to engage patients in their care through outreach activities, peforming patient screening and assessment, helping patients navigate service providers (including engagement and activation with primary care) and providing patient education and self-management assistance										
Task Identify CBOs to contract with in DY1, via: 1) project-specific work groups identifying CBOs to target and engage based on the services they provide and how those services address the predominant social determinants of health in the Bronx by primary condition (diabetes, CVD, asthma, etc), based on the initial Bronx CNA (November 2014); 2) CSO implement a survey of current CBO members of our PPS to profile their services and their interest and capacity to participate as 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
in our DSRIP projects; 3) hosting weekly forums with groups of CBOs designed to inform them about the CBO role as member organizations and to facilitate their participation in our DSRIP projects.										
Task Draft Master Services Agreement (MSA) and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure.										
Task Solicit comments on MSA from PPS members through distribution to members, opportunity for submission of written comments, and review in Committee and Sub-Committee meetings.										
Task Finalize MSA.										
Task Develop and finalize CBO project schedules in concert with Clinical Operational Plans.										
Task Review and negotiate project schedules with CBOs.										
Task Execute agreements and project schedules for CBOs.										
Task Develop patient engagement and activation protocols for priority projects, target subpopulations or interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data										
Task Begin patient outreach, engagement, screening/assessment, navigation activation and education for high priority projects and population										
Task Define patient engagement and patient engagement metrics. Define mechanisms for evaluation, feedback and continuous quality improvement.										

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
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.	IDS includes all required providers, including payer and social service organizations. The PPS finalized the Master Services Agreement (MSA) structure, implemented processes for collecting them, and collected MSAs covering approximately 75% of our providers (who account for 97% of PCP services to BPHC attributed members). Schedule As (exhibits to the MSA) have been developed and negotiated to invest in top line project management staff at these organizations. Request for Information ("RFI") has been solicited from these organizations, which detail the current and future state of IT, clinical and non-clinical workforce based on operational needs and PPS-adopted care deliver models, are being used to inform the first wave of fund distribution. Meanwhile, Clinical Operation Plans COPs have been developed to compile and communicate the collective policies and protocols developed, vetted, and agreed to by members of the PPS. Milestone is on track for completion.
Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	Based on efforts to date coordinating with our partner Health Homes on population health management strategies, we realized that coordinating with our partner ACO will be substantially more complex. We have a close working relationship with the ACO and HH and will view DSRIP as an opportunity to broaden that relationship. We are working on developing these relationships and leveraging members in our organization that have experience with population health. Milestone is on track for completion.
Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	We are building an IDS that has the capacity and diversity to ensure patients receive appropriate health care and community support. We developed the Clinical Operation Plans (COPs) for all projects, and have started to deploy them this quarter to help satisfy our immediate (3.4 and 3.5) and future (3.5-3.9) requirements and tasks. The COPs define sets of narratives, policies and procedures of how members will provide various services to patients. Milestone is on track for completion.
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.	We are executing a comprehensive plan to support our safety net providers in MU and PCMH which includes EHR support and connectivity of data captured therein. Our agreement with Bronx RHIO will serve as the foundation to achieve next quarter's tasks and those of the future to support this Milestone. This agreement is very close to being signed. We also have a strategy around funding for the adoption of the HIE by safety net providers, informed by an analysis of EMR and QE implementation and use by member organizations. Milestone is on track for completion.
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.	We are executing a comprehensive plan to support our safety net providers in MU and PCMH which includes EHR support and connectivity of data captured therein. A process has been started already to ensure all applicable providers meet PCMH and MU accreditation where possible and that we meet our obligation to the previously agreed tasks. We have hired and deployed expert PCMH consultants to perform detailed gap analysis with about 100 practices, with 60 locations already evaluated thus far. These documents and other sources were used to profile the EMRs of 84% of safety net physicians in the PPS. Funding has been earmarked for IT expansion and process for this funding's distribution have been developed and communicated to the member organizations. Milestone is on track for completion.
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	We are executing a comprehensive plan to support our safety net providers in MU and PCMH which includes use of targeted patient registries in conjunctions with our clinical projects. We have a comprehensive strategy in place for care management which includes the uses of registries, EHRs and IT platforms, and the completion of all agreed upon tasks by agreed upon dates. Last quarter registry elements and business requirements were developed and adopted and a PHM Gap Assessment and IT Gap Assessment were constructed. Registry elements were approved by the Quality and Care Innovations Subcommittee. The IT Subcommittee reviewed the registry strategy but approval from this subcommittee of the registry elements was determined to be unnecessary and less meaningful than originally determined, given the clinical expertise required that the IT Subcommittee does not offer. It was further determined that the Executive Committee would not need to approve this level of detail in the PHM strategy, give that its Clinical Committee had already conducted a thorough review and approval process. Consultants have been deployed to perform detailed Gap Analysis. Milestone is on track for completion.
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	We are executing a comprehensive plan to support our safety net providers in MU and PCMH which includes EHR support and connectivity of data captured therein. A process has been started to ensure all applicable providers meet PCMH and MU accreditation where possible and that we meet our obligation to the previously agreed tasks. Consultants have been deployed to perform detailed Gap Analysis with about 100 practices, with 60 locations already evaluated

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
meet EHR Meaningful Use standards by the end of DY 3.	thus far. 13 practices have already submitted their PCMH 2014 attestations, with twelve achieving level 3 and one still pending NCQA ruling. Contracting is currently ongoing and is in various stages, with six consulting groups, for the work on the remaining practices. These six consulting groups are part of a Community of Practice we are organizing to share and collaborate on PCMH transformation and possibly other population health initiatives. Milestone is on track for completion.
Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	The Chief Executive Officer with the Finance and Sustainability Co Chairs are in communication with MCOs to establish a contract. A strategy will be developed looking at the claims data and utilization to establish a Value Base Rate. The VBP will require certain deliverables from the providers that will improve population health and reduce hospitalization. Dates adjusted to align with Finance and Sustainability timeline.
Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	Once the contracts are in place with MCOs, strategy will be developed to review and discuss utilization trends, performance issues and payment reform. Teams from MCOs and BPHC CSO will jointly work in analyzing utilization trends and performance amongst the PPS providers. Dates adjusted to align with Finance and Sustainability timeline.
Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	BPHC will ensure that patient care is not compromised and at the same time providers are also compensated appropriately. The PPS and MCOs will monitor patient outcomes and make sure deliverables are met. Dates adjusted to align with Finance and Sustainability timeline.
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.	BPHC has continued to develop strategies for community-based organizations' (CBOs) involvement in service delivery for the at-risk population engaged in care management. Leveraging a list of social services most commonly utilized by the at-risk population, developed by BPHC's clinical work groups, as well as surveys on existing services offered by organizations within the PPS, BPHC has continued to develop a referral directory for use throughout the network. This directory will be searchable by zip code and service category and will eventually be included in the CCMS and/or referral management platform. A policy and procedure for "closed loop referral tracking" of both clinical and social service referral has been included in the cross-cutting section of BPHC's Clinical Operations Plan, to ensure linkages to needed services are tracked to completion. Community health workers have been included in the BPHC model care management staffing model and peer led initiatives, such as the Stanford Model, have been incorporated into BPHC's chronic disease management model. This milestone remains on track for completion. A funding structure is being developed to allow for additional contracting with CBOs for needed services.

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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Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

(1) A major risk we face in successfully implementing 2.a.iii is ensuring that participating providers have access to an electronic care management (CM) tool that can be shared across providers to effectively document and track patients engaged with CM services. Multiple IT systems and protocols are employed by Health Homes and PCMHs, and some partners do not have IT systems with the necessary capabilities. BPHC will leverage the MAPP tool, and will ensure that all community partners have access to an electronic care planning and management tool, which will facilitate documentation. The care planning tool will serve as a centralized resource for partners without the needed IT system in place, and a unifying resource for partners with varying IT systems. (2) Another risk to 2.a.iii is that patients lack an understanding about the long-term effects of chronic diseases, and as a result, many patients do not see the benefit to be gained from care management services. To overcome this barrier, BPHC will focus its patient education efforts on developing materials that integrate simply stated facts about the illness with evidence-based guidelines that take into account culturally relevant insight on topics such as self-management, diet, exercise, and medication adherence. These materials and topics will be integrated into CM staff training. BPHC will use patient level tactics such as motivational interviewing and incentives and population-level community-wide marketing strategies to inform and engage patients. Finally, BPHC recognizes that using culturally competent community-based outreach workers and peer educators along with evidence-based patient activation measure strategies are critical in engaging patients in CM services. (3) Reaching patients by phone and home visits is often difficult due to frequent changes in contact information. To overcome this challenge, BPHC will institute outreach standards that emphasize persistence and use of both telephonic outreach and in-person community outreach by primary care team members and partner community-based organizations. In addition, BPHC will identify strategies to provide high-risk patients with cell phones, mailboxes, and addresses. (4) Though CNA respondents reported availability of primary care, these services are unevenly spread across the borough, and significant shortages exist in some neighborhoods. SBH has recently signed an agreement with the Sophie Davis School of Biomedical Education at CUNY to be its primary hospital campus as it becomes a full-fledged medical school focused on the education of PCPs to serve diverse, needy communities. In addition, Montefiore operates a social medicine residency, which trains PCPs to work in the Bronx. BPHC also will recruit and train midlevel providers (i.e., nurse practitioners and physician assistants). We will collaborate with all Bronx PPSs to increase the number of PCPs recruited and retrained, and we will look at physician compensation models to identify ways to make the Bronx a more attractive place to practice. (5) It will be challenging to recruit and train sufficient CM staff to serve the needs of the Bronx. Recruiting Spanish-speaking CM staff will be a particular risk. BPHC's workforce strategy will be targeted towards mitigating this risk, such as through the CSO working with community colleges and coordinating with the 1199 Job Security Fund, Montefiore CMO, and NYSNA to identify capable workers and provide training in Spanish when needed. BPHC will also use alternative employment tactics, such as flexible hours and job sharing where feasible to attract a broader pool of workers. BPHC will coordinate with other Bronx PPSs on its workforce strategy, which will entail conducting joint recruitment efforts and better aligning compensation to ensure that Bronx PPSs are not competing against each other for care managers.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	57,600

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
0	0	0.00%	5,760	0.00%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (5,760)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
zstopak	Report(s)	36_PMDL2215_1_3_20160128174016_2.a.iii_-_Patient_Engagement_DY1_Q3.docx	2.a.iii - Patient Engagement DY1 Q3	01/28/2016 05:41 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task A clear strategic plan is in place which includes, at a minimum: - Definition of the Health Home At-Risk Intervention Program - Development of comprehensive care management plan, with definition of roles of PCMH/APC PCPs and HHs	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Develop a workplan and timeline to develop the clinical operations plan (COPs) and implement a strategy for the HH at-risk population that aligns with the patient engagement speed and scale application submission	Project		Completed	04/01/2015	05/15/2015	04/01/2015	05/15/2015	06/30/2015	DY1 Q1
Task Convene representative group of PPS members including Health Homes (HH), PCMHs, SUD providers and SMEs, and others to participate in developing project plan for HH at-risk project (2.a.iii)	Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Define the population to be targeted by the HH at-risk intervention, such as individuals with diabetes, substance use disorders, mild to moderate depression or other single uncontrolled chronic conditions (see requirement #5)	Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Define a care management (CM) staffing model, in conjunction with Workforce Subcommittee, to address the needs of the target population including staff qualifications, care team roles (including PCP and care manager), functions, and panel size of team members	Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 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
Task Develop financial model to cost out CM team	Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Develop and document the COP to define the elements of the program including the roles of PCPs and Health Homes, health information exchange and technology requirements, and evidence-based guidelines	Project		Completed	05/01/2015	10/31/2015	05/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Develop project implementation budget	Project		Completed	05/01/2015	10/31/2015	05/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Working with Workforce Subcommittee, design training and recruitment strategy for care managers and care teams	Project		Completed	06/30/2015	10/31/2015	06/30/2015	10/31/2015	12/31/2015	DY1 Q3
Task Submit COP and budget to Quality and Care Innovation Sub-Committee for approval	Project		Completed	08/01/2015	10/31/2015	08/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Prepare/disseminate gap analysis tool based on COP to participating providers to determine CM resource needs against project plan and care management team staffing model	Project		Completed	08/15/2015	10/31/2015	08/15/2015	10/31/2015	12/31/2015	DY1 Q3
Task Identify site-specific implementation teams.	Project		Completed	08/15/2015	10/31/2015	08/15/2015	10/31/2015	12/31/2015	DY1 Q3
Task Launch recruitment and training programs with participating providers	Project		Completed	10/01/2015	10/31/2015	10/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Complete assessment of CM staffing needs of each participating site	Project		Completed	08/01/2015	11/30/2015	08/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Define metrics for rapid cycle evaluation	Project		In Progress	09/01/2015	01/31/2016	09/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task Use rapid cycle evaluation to track implementation successes and shortcomings and develop corrective actions	Project		Not Started	02/01/2016	03/31/2017	02/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task	Provider	Practitioner - Primary	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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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
All practices meet NCQA 2014 Level 3 PCMH and APCM standards		Care Provider (PCP)							
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recruit or contract for PCMH practice certification resources as needed	Project		Completed	05/01/2015	12/31/2015	05/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition	Project		In Progress	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Perform gap analysis by practice and identify key priorities.	Project		In Progress	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.	Project		In Progress	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition	Project		Not Started	01/01/2016	11/30/2016	01/01/2016	11/30/2016	12/31/2016	DY2 Q3
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #3 Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY	Provider	Safety Net Practitioner - Primary Care Provider	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
requirements.		(PCP)							
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Case Management / Health Home	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Identify safety net provider data sharing requirements and assess partner and QE data sharing capabilities and current HIE participation	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Coordinate with Bronx RHIO to develop comprehensive HIE adoption program to encourage and support partner participation and integration	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Begin coordinated interface and service development with Bronx RHIO	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish BPHC program to manage support for safety net providers, including, but not limited to primary care providers, mental health and substance use providers, hospitals, and others, to ensure that all are actively sharing health information, coordinating with Bronx RHIO to encourage, track and support partner participation and integration/data sharing	Project		Not Started	03/01/2016	04/25/2016	03/01/2016	04/25/2016	06/30/2016	DY2 Q1
Task Track status and manage support to ensure that all PPS safety net providers are actively sharing health information through Bronx RHIO or alternative health information exchange	Project		Not Started	03/01/2016	03/31/2018	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.	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	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
into the assessment criteria).									
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Assess eligible participating partner EHR use relative to Meaningful Use and PCMH 2014 Level 3 standards	Project		Completed	06/30/2015	08/30/2015	06/30/2015	08/30/2015	09/30/2015	DY1 Q2
Task Establish BPHC program to educate, encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, including potential use of incentive-based payments for implementation	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Recruit or contract for EHR implementation resources as needed	Project		In Progress	11/01/2015	06/30/2016	11/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner EHR implementation and progress towards Meaningful Use and PCMH standards	Project		Not Started	08/01/2016	12/31/2016	08/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Track status and manage support to ensure all eligible safety net providers are using certified EHR systems that meet Meaningful Use and PCMH 2014 Level 3 standards	Project		In Progress	10/15/2015	03/15/2018	10/15/2015	03/15/2018	03/31/2018	DY3 Q4
Milestone #5 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform gap analysis and identify priories to achieving integration of patient record.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.	Project		Completed	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget to build registry and acquire necessary resources	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Launch registry and monitor its use and performance, evaluate	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.									
Milestone #6 Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Procedures to engage at-risk patients with care management plan instituted.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Develop clinical requirements/use cases and technical requirements for web-based comprehensive care management plan	Project		Completed	05/01/2015	06/30/2015	05/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Identify qualified coordinated care management (CCMS) vendors	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Design/document outreach, intake, assessment, and patient engagement process for HH at-risk population that includes development of written comprehensive care management plan and referrals to Health Homes, substance use providers, community-based organizations, and other providers	Project		Completed	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Convene representative group from PPS providers to participate in care management plan development process	Project		Completed	05/01/2015	10/31/2015	05/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Select/contract with CCMS system(s) that meet requirements	Project		In Progress	10/01/2015	04/01/2016	10/01/2015	04/01/2016	06/30/2016	DY2 Q1
Task Develop, in conjunction with Workforce Subcommittee, training curriculum for PPS provider staff	Project		In Progress	10/01/2015	04/01/2016	10/01/2015	04/01/2016	06/30/2016	DY2 Q1
Task Select metrics and use CCMS system to track if care management plan is successful in "reducing patient risk factors"	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Implement comprehensive care management plan system in all participating sites	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provide ongoing technical assistance support to participating	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4

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
sites									
Task Use rapid cycle evaluation to track implementation successes and shortcomings with regard to the reduction of patient risk factors and develop corrective actions	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Each identified PCP establish partnerships with the local Health Home for care management services.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Each identified PCP establish partnerships with the local Health Home for care management services.	Provider	Case Management / Health Home	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify participating primary care practices	Project		Completed	07/01/2015	10/31/2015	07/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Assess participating practices' care management staffing needs to meet care management service needs of HH at-risk population, with particular attention to the complex needs of patients with co-occurring disorders, homelessness and SUD.	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Begin developing partnership agreements with HHs, their downstream Care Management Agencies (CMAs) and primary care practices	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Complete partnership agreements with HHs, their downstream Care Management Agencies (CMAs) and primary care practices that include standards for care management services for HH at-risk patients, data collection and reporting, referral processes, care plan content, communication and other policies and procedures	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health	Project	N/A	In Progress	09/01/2015	12/31/2016	09/01/2015	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
departments).									
Task PPS has established partnerships to medical, behavioral health, and social services.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS has established partnerships to medical, behavioral health, and social services.	Provider	Case Management / Health Home	In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Identify CBO partners that can provide needed social support services to the HH at-risk population	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop policies and procedures for CBO-PCP-HH patient referral to mental health, substance abuse, and other services, patient follow up, use of Care Coordination Management Systems (CCMS) tool for care planning & tracking, participation in case conferences, and other policies and procedures, as needed	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop contractual agreements with CBOs and HHs to provide social support services to patients assessed as eligible for HH at-risk CM services	Project		In Progress	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Implement CBO-PCP-HH patient referral, patient follow up, care planning & tracking, participation in case conferences, and other protocols for facilitating and documenting service coordination in the CCMS, integrated with EHRs via HIE	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Ensure that select CBOs have access to relevant portions of the electronic care management plan/CCMS and are able to document relevant client information in the care management plan	Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Execute contractual agreements with CBOs and HHs to provide social support services to patients assessed as eligible for HH at-risk CM services	Project		Not Started	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone #9	Project	N/A	In Progress	05/01/2015	03/31/2017	05/01/2015	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
Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.									
Task PPS has adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate evidence-based practice guidelines developed and process implemented.	Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.	Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task PPS has included social services agencies in development of risk reduction and care practice guidelines.	Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Convene work groups composed of PCPs and subject matter experts, (SMEs) including MH/SUD and social service agencies, to define target population, select evidence- based guidelines (EBGs) for target population and make recommendations to Quality & Care Innovation Sub-Committee (QCI) on EBGs for chronic conditions and collaborative care.	Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Working with select CBOs, primary care practices and SMEs, including MH/SUD and social service agencies, develop educational materials, suitable to the needs, culture, literacy, and language of the target populations	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task QCI reviews educational materials and revises as needed; QCI approves educational materials	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task QCI agendas begin to include evaluation of evidence-based guidelines as a topic for discussion at least annually	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task CSO implements EBG and educational material dissemination plan across the PPS	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Develop mechanisms for regular review of project-selected evidence-based guidelines (EBGs) by implementation work group to assure our PPS is utilizing the most up-to-date tools and that those upadated guidelines/protocols continue to be clinically integrated across the PPS	Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Develop feedback mechansims for accountability and continuous quality improvement	Project		Not Started	01/01/2016	09/30/2016	01/01/2016	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 a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.										
Task A clear strategic plan is in place which includes, at a minimum: - Definition of the Health Home At-Risk Intervention Program - Development of comprehensive care management plan, with definition of roles of PCMH/APC PCPs and HHs										
Task Develop a workplan and timeline to develop the clinical operations plan (COPs) and implement a strategy for the HH at-risk population that aligns with the patient engagement speed and scale application submission										
Task Convene representative group of PPS members including Health Homes (HH), PCMHs, SUD providers and SMEs, and others to participate in developing project plan for HH at-risk project (2.a.iii)										
Task Define the population to be targeted by the HH at-risk intervention, such as individuals with diabetes, substance use disorders, mild to moderate depression or other single uncontrolled chronic conditions (see requirement #5)										
Task Define a care management (CM) staffing model, in conjunction with Workforce Subcommittee, to address the needs of the target population including staff qualifications, care team roles (including PCP and care manager), functions, and panel size of										

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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
team members										
Task Develop financial model to cost out CM team										
Task Develop and document the COP to define the elements of the program including the roles of PCPs and Health Homes, health information exchange and technology requirements, and evidence-based guidelines										
Task Develop project implementation budget										
Task Working with Workforce Subcommittee, design training and recruitment strategy for care managers and care teams										
Task Submit COP and budget to Quality and Care Innovation Sub-Committee for approval										
Task Prepare/disseminate gap analysis tool based on COP to participating providers to determine CM resource needs against project plan and care management team staffing model										
Task Identify site-specific implementation teams.										
Task Launch recruitment and training programs with participating providers										
Task Complete assessment of CM staffing needs of each participating site										
Task Define metrics for rapid cycle evaluation										
Task Use rapid cycle evaluation to track implementation successes and shortcomings and develop corrective actions										
Milestone #2 Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and APCM standards	0	0	0	0	0	0	0	0	0	0
Task Assess eligible participating PCP PCMH recognition status 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
opportunity to expand access to primary care based on PCMH-enabled practices										
Task Recruit or contract for PCMH practice certification resources as needed										
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition										
Task Perform gap analysis by practice and identify key priorities.										
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.										
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition										
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed.										
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.										
Milestone #3 Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	99	198	297	495	792
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	1	2	3	5	10
Task PPS uses alerts and secure messaging functionality.										

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Task Identify safety net provider data sharing requirements and assess partner and QE data sharing capabilities and current HIE participation										
Task Coordinate with Bronx RHIO to develop comprehensive HIE adoption program to encourage and support partner participation and integration										
Task Begin coordinated interface and service development with Bronx RHIO										
Task Establish BPHC program to manage support for safety net providers, including, but not limited to primary care providers, mental health and substance use providers, hospitals, and others, to ensure that all are actively sharing health information, coordinating with Bronx RHIO to encourage, track and support partner participation and integration/data sharing										
Task Track status and manage support to ensure that all PPS safety net providers are actively sharing health information through Bronx RHIO or alternative health information exchange										
Milestone #4 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	0	0	0	0	0	0	0	0	0
Task Assess eligible participating partner EHR use relative to Meaningful Use and PCMH 2014 Level 3 standards										
Task Establish BPHC program to educate, encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, including potential use of incentive-based payments for implementation										
Task Recruit or contract for EHR implementation resources as needed										
Task Begin actively encouraging, tracking and supporting partner EHR										

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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
implementation and progress towards Meaningful Use and PCMH standards										
Task Track status and manage support to ensure all eligible safety net providers are using certified EHR systems that meet Meaningful Use and PCMH 2014 Level 3 standards										
Milestone #5 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff										
Task Perform current state assessment of E.H.R. capabilities.										
Task Perform gap analysis and identify priories to achieving integration of patient record.										
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.										
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)										
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.										
Task Create budget to build registry and acquire necessary resources										
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries										
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data										

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Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care										
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.										
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.										
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.										
Milestone #6 Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.										
Task Procedures to engage at-risk patients with care management plan instituted.										
Task Develop clinical requirements/use cases and technical requirements for web-based comprehensive care management plan										
Task Identify qualified coordinated care management (CCMS) vendors										
Task Design/document outreach, intake, assessment, and patient engagement process for HH at-risk population that includes development of written comprehensive care management plan and referrals to Health Homes, substance use providers, community-based organizations, and other providers										
Task Convene representative group from PPS providers to participate in care management plan development process										
Task Select/contract with CCMS system(s) that meet requirements										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Develop, in conjunction with Workforce Subcommittee, training curriculum for PPS provider staff										
Task Select metrics and use CCMS system to track if care management plan is successful in "reducing patient risk factors"										
Task Implement comprehensive care management plan system in all participating sites										
Task Provide ongoing technical assistance support to participating sites										
Task Use rapid cycle evaluation to track implementation successes and shortcomings with regard to the reduction of patient risk factors and develop corrective actions										
Milestone #7 Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.										
Task Each identified PCP establish partnerships with the local Health Home for care management services.	0	0	0	0	0	0	0	0	0	0
Task Each identified PCP establish partnerships with the local Health Home for care management services.	0	0	0	0	0	1	2	3	5	10
Task Identify participating primary care practices										
Task Assess participating practices' care management staffing needs to meet care management service needs of HH at-risk population, with particular attention to the complex needs of patients with co-occurring disorders, homelessness and SUD.										
Task Begin developing partnership agreements with HHs, their downstream Care Management Agencies (CMAs) and primary care practices										
Task Complete partnership agreements with HHs, their downstream Care Management Agencies (CMAs) and primary care practices that include standards for care management services for HH at-risk patients, data collection and reporting, referral processes, care plan content, communication and other 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
Milestone #8 Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).										
Task PPS has established partnerships to medical, behavioral health, and social services.	0	0	0	0	0	0	0	0	0	0
Task PPS has established partnerships to medical, behavioral health, and social services.	0	0	0	0	0	1	2	3	5	10
Task PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.										
Task Identify CBO partners that can provide needed social support services to the HH at-risk population										
Task Develop policies and procedures for CBO-PCP-HH patient referral to mental health, substance abuse, and other services, patient follow up, use of Care Coordination Management Systems (CCMS) tool for care planning & tracking, participation in case conferences, and other policies and procedures, as needed										
Task Develop contractual agreements with CBOs and HHs to provide social support services to patients assessed as eligible for HH at-risk CM services										
Task Implement CBO-PCP-HH patient referral, patient follow up, care planning & tracking, participation in case conferences, and other protocols for facilitating and documenting service coordination in the CCMS, integrated with EHRs via HIE										
Task Ensure that select CBOs have access to relevant portions of the electronic care management plan/CCMS and are able to document relevant client information in the care management plan										
Task Execute contractual agreements with CBOs and HHs to provide social support services to patients assessed as eligible for HH at-risk CM services										
Milestone #9 Implement evidence-based practice guidelines to address risk										

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
factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.										
Task PPS has adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate evidence-based practice guidelines developed and process implemented.										
Task Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.										
Task PPS has included social services agencies in development of risk reduction and care practice guidelines.										
Task Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.										
Task Convene work groups composed of PCPs and subject matter experts, (SMEs) including MH/SUD and social service agencies, to define target population, select evidence- based guidelines (EBGs) for target population and make recommendations to Quality & Care Innovation Sub-Committee (QCI) on EBGs for chronic conditions and collaborative care.										
Task Working with select CBOs, primary care practices and SMEs, including MH/SUD and social service agencies, develop educational materials, suitable to the needs, culture, literacy, and language of the target populations										
Task QCI reviews educational materials and revises as needed; QCI approves educational materials										
Task QCI agendas begin to include evaluation of evidence-based guidelines as a topic for discussion at least annually										
Task CSO implements EBG and educational material dissemination plan across the PPS										
Task Develop mechanisms for regular review of project-selected evidence-based guidelines (EBGs) by implementation work group to assure our PPS is utilizing the most up-to-date tools and that those upadated guidelines/protocols continue to be clinically integrated across the 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 Develop feedback mechansims for accountability and continuous quality improvement										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.										
Task A clear strategic plan is in place which includes, at a minimum: - Definition of the Health Home At-Risk Intervention Program - Development of comprehensive care management plan, with definition of roles of PCMH/APC PCPs and HHs										
Task Develop a workplan and timeline to develop the clinical operations plan (COPs) and implement a strategy for the HH at-risk population that aligns with the patient engagement speed and scale application submission										
Task Convene representative group of PPS members including Health Homes (HH), PCMHs, SUD providers and SMEs, and others to participate in developing project plan for HH at-risk project (2.a.iii)										
Task Define the population to be targeted by the HH at-risk intervention, such as individuals with diabetes, substance use disorders, mild to moderate depression or other single uncontrolled chronic conditions (see requirement #5)										
Task Define a care management (CM) staffing model, in conjunction with Workforce Subcommittee, to address the needs of the target population including staff qualifications, care team roles (including PCP and care manager), functions, and panel size of team members										
Task Develop financial model to cost out CM team										
Task Develop and document the COP to define the elements of the program including the roles of PCPs and Health Homes, health information exchange and technology requirements, and evidence-based guidelines										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Develop project implementation budget										
Task Working with Workforce Subcommittee, design training and recruitment strategy for care managers and care teams										
Task Submit COP and budget to Quality and Care Innovation Sub-Committee for approval										
Task Prepare/disseminate gap analysis tool based on COP to participating providers to determine CM resource needs against project plan and care management team staffing model										
Task Identify site-specific implementation teams.										
Task Launch recruitment and training programs with participating providers										
Task Complete assessment of CM staffing needs of each participating site										
Task Define metrics for rapid cycle evaluation										
Task Use rapid cycle evaluation to track implementation successes and shortcomings and develop corrective actions										
Milestone #2 Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and APCM standards	149	749	749	749	749	749	749	749	749	749
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices										
Task Recruit or contract for PCMH practice certification resources as needed										
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior										

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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
leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition										
Task Perform gap analysis by practice and identify key priorities.										
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.										
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition										
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed.										
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.										
Milestone #3 Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	149	749	749	749	749	749	749	749	749	749
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	1,186	1,977	1,977	1,977	1,977	1,977	1,977	1,977	1,977	1,977
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	17	17	17	17	17	17	17	17	17	17
Task PPS uses alerts and secure messaging functionality.										
Task Identify safety net provider data sharing requirements and assess partner and QE data sharing capabilities and current HIE participation										
Task Coordinate with Bronx RHIO to develop comprehensive HIE adoption program to encourage and support partner participation and integration										

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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 Begin coordinated interface and service development with Bronx RHIO										
Task Establish BPHC program to manage support for safety net providers, including, but not limited to primary care providers, mental health and substance use providers, hospitals, and others, to ensure that all are actively sharing health information, coordinating with Bronx RHIO to encourage, track and support partner participation and integration/data sharing										
Task Track status and manage support to ensure that all PPS safety net providers are actively sharing health information through Bronx RHIO or alternative health information exchange										
Milestone #4 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	149	749	749	749	749	749	749	749	749	749
Task Assess eligible participating partner EHR use relative to Meaningful Use and PCMH 2014 Level 3 standards										
Task Establish BPHC program to educate, encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, including potential use of incentive-based payments for implementation										
Task Recruit or contract for EHR implementation resources as needed										
Task Begin actively encouraging, tracking and supporting partner EHR implementation and progress towards Meaningful Use and PCMH standards										
Task Track status and manage support to ensure all eligible safety net providers are using certified EHR systems that meet Meaningful Use and PCMH 2014 Level 3 standards										
Milestone #5 Perform population health management by actively using EHRs										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
and other IT platforms, including use of targeted patient registries, for all participating safety net providers.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff										
Task Perform current state assessment of E.H.R. capabilities.										
Task Perform gap analysis and identify priories to achieving integration of patient record.										
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.										
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)										
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.										
Task Create budget to build registry and acquire necessary resources										
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries										
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data										
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care										
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify										

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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
targeted patients and track those who are actively engaged for milestone reporting.										
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.										
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.										
Milestone #6 Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.										
Task Procedures to engage at-risk patients with care management plan instituted.										
Task Develop clinical requirements/use cases and technical requirements for web-based comprehensive care management plan										
Task Identify qualified coordinated care management (CCMS) vendors										
Task Design/document outreach, intake, assessment, and patient engagement process for HH at-risk population that includes development of written comprehensive care management plan and referrals to Health Homes, substance use providers, community-based organizations, and other providers										
Task Convene representative group from PPS providers to participate in care management plan development process										
Task Select/contract with CCMS system(s) that meet requirements										
Task Develop, in conjunction with Workforce Subcommittee, training curriculum for PPS provider staff										
Task Select metrics and use CCMS system to track if care management plan is successful in "reducing patient risk factors"										
Task Implement comprehensive care management plan system in all										

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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
participating sites										
Task Provide ongoing technical assistance support to participating sites										
Task Use rapid cycle evaluation to track implementation successes and shortcomings with regard to the reduction of patient risk factors and develop corrective actions										
Milestone #7 Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.										
Task Each identified PCP establish partnerships with the local Health Home for care management services.	149	749	749	749	749	749	749	749	749	749
Task Each identified PCP establish partnerships with the local Health Home for care management services.	17	17	17	17	17	17	17	17	17	17
Task Identify participating primary care practices										
Task Assess participating practices' care management staffing needs to meet care management service needs of HH at-risk population, with particular attention to the complex needs of patients with co-occurring disorders, homelessness and SUD.										
Task Begin developing partnership agreements with HHs, their downstream Care Management Agencies (CMAs) and primary care practices										
Task Complete partnership agreements with HHs, their downstream Care Management Agencies (CMAs) and primary care practices that include standards for care management services for HH at-risk patients, data collection and reporting, referral processes, care plan content, communication and other policies and procedures										
Milestone #8 Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).										
Task PPS has established partnerships to medical, behavioral health,	149	749	749	749	749	749	749	749	749	749

SBH Health System (PPS ID:36)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
and social services.										
Task PPS has established partnerships to medical, behavioral health, and social services.	17	17	17	17	17	17	17	17	17	17
Task PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.										
Task Identify CBO partners that can provide needed social support services to the HH at-risk population										
Task Develop policies and procedures for CBO-PCP-HH patient referral to mental health, substance abuse, and other services, patient follow up, use of Care Coordination Management Systems (CCMS) tool for care planning & tracking, participation in case conferences, and other policies and procedures, as needed										
Task Develop contractual agreements with CBOs and HHs to provide social support services to patients assessed as eligible for HH at-risk CM services										
Task Implement CBO-PCP-HH patient referral, patient follow up, care planning & tracking, participation in case conferences, and other protocols for facilitating and documenting service coordination in the CCMS, integrated with EHRs via HIE										
Task Ensure that select CBOs have access to relevant portions of the electronic care management plan/CCMS and are able to document relevant client information in the care management plan										
Task Execute contractual agreements with CBOs and HHs to provide social support services to patients assessed as eligible for HH at-risk CM services										
Milestone #9 Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.										
Task PPS has adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate evidence-based practice guidelines developed and process										

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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
implemented.										
Task Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.										
Task PPS has included social services agencies in development of risk reduction and care practice guidelines.										
Task Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.										
Task Convene work groups composed of PCPs and subject matter experts, (SMEs) including MH/SUD and social service agencies, to define target population, select evidence- based guidelines (EBGs) for target population and make recommendations to Quality & Care Innovation Sub-Committee (QCI) on EBGs for chronic conditions and collaborative care.										
Task Working with select CBOs, primary care practices and SMEs, including MH/SUD and social service agencies, develop educational materials, suitable to the needs, culture, literacy, and language of the target populations										
Task QCI reviews educational materials and revises as needed; QCI approves educational materials										
Task QCI agendas begin to include evaluation of evidence-based guidelines as a topic for discussion at least annually										
Task CSO implements EBG and educational material dissemination plan across the PPS										
Task Develop mechanisms for regular review of project-selected evidence-based guidelines (EBGs) by implementation work group to assure our PPS is utilizing the most up-to-date tools and that those upadated guidelines/protocols continue to be clinically integrated across the PPS										
Task Develop feedback mechansims for accountability and continuous quality improvement										

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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 a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.	The Health Home At-Risk Transitional Work Group (TWG), a group of subject matter experts representing organizations from across the BPHC PPS, held its final meeting on 10/15/2015. Over the course of its work from March to October 2015, the group successfully developed a vision and strategy for the Health Home At-Risk Intervention Program, including the identification of the program's target clinical conditions and social risk factors, an assessment tool based on that used in the Health Home context, a care management staffing model and job descriptions for each member of the team, a list of training requirements for care management team members, descriptions of the processes involved in care management under this program, and rapid cycle evaluation metrics to measure program progress and success. The clinical elements developed by the TWG were reviewed by the Quality and Care Innovations Subcommittee (QCIS) and revised based on feedback received. Members of the TWG and additional subject matter experts (including experts on housing/homelessness, substance use, and decarceration) agreed to participate in the next iteration of the work group—the Implementation Work Group (IWG, or "rapid deployment collaborative") —which will act as a project-specific clinical quality council and launch its work in early January 2016. A gap analysis were conducted via a request for information (RFI) process to determine the staffing and IT needs of BPHC's largest partner organizations in order to implement care coordination in their PCP sites. Additionally, the Project lead and Workforce Director met in person with each of these largest partners to understand more deeply their current state of care coordination and to discuss staffing, recruitment, and training needs. Meetings were held with the 1199 Training & Employment Fund (TEF) and CUNY representatives to begin developing a standard care coordinator training that will be offered to all BPHC partner organizations. This milestone remains on track for completion.
Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.	BPHC is executing a comprehensive plan to support our safety net providers in MU and PCMH which includes EHR support and connectivity of data captured therein. A process has begun to ensure all applicable providers meet PCMH and MU accreditation where possible and that the PPS meets its obligations with regard to the previously agreed tasks. Consultants have been deployed to perform detailed Gap Analysis with about 100 practices, with 60 locations already evaluated thus far. Thirteen (13) practices have already submitted their PCMH 2014 attestations, with twelve (12) achieving level 3 and one still pending NCQA ruling. Contracting is currently ongoing and is in various stages, with six consulting groups, for the work on the remaining practices. These six consulting groups are part of a Community of Practice BPHC is organizing to share and collaborate on PCMH transformation and possibly other population health initiatives. This milestone is on track for completion.
Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.	BPHC is executing a comprehensive plan to support member safety net providers in MU and PCMH, which includes EHR support and connectivity of data captured therein. BPHC's agreement with Bronx RHIO will serve as the foundation to achieve next quarter's tasks and those of the future to support this Milestone. This agreement is very close to being signed. BPHC also has developed a strategy regarding funding for the adoption of the HIE by safety net providers, informed by an analysis of EMR and QE implementation and use by member organizations. This milestone is on track for completion.
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.	BPHC is executing a comprehensive plan to support member safety net providers in MU and PCMH, which includes EHR support and connectivity of data captured therein. A process has already begun to ensure all applicable providers meet PCMH and MU accreditation where possible and that the PPS meets its obligations with regard to the previously agreed tasks. BPHC has hired and deployed expert PCMH consultants to perform detailed gap analysis with about 100 practices, with 60 locations already evaluated thus far. These documents and other sources were used to profile the EMRs of 84% of safety net physicians in the PPS. Funding has been earmarked for IT expansion and process for this funding's distribution have been developed and communicated to

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	the member organizations. This milestone is on track for completion.
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	BPHC is executing a comprehensive plan to support its safety net providers in MU and PCMH which includes use of targeted patient registries in conjunctions with our clinical projects. BPHC has a comprehensive strategy in place for care management, which includes the use of registries, EHRs and IT platforms, and the completion of all agreed upon tasks by agreed upon dates. In DY1Q3, registry elements and business requirements were developed and adopted and a PHM Gap Assessment and IT Gap Assessment were constructed. Registry elements were approved by the Quality and Care Innovations Subcommittee. The IT Subcommittee reviewed the registry strategy but approval from this subcommittee of the registry elements was determined to be unnecessary and less meaningful than originally determined, given the clinical expertise required that the IT Subcommittee does not offer. It was further determined that the Executive Committee would not need to approve this level of detail in the PHM strategy, give that its Clinical Committee had already conducted a thorough review and approval process. Consultants have been deployed to perform detailed PHM Gap Analysis. This milestone is on track for completion.
Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.	Based on the decisions made by the TWG with regard to target conditions and standard care management processes, a Clinical Operations Plan (COP) was developed for the Health Home At-Risk Intervention Program. The COP includes policies and procedures for each element of care coordination: intake, assessment, comprehensive care management plan development, ongoing care management, transitioning out of care management, annual update, and reactivation. The COP details the roles and responsibilities of PCP care team and care management team members in each of the processes described. A workgroup met weekly throughout Quarter 3 to discuss the development of a PPS-wide care coordination management system (CCMS) to be used for care plan development and management. The CCMS will have the capacity to communicate in a bidirectional manner with each practice's EMR and will connect to the RHIO in order to share relevant information between providers along the continuum of care. As arrangements continue to be made to procure and develop the CCMS, interim solutions have also been developed; these include plans to expand and improve the care coordination notes or modules currently present in some partners' EMRs, as well as flat file templates for organizations whose EMRs lack such capabilities. This milestone remains on track for completion.
Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.	During this reporting period BPHC engaged in a series of meetings with leadership from each of the three Health Home agencies in the PPS (Bronx Accountable Healthcare Network [BAHN], Coordinated Behavioral Care, Inc [CBC], and Community Care Management Partners [CCMP]) to understand current procedures for referrals into the Health Home program and to explore expanding bottom-up referral processes from primary care practices. While large primary care practices will have care management teams embedded in their PCMH care teams, arrangements are also being explored for Health Home care management agencies (CMAs) to host non-embedded care management staff to provide services to patients in small primary care practices. Meetings have also been held with each of the large primary care organizations in the PPS to learn about their current practices regarding identification and bottom-up referrals for Health Home-eligible patients. Current capacity to provide care management to the Health Home At-Risk population and associated staffing needs were assessed. This milestone remains on track for completion.
Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).	BPHC has continued to develop strategies for community-based organizations' (CBOs) involvement in service delivery for the at-risk population engaged in care management. Leveraging a list of social services most commonly utilized by the at-risk population (developed by the Health Home At-Risk TWG), as well as surveys on existing services offered by organizations within the PPS, BPHC has continued to develop a referral directory for use throughout the network. This directory will be searchable by zip code and service category and will eventually be included in the CCMS and/or referral management platform. A policy and procedure for "closed loop referral tracking" of both clinical and social service referral has been included in the cross-cutting section of BPHC's Clinical Operations Plan, to ensure linkages to needed services are tracked to completion. This milestone remains on track for completion.
Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.	The evidence-based practice of care management for patients with uncontrolled chronic diseases, high utilization, and social risk factors has been adopted as the strategy for engaging health home at-risk patients to reduce their risk factors and better control their health. Evidence-based guidelines for disease management have been selected and approved via the BPHC governance structure for CVD, diabetes, and asthma patients. The Health Home At-Risk IWG (to launch in early DY1, Q4) will oversee the selection of recommended evidence-based guidelines for the remaining chronic conditions targeted by BPHC's

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	Health Home At-Risk Intervention Program. The IWG will also work in collaboration with the Cultural Competency and Health Literacy Work Group and CBO partners to develop culturally and linguistically appropriate educational materials for patients. This milestone remains on track for completion.

Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

BPHC is implementing Project 2.b.iii through enhancement and expansion of the Montefiore Care Management Organization's existing Clinical Navigator program and the implementation of admission diversion strategies for patients with mental illness (e.g. Riverdale Mental Health Association's Parachute NYC program). Throughout DSRIP, BPHC seeks to address risks to the implementation of Project 2.b.iii using the mitigation strategies described below.
(1) A key risk associated with BPHC's strategy for 2.b.iii includes the possibility of delayed expansion of the Clinical Navigator program due to recruitment and training challenges. To mitigate this risk, Montefiore's CMO has been actively engaged in the DSRIP planning process and has created buy-in for the expansion of the Clinical Navigator program and modifications to customize it to DSRIP based on lessons learned. To further ease the transition, BPHC will stagger the DSRIP program expansion, beginning at Montefiore emergency departments (EDs) and then moving to the SBH ED. BPHC is contracting with the CMO to help lead program development, training, recruitment and hiring, and other programmatic functions to minimize delays and ensure proper programmatic oversight.
(2) Unstable housing/BH/SUD may impact patient compliance. CBOs can assist with mitigating these risks. Evidence-based programs such as Parachute NYC and Critical Time interventions, which provide alternatives to ED visits and assist with care transitions suffer from a lack of consistent funding sources. Discussions with MCOs regarding a payment mechanism to sustain programs like these will be crucial to their long term sustainability. To mitigate risks associated with funding challenges, BPHC will work with NYCDOHMH, Riverdale Mental Health Association, and the Visiting Nurse Service of New York to develop an approach to finalizing negotiations with MCOs regarding program payments and "marketing" such programs more intensively to ED physicians, psychiatrists, Health Homes, the New York Police Department, and CBOs.
(3) Many of the targeted patients for this project are in need of social as well as medical services. However, many arrive at the ED during off-hours, limiting the time in which staff can connect patients with primary care providers, urgent care centers, Health Homes and social service providers. In addition, ED providers often lack the knowledge and time to connect patients with social service agencies and the Parachute NYC program. To mitigate these risks, BPHC will expand the hours of the CMO's existing Clinical Navigator program to better account for individuals who arrive at the ED and need support services during "off hours." BPHC is also developing a web-based directory of preferred CBO providers that will provide a comprehensive source of information on the scope of social services provided across the PPS.
(4) IT challenges across providers present additional barriers to ED triage and care coordination efforts. Many of the alternatives to the ED, including urgent care centers, Parachute NYC, PCPs, and CBOs do not have EMR data sharing capabilities and are not connected to the Bronx RHIO. Without these capabilities, patient information is not accessible at the point of care and cannot be shared electronically with patients' existing PCPs. Based on strategies developed by the PPS's IT planning team, during DY 1 and 2, BPHC will implement common assessment and risk stratification tools; make a care planning application accessible to all providers with whom the patient is engaged; promote greater adoption and use of EHRs and HIE among providers; and utilize a patient portal.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	19,600

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
0	2,051	52.32%	1,869	10.46%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (3,920)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
zstopak	Baseline or Performance Documentation	36_PMDL2715_1_3_20160202142351_BPHC-PATIENTLIST-2biii_Q3.xlsx	2.b.iii Patient Engagement DY1 Q3	02/02/2016 02:24 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Establish ED care triage program for at-risk populations	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Stand up program based on project requirements	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify key stakeholders and initiate regular ED care triage task force meetings	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Conduct preliminary site visits to participating EDs	Project		Completed	08/15/2015	12/31/2015	08/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish workflow triage model with input from task force and participating ED site-specific implementation teams	Project		Completed	08/15/2015	12/31/2015	08/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task Draft job descriptions, staffing and recruitment plan, in consultation with the Workforce Subcommittee	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify a documentation platform for templates and tools developed for ED care triage	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop guidelines and assessment template/tool for use by Patient Navigator, including mechanisms to identify patients who are already engaged in HHs and those who are eligible for HHs	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop guidelines and assessment template/tool for assisting patient in selecting a PCP	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop guidelines and assessment template for scheduling follow-up PCP/BH provider/Other provider	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop guidelines and assessment template to be used in identifying patient's need for social supports and the process of	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

SBH Health System (PPS ID:36)

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
referral to CBOs, with particular attention to the complex needs of patients with co-occurring disorders, homelessness and SUD									
Task Develop standard procedures for notifying and sharing information with PCP / HH care manager / other provider	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop standard procedures for referral to behavioral health support services for eligible patients, with particular attention to the complex needs of patients with co-occurring disorders, homelessness and SUD	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop specifications to generate alerts for patients to be targeted in ED care triage; specify criteria for intervention	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop training curriculum for Patient Navigators and ED staff using evidence-based care management principles and project specific procedures and tools	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Finalize compilation of all documentation into a Clinical Operations Plan (COP) for ED Care Triage for At-Risk Populations	Project		Not Started	03/01/2016	06/30/2016	03/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Finalize budget for ED Care Triage for At-Risk Populations	Project		Not Started	03/01/2016	06/30/2016	03/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Submit elements of the COP to Quality and Care Innovation Sub-Committee (QCIS) for approval	Project		Not Started	04/01/2016	08/31/2016	04/01/2016	08/31/2016	09/30/2016	DY2 Q2
Task Establish plan for data exchange and systems for documenting ED Care Triage activities across the PPS	Project		Not Started	04/01/2016	08/31/2016	04/01/2016	08/31/2016	09/30/2016	DY2 Q2
Task Identify and catalogue available community resources, using the CNA as a starting point to create a Community Resources Database	Project		In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Survey participating providers to identify gaps in services and identify additional potential community organization partners	Project		In Progress	07/15/2015	03/31/2016	07/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Define processes for referral, and access to information among providers, and feedback processes to the practices electronically	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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SBH Health System (PPS ID:36)

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
with interim manual processes as needed in conjunction with IT subcommittee									
Task Establish and document referral and follow-up procedures for the sites, with a mechanism for sites to audit adherence and report to QCIS	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify community organizations for inclusion in the initial iteration of the Community Resource Database, sign agreements with with community based organizations and establish process to facilitate feedback to and from community organizations	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Perform regular checks of Community Resource Database to ensure data is up to date and accurate and to identify additional resources to consider including	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Establish the schedule and materials for periodic staff training on the warm transfer and referral tracking	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Orient hospital staff and community-based partners on the project	Project		In Progress	10/15/2015	03/31/2016	10/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop and implement registry reporting capabilities to track and intervene on patients to be targeted by ED care triage	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Recruit and hire Patient Navigators	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Train Patient Navigators, their supervisors, and ED staff using the curriculum developed including use of Community Resource Database, with particular attention to the complex needs of patients with co-occurring disorders, homelessness and SUD	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling.	Project	N/A	In Progress	06/30/2015	03/31/2018	06/30/2015	03/31/2018	03/31/2018	DY3 Q4

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SBH Health System (PPS ID:36)

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
a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable									
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	06/30/2015	03/31/2018	06/30/2015	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	06/30/2015	03/31/2018	06/30/2015	03/31/2018	03/31/2018	DY3 Q4
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	Provider	Safety Net 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 Encounter Notification Service (ENS) is installed in all PCP offices and EDs	Provider	Safety Net Hospital	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices	Project		Completed	06/30/2015	12/31/2015	06/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recruit or contract for PCMH practice certification resources as needed	Project		Completed	06/30/2015	12/31/2015	06/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition	Project		In Progress	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Perform gap analysis by practice and identify key priorities.	Project		In Progress	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Finalize strategy to support primary care physicians with	Project		In Progress	10/01/2015	04/15/2016	10/01/2015	04/15/2016	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
achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.									
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition	Project		Not Started	01/01/2016	11/30/2016	01/01/2016	11/30/2016	12/31/2016	DY2 Q3
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS wide PCMH sub-committee as needed.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Assess eligible participating partner EHR use relative to Meaningful Use and PCMH 2014 Level 3 standards	Project		Completed	06/30/2015	08/30/2015	06/30/2015	08/30/2015	09/30/2015	DY1 Q2
Task Establish BPHC program to educate, encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, including potential use of incentive-based payments for implementation	Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Recruit or contract for EHR implementation resources as needed	Project		In Progress	11/01/2015	04/01/2016	11/01/2015	04/01/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner EHR implementation and progress towards Meaningful Use and PCMH standards	Project		Not Started	08/01/2016	12/31/2016	08/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Track status and manage support to ensure all eligible safety net providers are using certified EHR systems that meet Meaningful Use and PCMH 2014 Level 3 standards	Project		In Progress	10/15/2015	03/15/2018	10/15/2015	03/15/2018	03/31/2018	DY3 Q4
Task Identify safety net provider data sharing requirements and ENS capabilities and assess partner and QE data sharing capabilities and current HIE participation	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Coordinate with Bronx RHIO to develop comprehensive HIE adoption program to encourage and support partner participation and integration	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Begin coordinated interface and service development with Bronx RHIO	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task	Project		Not Started	03/01/2016	04/25/2016	03/01/2016	04/25/2016	06/30/2016	DY2 Q1

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SBH Health System (PPS ID:36)

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
Establish BPHC program to manage support for safety net providers to ensure that all are actively sharing health information, coordinating with Bronx RHIO to encourage, track and support partner participation and integration/data sharing									
Task Track status and manage support to ensure that all PPS safety net providers are actively sharing health information through Bronx RHIO/ENS/alternative health information exchange	Project		Not Started	03/01/2016	03/31/2018	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor the use of ENS for communications related to ED Care Triage	Project		Not Started	03/01/2016	03/31/2018	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	Project	N/A	Not Started	09/01/2016	03/31/2018	09/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task A defined process for triage of patients from patient navigators to non-emergency PCP and needed community support resources is in place.	Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Implement ED care triage protocols, as outlined in Milestone 1	Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provide technical assistance to site-specific implementation teams	Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Monitor the speed with which patients receive an appointment	Project		Not Started	09/01/2016	03/31/2017	09/01/2016	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
with PCP/specialist/BH. Troubleshoot with PCPs/others as necessary									
Task Patient Navigation Team conducts telephonic follow-up with patient and PCP/HH/behavioral health/appropriate specilaty service/CBO/other support service to ensure access to care, community support resources and to track appointment completion.	Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Modify Clinical Operations Plan procedures to reflect lessons learned, in conjunction with task force	Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has protocols and operations in place to transport non-acute patients to appropriate care site. (Optional).	Provider	Safety Net Hospital	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	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 Perform gap analysis and identify priories to achieving integration of patient record.	Project		On Hold	04/01/2015	12/31/2015	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.	Project		On Hold	04/01/2015	11/30/2015	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)	Project		On Hold	10/01/2015	12/31/2015	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Engage IT Subcommittee to identify technology and resource	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1

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SBH Health System (PPS ID:36)

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 for registry, including technical platform for hosting registry.									
Task Create budget to build registry and acquire necessary resources	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.	Project		Not Started	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 Establish ED care triage program for at-risk populations										
Task										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Stand up program based on project requirements										
Task Identify key stakeholders and initiate regular ED care triage task force meetings										
Task Conduct preliminary site visits to participating EDs										
Task Establish workflow triage model with input from task force and participating ED site-specific implementation teams										
Task Draft job descriptions, staffing and recruitment plan, in consultation with the Workforce Subcommittee										
Task Identify a documentation platform for templates and tools developed for ED care triage										
Task Develop guidelines and assessment template/tool for use by Patient Navigator, including mechanisms to identify patients who are already engaged in HHs and those who are eligible for HHs										
Task Develop guidelines and assessment template/tool for assisting patient in selecting a PCP										
Task Develop guidelines and assessment template for scheduling follow-up PCP/BH provider/Other provider										
Task Develop guidelines and assessment template to be used in identifying patient's need for social supports and the process of referral to CBOs, with particular attention to the complex needs of patients with co-occurring disorders, homelessness and SUD										
Task Develop standard procedures for notifying and sharing information with PCP / HH care manager / other provider										
Task Develop standard procedures for referral to behavioral health support services for eligible patients, with particular attention to the complex needs of patients with co-occurring disorders, homelessness and SUD										
Task Develop specifications to generate alerts for patients to be targeted in ED care triage; specify criteria for intervention										
Task Develop training curriculum for Patient Navigators and ED staff using evidence-based care management principles and project										

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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
specific procedures and tools										
Task Finalize compilation of all documentation into a Clinical Operations Plan (COP) for ED Care Triage for At-Risk Populations										
Task Finalize budget for ED Care Triage for At-Risk Populations										
Task Submit elements of the COP to Quality and Care Innovation Sub-Committee (QCIS) for approval										
Task Establish plan for data exchange and systems for documenting ED Care Triage activities across the PPS										
Task Identify and catalogue available community resources, using the CNA as a starting point to create a Community Resources Database										
Task Survey participating providers to identify gaps in services and identify additional potential community organization partners										
Task Define processes for referral, and access to information among providers, and feedback processes to the practices electronically with interim manual processes as needed in conjunction with IT subcommittee										
Task Establish and document referral and follow-up procedures for the sites, with a mechanism for sites to audit adherence and report to QCIS										
Task Identify community organizations for inclusion in the initial iteration of the Community Resource Database, sign agreements with with community based organizations and establish process to facilitate feedback to and from community organizations										
Task Perform regular checks of Community Resource Database to ensure data is up to date and accurate and to identify additional resources to consider including										
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices										
Task Establish the schedule and materials for periodic staff training 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
the warm transfer and referral tracking										
Task Orient hospital staff and community-based partners on the project										
Task Develop and implement registry reporting capabilities to track and intervene on patients to be targeted by ED care triage										
Task Recruit and hire Patient Navigators										
Task Train Patient Navigators, their supervisors, and ED staff using the curriculum developed including use of Community Resource Database, with particular attention to the complex needs of patients with co-occurring disorders, homelessness and SUD										
Milestone #2 Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	0	0	0	0	0	0	0	0	0	0
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)										
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	0	0	0	0	0	0	0	0	0	0
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	0	0	0	0	0	0	0	0	0	0
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices										

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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 Recruit or contract for PCMH practice certification resources as needed										
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition										
Task Perform gap analysis by practice and identify key priorities.										
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.										
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition										
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS wide PCMH sub-committee as needed.										
Task Assess eligible participating partner EHR use relative to Meaningful Use and PCMH 2014 Level 3 standards										
Task Establish BPHC program to educate, encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, including potential use of incentive-based payments for implementation										
Task Recruit or contract for EHR implementation resources as needed										
Task Begin actively encouraging, tracking and supporting partner EHR implementation and progress towards Meaningful Use and PCMH standards										
Task Track status and manage support to ensure all eligible safety net providers are using certified EHR systems that meet Meaningful Use and PCMH 2014 Level 3 standards										
Task Identify safety net provider data sharing requirements and ENS capabilities and assess partner and QE data sharing capabilities and current HIE participation										

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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 Coordinate with Bronx RHIO to develop comprehensive HIE adoption program to encourage and support partner participation and integration										
Task Begin coordinated interface and service development with Bronx RHIO										
Task Establish BPHC program to manage support for safety net providers to ensure that all are actively sharing health information, coordinating with Bronx RHIO to encourage, track and support partner participation and integration/data sharing										
Task Track status and manage support to ensure that all PPS safety net providers are actively sharing health information through Bronx RHIO/ENS/alternative health information exchange										
Task Monitor the use of ENS for communications related to ED Care Triage										
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.										
Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).										
Task A defined process for triage of patients from patient navigators to non-emergency PCP and needed community support resources is in place.										
Task Implement ED care triage protocols, as outlined in Milestone 1										
Task Provide technical assistance to site-specific implementation teams										

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DSRIP Implementation Plan Project

SBH Health System (PPS ID:36)

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 Monitor the speed with which patients receive an appointment with PCP/specialist/BH. Troubleshoot with PCPs/others as necessary										
Task Patient Navigation Team conducts telephonic follow-up with patient and PCP/HH/behavioral health/appropriate specilaty service/CBO/other support service to ensure access to care, community support resources and to track appointment completion.										
Task Modify Clinical Operations Plan procedures to reflect lessons learned, in conjunction with task force										
Milestone #4 Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)										
Task PPS has protocols and operations in place to transport non-acute patients to appropriate care site. (Optional).	0	0	0	0	0	0	0	0	0	0
Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Perform gap analysis and identify priories to achieving integration of patient record.										
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.										
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)										
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.										
Task Create budget to build registry and acquire necessary 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
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries										
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data										
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care										
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.										
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.										
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Establish ED care triage program for at-risk populations										
Task Stand up program based on project requirements										
Task Identify key stakeholders and initiate regular ED care triage task force meetings										
Task Conduct preliminary site visits to participating EDs										
Task Establish workflow triage model with input from task force and participating ED site-specific implementation teams										

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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 Draft job descriptions, staffing and recruitment plan, in consultation with the Workforce Subcommittee										
Task Identify a documentation platform for templates and tools developed for ED care triage										
Task Develop guidelines and assessment template/tool for use by Patient Navigator, including mechanisms to identify patients who are already engaged in HHs and those who are eligible for HHs										
Task Develop guidelines and assessment template/tool for assisting patient in selecting a PCP										
Task Develop guidelines and assessment template for scheduling follow-up PCP/BH provider/Other provider										
Task Develop guidelines and assessment template to be used in identifying patient's need for social supports and the process of referral to CBOs, with particular attention to the complex needs of patients with co-occurring disorders, homelessness and SUD										
Task Develop standard procedures for notifying and sharing information with PCP / HH care manager / other provider										
Task Develop standard procedures for referral to behavioral health support services for eligible patients, with particular attention to the complex needs of patients with co-occurring disorders, homelessness and SUD										
Task Develop specifications to generate alerts for patients to be targeted in ED care triage; specify criteria for intervention										
Task Develop training curriculum for Patient Navigators and ED staff using evidence-based care management principles and project specific procedures and tools										
Task Finalize compilation of all documentation into a Clinical Operations Plan (COP) for ED Care Triage for At-Risk Populations										
Task Finalize budget for ED Care Triage for At-Risk Populations										
Task Submit elements of the COP to Quality and Care Innovation Sub-Committee (QCIS) for approval										

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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 Establish plan for data exchange and systems for documenting ED Care Triage activities across the PPS										
Task Identify and catalogue available community resources, using the CNA as a starting point to create a Community Resources Database										
Task Survey participating providers to identify gaps in services and identify additional potential community organization partners										
Task Define processes for referral, and access to information among providers, and feedback processes to the practices electronically with interim manual processes as needed in conjunction with IT subcommittee										
Task Establish and document referral and follow-up procedures for the sites, with a mechanism for sites to audit adherence and report to QCIS										
Task Identify community organizations for inclusion in the initial iteration of the Community Resource Database, sign agreements with with community based organizations and establish process to facilitate feedback to and from community organizations										
Task Perform regular checks of Community Resource Database to ensure data is up to date and accurate and to identify additional resources to consider including										
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices										
Task Establish the schedule and materials for periodic staff training on the warm transfer and referral tracking										
Task Orient hospital staff and community-based partners on the project										
Task Develop and implement registry reporting capabilities to track and intervene on patients to be targeted by ED care triage										
Task Recruit and hire Patient Navigators										
Task Train Patient Navigators, their supervisors, and ED staff using										

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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
the curriculum developed including use of Community Resource Database, with particular attention to the complex needs of patients with co-occurring disorders, homelessness and SUD										
Milestone #2 Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	84	423	423	423	423	423	423	423	423	423
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)										
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	84	423	423	423	423	423	423	423	423	423
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	0	5	5	5	5	5	5	5	5	5
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices										
Task Recruit or contract for PCMH practice certification resources as needed										
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition										
Task Perform gap analysis by practice and identify key priorities.										
Task Finalize strategy to support primary care physicians 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
achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.										
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition										
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS wide PCMH sub-committee as needed.										
Task Assess eligible participating partner EHR use relative to Meaningful Use and PCMH 2014 Level 3 standards										
Task Establish BPHC program to educate, encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, including potential use of incentive-based payments for implementation										
Task Recruit or contract for EHR implementation resources as needed										
Task Begin actively encouraging, tracking and supporting partner EHR implementation and progress towards Meaningful Use and PCMH standards										
Task Track status and manage support to ensure all eligible safety net providers are using certified EHR systems that meet Meaningful Use and PCMH 2014 Level 3 standards										
Task Identify safety net provider data sharing requirements and ENS capabilities and assess partner and QE data sharing capabilities and current HIE participation										
Task Coordinate with Bronx RHIO to develop comprehensive HIE adoption program to encourage and support partner participation and integration										
Task Begin coordinated interface and service development with Bronx RHIO										
Task Establish BPHC program to manage support for safety net providers to ensure that all are actively sharing health information, coordinating with Bronx RHIO to encourage, track and support partner participation and integration/data sharing										
Task Track status and manage support to ensure that all PPS safety										

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
net providers are actively sharing health information through Bronx RHIO/ENS/alternative health information exchange										
Task Monitor the use of ENS for communications related to ED Care Triage										
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.										
Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).										
Task A defined process for triage of patients from patient navigators to non-emergency PCP and needed community support resources is in place.										
Task Implement ED care triage protocols, as outlined in Milestone 1										
Task Provide technical assistance to site-specific implementation teams										
Task Monitor the speed with which patients receive an appointment with PCP/specialist/BH. Troubleshoot with PCPs/others as necessary										
Task Patient Navigation Team conducts telephonic follow-up with patient and PCP/HH/behavioral health/appropriate specilaty service/CBO/other support service to ensure access to care, community support resources and to track appointment completion.										
Task Modify Clinical Operations Plan procedures to reflect lessons learned, in conjunction with task force										
Milestone #4 Established protocols allowing ED and first responders - under										

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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
supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)										
Task PPS has protocols and operations in place to transport non-acute patients to appropriate care site. (Optional).	0	0	0	0	0	0	0	0	0	0
Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Perform gap analysis and identify priories to achieving integration of patient record.										
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.										
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)										
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.										
Task Create budget to build registry and acquire necessary resources										
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries										
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data										
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care										
Task Execute registry testing plan and training program for providers										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.										
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.										
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish ED care triage program for at-risk populations	Three tasks (1.02, 1.03 and 1.04) due this quarter were all completed and supporting documentation complete. Task 1.02: Key stakeholders from PPS clinical and community partners (including health homes) have been identified as well as engaged and regular ED care triage implementation work group meetings have commenced meeting. The first official meeting took place on 10/29/15 with the next meeting scheduled for 1/25/16. As well a project design task force with joint membership from PPS hospitals (SBH Health System and the Montefiore Care Management Organization (CMO) acting as a vendor on this project's design) operations staff has started meeting with the first meeting held on 12/17. Montefiore held its own ED Stakeholder meeting with representatives from participating EDs on 12/17 as well. The next joint design meeting is scheduled for 1/13/15 with bi-weekly design meetings thereafter. Task 1.03 Site Visits: In-person site visits were conducted at SBH Health System Emergency departments and the Moses campus of Montefiore by BPHC staff. Representatives from other participating EDs were engaged through stakeholder meetings. Task 1.04 Workflow: A draft of the proposed workflow was presented to the ED project design task force at the December meeting. Design meetings in January will be devoted to defining the target population to receive the intervention as well as drafting criteria for a worklist for the ED Navigator to see patients. The role and responsibilities of ED Navigator as well as job descriptions will also be discussed. The target population criteria, worklist variables and job descriptions will be presented to the ED implementation work group at the 1/25 meeting. Guidelines and assessment tools will be discussed at future design meetings and presented to the next implementation work group. All tasks due in Q4 are on track for completion. Milestone is on track for completion.
Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS	BPHC is executing a comprehensive plan to support our safety net providers in MU and PCMH which includes EHR support and connectivity of data captured therein. A process has been started to ensure all applicable providers meet PCMH and MU accreditation where possible and that we meet our obligation to the previously agreed tasks. Consultants have been deployed to perform detailed Gap Analysis with about 100 practices, with 60 locations already evaluated thus far. 13 practices have already submitted their PCMH 2014 attestations, with twelve achieving level 3 and one still pending NCQA ruling. Contracting is

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable	currently ongoing and is in various stages, with six consulting groups, for the work on the remaining practices. These six consulting groups are part of a Community of Practice we are organizing to share and collaborate on PCMH transformation and possibly other population health initiatives. This work included assessing current EHR capabilities/standards at the sites and formulating a plan to meet MU and PCMH Level 3 standards by the end of DY3, with the support of the CSO. To ensure the development of an effective encounter notification system (ENS), the CSO is working to establish RHIO/SHIN-NY functionalities and a Care Coordination Management System (CCMS) platform to which both Health Homes and Emergency Departments will be connected. Additional detail is provided in the narrative section of Milestone 5. Milestone is on track for completion.
For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	
Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)	
Use EHRs and other technical platforms to track all patients engaged in the project.	BPHC is executing a comprehensive plan to support our safety net providers in MU and PCMH which includes EHR support and connectivity of data captured therein. Our agreement with Bronx RHIO will serve as the foundation to achieve next quarter's tasks and those of the future to support this Milestone. This agreement is very close to being signed. We also have a strategy around funding for the adoption of the HIE by safety net providers, informed by an analysis of EMR and QE implementation and use by member organizations. Additionally, use of the RHIO and SHIN-NY is one of the technology components/tools being incorporated into the patient flow section of the Clinical Operations Plan. An assessment of current state capabilities including ENS has been completed during this quarter. BPHC is executing a comprehensive plan to support their safety net providers in MU and PCMH which includes use of targeted patient registries in conjunctions with our clinical projects. We have a comprehensive strategy in place for care management which includes the uses of registries, EHRs and IT platforms, and the completion of all agreed upon tasks by agreed upon dates. Last quarter registry elements and business requirements were developed and adopted and a PHM Gap Assessment and IT Gap Assessment were constructed. Registry elements were approved by the Quality and Care Innovations Subcommittee. The IT Subcommittee reviewed the registry strategy but approval from this subcommittee of the registry elements was determined to be unnecessary and less meaningful than originally determined, given the clinical expertise required that the IT Subcommittee does not offer. It was further determined that the Executive Committee would not need to approve this level of detail in the PHM strategy, give that its Clinical Committee had already conducted a thorough review and approval process. Consultants have been deployed to perform detailed Gap Analysis. The ED Care Triage / Care Transitions Implementation Workgroup will approve target population criteria and worklist criteria as developed by the project design task forces in order to further define population health management requirements for patient engagement and strategies for tracking through the RHIO and/or

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	CCMS platform. This information will be relevant to the development of the CCMS platform and the patient registries to be developed through the platform, which will be used in care planning and referral tracking. Patient consent to share information across practices will be a critical component for the success of this project. Milestone is on track for completion.

Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

Hospitals often fail to link patients post discharge to the home-based services & patient self-management programs needed to meet DSRIP's targeted reduction in 30-day readmissions. PPS will enhance & expand the Care Management Resource Unit (CMRU) at Montefiore & assist SBH in establishing a CMRU-like function to expand access & links to care management resources & social services to help patients stay out of the hospital. These efforts will be bolstered by PPS policies & procedures that will require follow up for a 30-day period post discharge, as well as culturally & linguistically appropriate education materials.
PPS will assess the need for more medically complex units in skilled nursing facilities (SNFs) & additional SNF staff training to prevent frequent patient bounce back. There is often inadequate coordination & communication between hospitals, care transition nurses, Health Home (HH) care managers, physicians, & home health care agencies that are key to effective care transition services & appropriate "hand offs" among providers. In addition, hospital staff do not always recognize the value of CBOs in managing care transitions. Furthermore, economic, cultural, & linguistic barriers contribute to challenges in accessing the healthcare system, non-compliance with discharge regiments, & high readmission rates. To mitigate these risks, members of BPHC care teams will be able to access a web-based care planning tool & communicate easily with one another. PPS will support a communication plan to make care team members aware of the value of the tool in patients' transitions to care management through a SNF, HH, CBO, or other PPS provider. BPHC & Montefiore CMO will develop training & tools to address cultural competency, language barriers, & detail the elements of the care transitions model & roles of each care transition team member, including hospital-based staff, HH care managers, & CBOs providing social services, with particular attention to homeless individuals. Unstable housing/BH/SUD may impact readmissions; CBO partners will be actively engaged to assist in mitigating these risks.
Recruiting & training care management staff, particularly Spanish speaking staff with experience & training working with behavioral health patients presents a challenge to care coordination & readmission reduction efforts. According to the CNA, lack of funding & low salaries have made such hiring difficult. PPS will work with local community colleges, CBOs, 1199 training fund & NYSNA to help recruit & train a pipeline of care management staff & offer competitive salaries, flexible hours, & job sharing, as feasible, to improve recruitment & retention. PPS will work with workforce partners to train staff on the Critical Time Intervention to help address current gaps in identifying & treating behavioral health needs.
Existing policies & procedures for early notification of planned discharges differ among hospitals. From interviews with hospital staff, we know that HH care managers are not always notified when their patients are being discharged (if they have consents), particularly if they are discharged earlier than expected or from a hospital not subscribed to RHIO alerts. PPS will require hospitals PCPs to have RHIO connectivity & use subscriptions/alerts & will establish protocols requiring notification of discharges to care team members within a specified time period. Protocols will also establish an early notification system to ensure patients who meet program criteria have a comprehensive care transition plan completed no later than the day prior to the projected discharge. IT resource gaps will be addressed by CSO, building on existing & adding new IT capabilities, including a care plan & management platform, patient registries, direct messaging, patient risk stratification, standardized e-discharge summaries, & expanded HIE

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	14,700

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
0	0		0	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
zstopak	Baseline or Performance Documentation	36_PMDL2815_1_3_20160201165956_2.b.iv_-_Patient_Engagement_DY1_Q3.docx	Patient Engagement Q3	02/01/2016 05:00 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 2.b.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	09/01/2015	03/31/2017	09/01/2015	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	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Engage partners, including health homes (HH), to promote project understanding and partner alignment.	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify key stakeholders and initiate Care Transitions (CT) work group	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Conduct preliminary site visits to participating in-patient settings	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Orient hospital staff to the project	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop job description and staffing plan, in consultation with the Workforce Subcommittee	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Map comprehensive list of care and social services used by patients in the home or other non-medical setting	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop criteria for identifying and targeting patients most at risk for readmission, to facilitate the creation of patient registries and alerts	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify electronic patient stratification tool or algorithm to identify the 'at risk' population	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Establish workflow triage model with input from CT work group and participating site-specific implementation teams	Project		In Progress	11/15/2015	02/01/2016	11/15/2015	02/01/2016	03/31/2016	DY1 Q4
Task Establish plan for data exchange and systems for documenting CT program activities across the PPS	Project		In Progress	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop guidelines and assessment template/tools for the determination of HH and CT eligibility by CT team	Project		In Progress	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop guidelines and assessment template/tools for assisting patient in selecting a PCP	Project		In Progress	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop guidelines and assessment template/tools for scheduling follow-up PCP appointment, specialty care, CBO care, and/or a medical visit in a non-traditional setting (e.g. house call, telehealth)	Project		In Progress	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop guidelines and assessment template/tools to be used in identifying patient's need for social supports and the process of referral to CBOs	Project		In Progress	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop standard procedures for notifying and sharing information with PCP / HH care manager / or other provider, as needed	Project		In Progress	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop standard procedures for referral to behavioral health support services for eligible patients	Project		In Progress	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize compilation of all documentation into a Clinical Operations Plan (COP) for CT intervention	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Finalize budget for CT intervention	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Submit elements of COP to Quality and Care Innovation Sub-Committee (QCIS) for approval	Project		Not Started	03/01/2016	05/31/2016	03/01/2016	05/31/2016	06/30/2016	DY2 Q1
Task Develop training curriculum for CT staff using evidence-based care management principles and project specific procedures and	Project		Not Started	03/01/2016	06/30/2016	03/01/2016	06/30/2016	06/30/2016	DY2 Q1

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tools. Training curriculum will emphasize cultural competence and health literacy									
Task Convene representative group of PPS members to form CT work group, including hospitals, BH and SUD SMEs to review Critical Time Intervention strategies and to create workplan.	Project		In Progress	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Define the population to be targeted by Critical Time Intervention strategies	Project		In Progress	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task In conjunction with the Workforce subcommittee, define a Critical Time Intervention staffing model, to address the needs of the target population including staff qualifications, roles, functions, and panel size of team members	Project		In Progress	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop financial model to cost out Critical Time Intervention team	Project		In Progress	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop and document the COP to define the elements of the Critical Time Intervention program including the roles of PCPs, BH specialists, HHs, HIE and technology requirements, and evidence-based guidelines	Project		In Progress	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Working with Workforce Subcommittee, design training and recruitment strategy for Critical Time Intervention staffing	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Develop Critical Time Intervention implementation budget	Project		Not Started	03/01/2016	06/30/2016	03/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Submit elements of Critical Time Intervention COP to QCIS for approval	Project		Not Started	03/01/2016	05/31/2016	03/01/2016	05/31/2016	06/30/2016	DY2 Q1
Task Prepare/disseminate gap analysis tool based on COP to participating providers to determine Critical Time Intervention resource needs against project plan and care management team staffing model	Project		Not Started	02/01/2016	06/30/2016	02/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Complete assessment of Critical Time Intervention staffing needs across the PPS in conjunction with the Workforce Subcommittee	Project		Not Started	02/01/2016	05/31/2016	02/01/2016	05/31/2016	06/30/2016	DY2 Q1

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Task Develop a registry of patients to be targeted for intervention	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Establish technology interfaces to ensure frequent automated updates of registry data	Project		Not Started	04/04/2016	06/30/2016	04/04/2016	06/30/2016	06/30/2016	DY2 Q1
Task Implement CCMS and/or other systems and services with patient registries and other features required for PHM	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Recruit and hire needed CT staff	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Train CT staff and their supervisors	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify implementation teams for Critical Time Intervention	Project		Not Started	03/01/2016	03/31/2017	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Launch recruitment and training programs with Critical Time Intervention participating providers	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Establish mechanisms for feedback and monitoring for Continuous Quality Improvement (CQI)	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task CT staff implement Care Transitions interventions, using project-specific templates, tools and procedures	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task CT staff conduct telephonic follow-up with patient and PCP/HH/BH/other support service to ensure access to care and all follow up appointments were completed.	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Modify COP procedures to reflect lessons learned, in conjunction with task force	Project		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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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.	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Meet with payers to identify triggers and processes for payer care coordination and chronic care services to ensure coordination and prevent gaps in care and/or redundant services, as part of a value-based payment strategy, outlined below.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop partnership agreements with payers affirming coverage and coordination of service benefits. Include HHs in the development of this payment strategy.	Project		Not Started	03/01/2016	03/31/2017	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Review final State value-based payment roadmap and PPS value-based payment plan	Project		Completed	07/01/2015	08/31/2015	07/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task Identify Medicaid MCOs engaged with our attributed patients and actively engage them in developing new and strengthening existing value-based payment arrangements through a structured stakeholder engagement process.	Project		Completed	09/01/2015	11/15/2015	09/01/2015	11/15/2015	12/31/2015	DY1 Q3
Task Establish partner value-based payment reporting requirements and procedures to enable ongoing monitoring of value-based payments and care transitions.	Project		Not Started	03/01/2016	09/30/2016	03/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Develop detailed analysis of PPS partners' existing value-based payment arrangements with Medicaid MCOs and other payers by reviewing claims-level data, with attention to HHs	Project		Completed	09/30/2015	12/31/2015	09/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Engage MCOs in defining PPS MCO contracting strategy and organizational requirements necessary to support the development of contracts with Medicaid MCOs	Project		Completed	09/15/2015	12/01/2015	09/15/2015	12/01/2015	12/31/2015	DY1 Q3
Task Engage PPS partners, especially HHs, to assist in defining PPS	Project		In Progress	11/15/2015	02/01/2016	11/15/2015	02/01/2016	03/31/2016	DY1 Q4

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MCO contracting strategy and organizational requirements necessary to support the development of contracts with Medicaid MCOs									
Task Develop or contract with an organizational structure (e.g. HH) or multiple organizational structures to support contracting with Medicaid MCOs and other payers as an integrated system	Project		In Progress	11/15/2015	02/15/2016	11/15/2015	02/15/2016	03/31/2016	DY1 Q4
Task Develop value-based payment arrangements for presentation to Medicaid MCOs and other payers	Project		Not Started	02/15/2016	03/31/2016	02/15/2016	03/31/2016	03/31/2016	DY1 Q4
Task Develop PPS plan, overseen by Finance and Sustainability Sub-committee, to achieve 90% value based payments by DY5 and present to the Executive Committee for review and signoff	Project		In Progress	07/15/2015	12/31/2016	07/15/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS has agreement in place with MCOs and HHs related to coordination of CT intervention for populations at-risk for re-admission	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Monitor use of assessment tool to identify HH-eligible patients	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Ensure eligibility is noted in patient's EHR	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Monitor rates of referrals to HH services based on eligibility	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	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	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Required network social services, including medically tailored home food services, are provided in care transitions.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop a web-based directory of preferred CBO/social service providers, including medically tailored home food services, that will provide a comprehensive source of information on the scope of social services provided across the PPS.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Analyze Community Needs Assessment data, Medicaid data base/MAPP, and PPS partner data for 30 day hospital readmissions over the past 12 months	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task	Project		In Progress	07/01/2015	12/31/2016	07/01/2015	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
Identify and catalog available community resources, using the CNA as a starting point to create a Community Resources Database									
Task Survey participating providers to identify gaps in services and identify additional potential community organization partners	Project		In Progress	07/15/2015	03/31/2016	07/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Define processes for referral, and access to information among providers, and feedback processes to the practices electronically with interim manual processes as needed in conjunction with IT subcommittee	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish and document referral and follow-up procedures for the sites, with a mechanism for sites to audit adherence and report to QCIS	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify community organizations for inclusion in the initial iteration of the Community Resource Database, sign agreements with with community based organizations and establish process to facilitate feedback to and from community organizations	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Perform regular checks of Community Resource Database to ensure data is up to date and accurate and to identify additional resources to consider including	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Establish the schedule and materials for periodic staff training on the warm transfer and referral tracking	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	Project	N/A	Not Started	04/01/2016	03/31/2017	04/01/2016	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)	Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Practitioner - Non-Primary Care Provider (PCP)	Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Hospital	Not Started	04/01/2016	03/31/2017	04/01/2016	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		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop and implement policies and procedures for early notification of planned discharges.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop communications plan between in-patient and CT staff	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Monitor early notification of planned discharge and modify procedures as necessary, using CQI	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provide pre-discharge visits that educate patients and caregivers about their conditions and how to manage them, review discharge summaries and care plans, and perform medication reconciliation	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Ensure hospital policies and procedures allow access by care managers for patients identified for CT intervention	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Project	N/A	In Progress	08/15/2015	03/31/2017	08/15/2015	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		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Ensure that transition plans include the following elements: a. Flag patients at if high-risk for readmission b. Medication reconciliation	Project		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4

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c. Methods to identify and respond to worsening condition d. Interdisciplinary team approach e. Engaged primary provider f. Information dissemination									
Task Develop and implement policies and procedures for including care transitions plans in the patient's medical record	Project		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify and document required clinical and care management protocols for priority programs, projects and interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data	Project		Completed	08/15/2015	10/15/2015	08/15/2015	10/15/2015	12/31/2015	DY1 Q3
Task Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations for how interventions will be logged, tracked and reported	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Deploy systems to improve and promote effective care transitions, include protocols for tracking and follow-up	Project		Not Started	01/15/2016	02/28/2016	01/15/2016	02/28/2016	03/31/2016	DY1 Q4
Task Operationalize partner and workforce roles by providing gap analysis and appropriate training to clinicians and care management staff (including licensed care managers, care coordinators, patient navigators/community health workers, medical assistants and front-office staff)	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Establish data collection, survey and reporting mechanisms to enable BPHC monitoring to ensure that patients are receiving appropriate health care and community support in priority projects, based on needs identified in prior planning activities	Project		Not Started	02/01/2016	06/15/2016	02/01/2016	06/15/2016	06/30/2016	DY2 Q1
Task Review process for rapid cycle evaluation and continuous improvement of data collection, survey and reporting methods based on priority project experience and modify process as needed to ensure patients receive appropriate health care and community support	Project		Not Started	08/01/2016	09/01/2016	08/01/2016	09/01/2016	09/30/2016	DY2 Q2

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Task Monitor record of transition plan in the interoperable EHR, as well as whether PCP has accessed the plan (if feasible)	Project		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Convene providers from different care settings to define specific information and clinical data to include in the care transition record shared between sending and receiving providers, as patient goes from one care setting to another. Resources designed by the National Transition of Care Coalition will be considered.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #6 Ensure that a 30-day transition of care period is established.	Project	N/A	Not Started	06/30/2016	03/31/2017	06/30/2016	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		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Establish a process and structure to conduct a detailed review of all discharges leading to readmission within 30 days.	Project		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Use the analysis and the ongoing review data to inform services to involve in this project.	Project		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Work with partners to define how to document and communicate 30-day transition period of care.	Project		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Incorporate the 30 day care transition period into payer agreements.	Project		Not Started	06/30/2016	03/31/2017	06/30/2016	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	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 Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Task Perform gap analysis and identify priories to achieving integration of patient record.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.	Project		Completed	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget to build registry and acquire necessary resources	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data	Project		Not Started	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
security requirements across the system.									
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care	Project		Not Started	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.										
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.										
Task Engage partners, including health homes (HH), to promote project understanding and partner alignment.										
Task Identify key stakeholders and initiate Care Transitions (CT) work group										
Task Conduct preliminary site visits to participating in-patient settings										
Task Orient hospital staff to the project										
Task Develop job description and staffing plan, in consultation with the Workforce Subcommittee										
Task Map comprehensive list of care and social services used by patients in the home or other non-medical setting										
Task Develop criteria for identifying and targeting patients most at risk for readmission, to facilitate the creation of patient registries and alerts										
Task Identify electronic patient stratification tool or algorithm to identify the 'at risk' population										
Task Establish workflow triage model with input from CT work group										

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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 participating site-specific implementation teams										
Task Establish plan for data exchange and systems for documenting CT program activities across the PPS										
Task Develop guidelines and assessment template/tools for the determination of HH and CT eligibility by CT team										
Task Develop guidelines and assessment template/tools for assisting patient in selecting a PCP										
Task Develop guidelines and assessment template/tools for scheduling follow-up PCP appointment, specialty care, CBO care, and/or a medical visit in a non-traditional setting (e.g. house call, telehealth)										
Task Develop guidelines and assessment template/tools to be used in identifying patient's need for social supports and the process of referral to CBOs										
Task Develop standard procedures for notifying and sharing information with PCP / HH care manager / or other provider, as needed										
Task Develop standard procedures for referral to behavioral health support services for eligible patients										
Task Finalize compilation of all documentation into a Clinical Operations Plan (COP) for CT intervention										
Task Finalize budget for CT intervention										
Task Submit elements of COP to Quality and Care Innovation Sub-Committee (QCIS) for approval										
Task Develop training curriculum for CT staff using evidence-based care management principles and project specific procedures and tools. Training curriculum will emphasize cultural competence and health literacy										
Task Convene representative group of PPS members to form CT work group, including hospitals, BH and SUD SMEs to review Critical Time Intervention strategies and to create workplan.										

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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 Define the population to be targeted by Critical Time Intervention strategies										
Task In conjunction with the Workforce subcommittee, define a Critical Time Intervention staffing model, to address the needs of the target population including staff qualifications, roles, functions, and panel size of team members										
Task Develop financial model to cost out Critical Time Intervention team										
Task Develop and document the COP to define the elements of the Critical Time Intervention program including the roles of PCPs, BH specialists, HHs, HIE and technology requirements, and evidence-based guidelines										
Task Working with Workforce Subcommittee, design training and recruitment strategy for Critical Time Intervention staffing										
Task Develop Critical Time Intervention implementation budget										
Task Submit elements of Critical Time Intervention COP to QCIS for approval										
Task Prepare/disseminate gap analysis tool based on COP to participating providers to determine Critical Time Intervention resource needs against project plan and care management team staffing model										
Task Complete assessment of Critical Time Intervention staffing needs across the PPS in conjunction with the Workforce Subcommittee										
Task Develop a registry of patients to be targeted for intervention										
Task Establish technology interfaces to ensure frequent automated updates of registry data										
Task Implement CCMS and/or other systems and services with patient registries and other features required for PHM										
Task Recruit and hire needed CT staff										
Task Train CT staff and their supervisors										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Identify implementation teams for Critical Time Intervention										
Task Launch recruitment and training programs with Critical Time Intervention participating providers										
Task Establish mechanisms for feedback and monitoring for Continuous Quality Improvement (CQI)										
Task CT staff implement Care Transitions interventions, using project-specific templates, tools and procedures										
Task CT staff conduct telephonic follow-up with patient and PCP/HH/BH/other support service to ensure access to care and all follow up appointments were completed.										
Task Modify COP procedures to reflect lessons learned, in conjunction with task force										
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 Meet with payers to identify triggers and processes for payer care coordination and chronic care services to ensure coordination and prevent gaps in care and/or redundant services, as part of a value-based payment strategy, outlined below.										
Task Develop partnership agreements with payers affirming coverage and coordination of service benefits. Include HHs in the development of this payment strategy.										
Task Review final State value-based payment roadmap and PPS value-based payment plan										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Identify Medicaid MCOs engaged with our attributed patients and actively engage them in developing new and strengthening existing value-based payment arrangements through a structured stakeholder engagement process.										
Task Establish partner value-based payment reporting requirements and procedures to enable ongoing monitoring of value-based payments and care transitions.										
Task Develop detailed analysis of PPS partners' existing value-based payment arrangements with Medicaid MCOs and other payers by reviewing claims-level data, with attention to HHs										
Task Engage MCOs in defining PPS MCO contracting strategy and organizational requirements necessary to support the development of contracts with Medicaid MCOs										
Task Engage PPS partners, especially HHs, to assist in defining PPS MCO contracting strategy and organizational requirements necessary to support the development of contracts with Medicaid MCOs										
Task Develop or contract with an organizational structure (e.g. HH) or multiple organizational structures to support contracting with Medicaid MCOs and other payers as an integrated system										
Task Develop value-based payment arrangements for presentation to Medicaid MCOs and other payers										
Task Develop PPS plan, overseen by Finance and Sustainability Sub-committee, to achieve 90% value based payments by DY5 and present to the Executive Committee for review and signoff										
Task PPS has agreement in place with MCOs and HHs related to coordination of CT intervention for populations at-risk for re-admission										
Task Monitor use of assessment tool to identify HH-eligible patients										
Task Ensure eligibility is noted in patient's EHR										
Task Monitor rates of referrals to HH services based on eligibility										
Milestone #3 Ensure required social services participate in the project.										

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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 Required network social services, including medically tailored home food services, are provided in care transitions.										
Task Develop a web-based directory of preferred CBO/social service providers, including medically tailored home food services, that will provide a comprehensive source of information on the scope of social services provided across the PPS.										
Task Analyze Community Needs Assessment data, Medicaid data base/MAPP, and PPS partner data for 30 day hospital readmissions over the past 12 months										
Task Identify and catalog available community resources, using the CNA as a starting point to create a Community Resources Database										
Task Survey participating providers to identify gaps in services and identify additional potential community organization partners										
Task Define processes for referral, and access to information among providers, and feedback processes to the practices electronically with interim manual processes as needed in conjunction with IT subcommittee										
Task Establish and document referral and follow-up procedures for the sites, with a mechanism for sites to audit adherence and report to QCIS										
Task Identify community organizations for inclusion in the initial iteration of the Community Resource Database, sign agreements with with community based organizations and establish process to facilitate feedback to and from community organizations										
Task Perform regular checks of Community Resource Database to ensure data is up to date and accurate and to identify additional resources to consider including										
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices										
Task Establish the schedule and materials for periodic staff training on the warm transfer and referral tracking										

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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 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	0	0	0	37	74	186	411	749
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	0	0	131	262	658	1,449	2,636
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	0	0	1	2	3	6	12
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 Develop and implement policies and procedures for early notification of planned discharges.										
Task Develop communications plan between in-patient and CT staff										
Task Monitor early notification of planned discharge and modify procedures as necessary, using CQI										
Task Provide pre-discharge visits that educate patients and caregivers about their conditions and how to manage them, review discharge summaries and care plans, and perform medication reconciliation										
Task Ensure hospital policies and procedures allow access by care managers for patients identified for CT intervention										
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.										
Task Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.										
Task Ensure that transition plans include the following elements:										

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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
a. Flag patients at if high-risk for readmission b. Medication reconciliation c. Methods to identify and respond to worsening condition d. Interdisciplinary team approach e. Engaged primary provider f. Information dissemination										
Task Develop and implement policies and procedures for including care transitions plans in the patient's medical record										
Task Identify and document required clinical and care management protocols for priority programs, projects and interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data										
Task Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations for how interventions will be logged, tracked and reported										
Task Deploy systems to improve and promote effective care transitions, include protocols for tracking and follow-up										
Task Operationalize partner and workforce roles by providing gap analysis and appropriate training to clinicians and care management staff (including licensed care managers, care coordinators, patient navigators/community health workers, medical assistants and front-office staff)										
Task Establish data collection, survey and reporting mechanisms to enable BPHC monitoring to ensure that patients are receiving appropriate health care and community support in priority projects, based on needs identified in prior planning activities										
Task Review process for rapid cycle evaluation and continuous improvement of data collection, survey and reporting methods based on priority project experience and modify process as needed to ensure patients receive appropriate health care and community support										
Task Monitor record of transition plan in the interoperable EHR, as well as whether PCP has accessed the plan (if feasible)										
Task Convene providers from different care settings to define 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
information and clinical data to include in the care transition record shared between sending and receiving providers, as patient goes from one care setting to another. Resources designed by the National Transition of Care Coalition will be considered.										
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 Establish a process and structure to conduct a detailed review of all discharges leading to readmission within 30 days.										
Task Use the analysis and the ongoing review data to inform services to involve in this project.										
Task Work with partners to define how to document and communicate 30-day transition period of care.										
Task Incorporate the 30 day care transition period into payer agreements.										
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 Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff										
Task Perform current state assessment of E.H.R. capabilities.										
Task Perform gap analysis and identify priories to achieving integration of patient record.										
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.										
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology										

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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
Subcommittee and Executive Committee)										
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.										
Task Create budget to build registry and acquire necessary resources										
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries										
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data										
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care										
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting										
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.										
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care										

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.										

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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 Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.										
Task Engage partners, including health homes (HH), to promote project understanding and partner alignment.										
Task Identify key stakeholders and initiate Care Transitions (CT) work group										
Task Conduct preliminary site visits to participating in-patient settings										
Task Orient hospital staff to the project										
Task Develop job description and staffing plan, in consultation with the Workforce Subcommittee										
Task Map comprehensive list of care and social services used by patients in the home or other non-medical setting										
Task Develop criteria for identifying and targeting patients most at risk for readmission, to facilitate the creation of patient registries and alerts										
Task Identify electronic patient stratification tool or algorithm to identify the 'at risk' population										
Task Establish workflow triage model with input from CT work group and participating site-specific implementation teams										
Task Establish plan for data exchange and systems for documenting CT program activities across the PPS										
Task Develop guidelines and assessment template/tools for the determination of HH and CT eligibility by CT team										
Task Develop guidelines and assessment template/tools for assisting patient in selecting a PCP										
Task Develop guidelines and assessment template/tools for scheduling follow-up PCP appointment, specialty care, CBO care, and/or a medical visit in a non-traditional setting (e.g. house call, telehealth)										
Task										

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Develop guidelines and assessment template/tools to be used in identifying patient's need for social supports and the process of referral to CBOs										
Task Develop standard procedures for notifying and sharing information with PCP / HH care manager / or other provider, as needed										
Task Develop standard procedures for referral to behavioral health support services for eligible patients										
Task Finalize compilation of all documentation into a Clinical Operations Plan (COP) for CT intervention										
Task Finalize budget for CT intervention										
Task Submit elements of COP to Quality and Care Innovation Sub-Committee (QCIS) for approval										
Task Develop training curriculum for CT staff using evidence-based care management principles and project specific procedures and tools. Training curriculum will emphasize cultural competence and health literacy										
Task Convene representative group of PPS members to form CT work group, including hospitals, BH and SUD SMEs to review Critical Time Intervention strategies and to create workplan.										
Task Define the population to be targeted by Critical Time Intervention strategies										
Task In conjunction with the Workforce subcommittee, define a Critical Time Intervention staffing model, to address the needs of the target population including staff qualifications, roles, functions, and panel size of team members										
Task Develop financial model to cost out Critical Time Intervention team										
Task Develop and document the COP to define the elements of the Critical Time Intervention program including the roles of PCPs, BH specialists, HHs, HIE and technology requirements, and evidence-based guidelines										
Task Working with Workforce Subcommittee, design training and										

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recruitment strategy for Critical Time Intervention staffing										
Task Develop Critical Time Intervention implementation budget										
Task Submit elements of Critical Time Intervention COP to QCIS for approval										
Task Prepare/disseminate gap analysis tool based on COP to participating providers to determine Critical Time Intervention resource needs against project plan and care management team staffing model										
Task Complete assessment of Critical Time Intervention staffing needs across the PPS in conjunction with the Workforce Subcommittee										
Task Develop a registry of patients to be targeted for intervention										
Task Establish technology interfaces to ensure frequent automated updates of registry data										
Task Implement CCMS and/or other systems and services with patient registries and other features required for PHM										
Task Recruit and hire needed CT staff										
Task Train CT staff and their supervisors										
Task Identify implementation teams for Critical Time Intervention										
Task Launch recruitment and training programs with Critical Time Intervention participating providers										
Task Establish mechanisms for feedback and monitoring for Continuous Quality Improvement (CQI)										
Task CT staff implement Care Transitions interventions, using project-specific templates, tools and procedures										
Task CT staff conduct telephonic follow-up with patient and PCP/HH/BH/other support service to ensure access to care and all follow up appointments were completed.										
Task Modify COP procedures to reflect lessons learned, in conjunction with task force										

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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 Meet with payers to identify triggers and processes for payer care coordination and chronic care services to ensure coordination and prevent gaps in care and/or redundant services, as part of a value-based payment strategy, outlined below.										
Task Develop partnership agreements with payers affirming coverage and coordination of service benefits. Include HHs in the development of this payment strategy.										
Task Review final State value-based payment roadmap and PPS value-based payment plan										
Task Identify Medicaid MCOs engaged with our attributed patients and actively engage them in developing new and strengthening existing value-based payment arrangements through a structured stakeholder engagement process.										
Task Establish partner value-based payment reporting requirements and procedures to enable ongoing monitoring of value-based payments and care transitions.										
Task Develop detailed analysis of PPS partners' existing value-based payment arrangements with Medicaid MCOs and other payers by reviewing claims-level data, with attention to HHs										
Task Engage MCOs in defining PPS MCO contracting strategy and organizational requirements necessary to support the development of contracts with Medicaid MCOs										

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Task Engage PPS partners, especially HHs, to assist in defining PPS MCO contracting strategy and organizational requirements necessary to support the development of contracts with Medicaid MCOs										
Task Develop or contract with an organizational structure (e.g. HH) or multiple organizational structures to support contracting with Medicaid MCOs and other payers as an integrated system										
Task Develop value-based payment arrangements for presentation to Medicaid MCOs and other payers										
Task Develop PPS plan, overseen by Finance and Sustainability Sub-committee, to achieve 90% value based payments by DY5 and present to the Executive Committee for review and signoff										
Task PPS has agreement in place with MCOs and HHs related to coordination of CT intervention for populations at-risk for re-admission										
Task Monitor use of assessment tool to identify HH-eligible patients										
Task Ensure eligibility is noted in patient's EHR										
Task Monitor rates of referrals to HH services based on eligibility										
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 Develop a web-based directory of preferred CBO/social service providers, including medically tailored home food services, that will provide a comprehensive source of information on the scope of social services provided across the PPS.										
Task Analyze Community Needs Assessment data, Medicaid data base/MAPP, and PPS partner data for 30 day hospital readmissions over the past 12 months										
Task Identify and catalog available community resources, using the CNA as a starting point to create a Community Resources Database										

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Task Survey participating providers to identify gaps in services and identify additional potential community organization partners										
Task Define processes for referral, and access to information among providers, and feedback processes to the practices electronically with interim manual processes as needed in conjunction with IT subcommittee										
Task Establish and document referral and follow-up procedures for the sites, with a mechanism for sites to audit adherence and report to QCIS										
Task Identify community organizations for inclusion in the initial iteration of the Community Resource Database, sign agreements with with community based organizations and establish process to facilitate feedback to and from community organizations										
Task Perform regular checks of Community Resource Database to ensure data is up to date and accurate and to identify additional resources to consider including										
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices										
Task Establish the schedule and materials for periodic staff training on the warm transfer and referral tracking										
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.	749	749	749	749	749	749	749	749	749	749
Task Policies and procedures are in place for early notification of planned discharges.	2,636	2,636	2,636	2,636	2,636	2,636	2,636	2,636	2,636	2,636
Task Policies and procedures are in place for early notification of planned discharges.	12	12	12	12	12	12	12	12	12	12
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
and advisement.										
Task Develop and implement policies and procedures for early notification of planned discharges.										
Task Develop communications plan between in-patient and CT staff										
Task Monitor early notification of planned discharge and modify procedures as necessary, using CQI										
Task Provide pre-discharge visits that educate patients and caregivers about their conditions and how to manage them, review discharge summaries and care plans, and perform medication reconciliation										
Task Ensure hospital policies and procedures allow access by care managers for patients identified for CT intervention										
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.										
Task Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.										
Task Ensure that transition plans include the following elements: a. Flag patients at if high-risk for readmission b. Medication reconciliation c. Methods to identify and respond to worsening condition d. Interdisciplinary team approach e. Engaged primary provider f. Information dissemination										
Task Develop and implement policies and procedures for including care transitions plans in the patient's medical record										
Task Identify and document required clinical and care management protocols for priority programs, projects and interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data										

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Task Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations for how interventions will be logged, tracked and reported										
Task Deploy systems to improve and promote effective care transitions, include protocols for tracking and follow-up										
Task Operationalize partner and workforce roles by providing gap analysis and appropriate training to clinicians and care management staff (including licensed care managers, care coordinators, patient navigators/community health workers, medical assistants and front-office staff)										
Task Establish data collection, survey and reporting mechanisms to enable BPHC monitoring to ensure that patients are receiving appropriate health care and community support in priority projects, based on needs identified in prior planning activities										
Task Review process for rapid cycle evaluation and continuous improvement of data collection, survey and reporting methods based on priority project experience and modify process as needed to ensure patients receive appropriate health care and community support										
Task Monitor record of transition plan in the interoperable EHR, as well as whether PCP has accessed the plan (if feasible)										
Task Convene providers from different care settings to define specific information and clinical data to include in the care transition record shared between sending and receiving providers, as patient goes from one care setting to another. Resources designed by the National Transition of Care Coalition will be considered.										
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 Establish a process and structure to conduct a detailed review of all discharges leading to readmission within 30 days.										
Task Use the analysis and the ongoing review data to inform services										

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SBH Health System (PPS ID:36)

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 involve in this project.										
Task Work with partners to define how to document and communicate 30-day transition period of care.										
Task Incorporate the 30 day care transition period into payer agreements.										
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 Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff										
Task Perform current state assessment of E.H.R. capabilities.										
Task Perform gap analysis and identify priories to achieving integration of patient record.										
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.										
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)										
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.										
Task Create budget to build registry and acquire necessary resources										
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries										
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care										
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting										
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.										
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	The four tasks (1.02, 1.03, 1.04 and 1.05) due this quarter were all completed. As part of 1.02, Engaging partners, BPHC is actively engaged in working with its vendor organization—Montefiore Care Management Organization (CMO)—to design the 30-day care transitions intervention on BPHC inpatient units as well as develop documentation that will result in a care transitions plan. As well the DSRIP launch held on December 3, 2015 introduced all BPHC partners to the projects at a high level. DSRIP Program Directors (DPDs) at the major BPHC partner sites were introduced to the Care Transitions project at their orientation on 12/18/15 and again in a project-specific orientation on 1/7/16. Initial meetings with all three health homes (Bronx Accountable Health Network, CBC and CCMP) participating in BPHC were conducted to orient health homes to the project, discuss increasing direct or bottoms-up referrals from the discharging institution for eligible patients as well as the possibility of health home care managers being trained to conduct the Critical Time Intervention (CTI). Supporting documentation includes minutes from the DPD orientation, DSRIP launch and Health Home meetings. As part of 1.03, key stakeholders at both Montefiore and SBH Health System as well as key community partners such as BronxWorks and Riverdale Mental Health Association were identified and convened for the first joint ED Care Triage/30-day Care Transitions Implementation Workgroup which met on 10/29/15. A second meeting is scheduled for 1/25/16. Care Transitions Project Design meetings commenced on 12/7 and have focused on defining the target population as well as drafting criteria for a

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	work list (for the inpatient care coordinator) based on an analysis of the BPHC Community Needs Assessment (CNA) and AHRQ's evidence based guidelines for criteria that lead to potentially preventable readmissions (PPR). Together with the vendor, BPHC has been orienting hospital staff (Task 1.05) at SBH Health System to replication of the Montefiore CMO's Post Discharge Call Program and Care Management Resource Unit (CMRU). In addition, plans are in place to collectively design the inpatient component of the program where hospital based care coordinators will conduct assessments and formulate care transitions plans prior to discharge. As part of task 1.04 site visits were conducted to participating inpatient units by members of BPHC site specific implementation teams and the CMO acting as vendor. The PPS has formed a Care Transitions (CT) rapid deployment collaborative/implementation work group (IWG), which will meet roughly bi-monthly starting on 10/29/15 and again on to provide input and technical assistance to the expansion of the 30-Day Care Transitions model and act as a clinical quality council. Milestone is on track for completion.
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.	The Finance and Sustainability Committee continues the process identification of Managed Care Organization (MCOs) who have VBP in place that serve the PPS attributed population. The meeting on 12/2 started the process of engagement. Tasks related to engagement have been moved out to DY2Q1 due to the need for more time for the committee to engage MCOs. The Committee is working with key stakeholder Chief Financial Officers to engage MCOs to expand VBP, per the vision described in the Roadmap document. Milestone is on track for completion.
Ensure required social services participate in the project.	There were no tasks for this milestone due this quarter. Efforts in progress continue from the last update. The BPHC Care Transitions Design team is in the process of identifying and sharing to create a joint list of the most frequently used CBOs. Lists exist with both social work departments and online on Montefiore's intranet. PPS-wide surveys and various activities undertaken with Community-based organizations (CBOs) as part of the BPHC community engagement strategy and community engagement plan development. In coordination with these partners, the PPS is creating a directory of available services that will be searchable by zip code and service to be shared throughout the network. Systems for referrals and care coordination are being identified and protocols for "closed loop referral processes" are being written as part of the Clinical Operations Plan. BPHC is developing relationship and moving towards establishing formal partnerships with Health Home Care Management Agencies and Skilled Nursing Facilities to whom many transitioning patients will likely be referred. Community-based services for mental health and substance abuse patients have been engaged to provide specific transition assistance and more formal partnerships are in progress. In particular, in an effort to provide assistance to homeless patients through the work of the SBH team active participation in the MAX series, and other at-risk patients in need of longer-term transition assistance due to specific social factors, vendors are being sought for training and hiring/expanding the roles of case workers within health homes using the Critical Time Intervention (CTI) model. Milestone is on track for completion.
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.	The Care Transitions design task force led by Montefiore's Care Management Organization (CMO) acting as vendor has developed a prototype for a care plan to be included in the EMR and eventually to live in the care coordination management system (CCMS), likely Acupera (we are in process of contracting with them). Prior to Acupera rollout PPS wide, an interim solution using an Allscripts module both hospitals already use is being considered. Drafts of templates for documentation and storage of the care transitions plan in this Allscripts care manager module have been These plans will be shared via the CCMS currently under development and documented in the patient's medical record. As described in the narrative for Milestone 3, the Critical Time Intervention (CTI) model is being evaluated for inclusion as an evidence-based practice and to be implemented as a community-based intervention among a high-risk severely mentally ill (SMI) and/or homeless, substance use disorder (SUD) and recently decarcerated population. Criteria for CTI intervention are being finalized and will be discussed with the Implementation Workgroup as well as with a subgroup of SMEs who will define the target population and drive the referral process likely in March 2016. Data have been collected to determine the size of the population for this intervention and efforts are being made to work with health homes to properly staff and train the appropriate number of staff to deliver the intervention through health homes as well as leverage existing

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	community resources that run CTI programs within our PPS. The Implementation Workgroup will contribute to the development of metrics for rapid cycle evaluation and will act as a clinical quality council. Milestone is on track for completion.
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.	BPHC is executing a comprehensive plan to support our safety net providers in MU and PCMH which includes EHR support and connectivity of data captured therein. Our agreement with Bronx RHIO will serve as the foundation to achieve next quarter's tasks and those of the future to support this Milestone. This agreement is very close to being signed. We also have a strategy around funding for the adoption of the HIE by safety net providers, informed by an analysis of EMR and QE implementation and use by member organizations. Additionally, use of the RHIO and SHIN-NY is one of the technology components/tools being incorporated into the patient flow section of the Clinical Operations Plan. An assessment of current state capabilities including ENS has been completed during this quarter. BPHC is executing a comprehensive plan to support their safety net providers in MU and PCMH which includes use of targeted patient registries in conjunctions with our clinical projects. We have a comprehensive strategy in place for care management which includes the uses of registries, EHRs and IT platforms, and the completion of all agreed upon tasks by agreed upon dates. Last quarter registry elements and business requirements were developed and adopted and a PHM Gap Assessment and IT Gap Assessment were constructed. Registry elements were approved by the Quality and Care Innovations Subcommittee. The IT Subcommittee reviewed the registry strategy but approval from this subcommittee of the registry elements was determined to be unnecessary and less meaningful than originally determined, given the clinical expertise required that the IT Subcommittee does not offer. It was further determined that the Executive Committee would not need to approve this level of detail in the PHM strategy, give that its Clinical Committee had already conducted a thorough review and approval process. Consultants have been deployed to perform detailed Gap Analysis. The ED Care Triage / Care Transitions Implementation Workgroup will approve target population criteria and worklist criteria as developed by the project design task forces in order to further define population health management requirements for patient engagement and strategies for tracking through the RHIO and/or CCMS platform. This information will be relevant to the development of the CCMS platform and the patient registries to be developed through the platform, which will be used in care planning and referral tracking. Patient consent to share information across practices will be a critical component for the success of this project. Milestone is on track for completion.

Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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Project 3.a.i – Integration of primary care and behavioral health services

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

Instructions :

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

This project marks a significant cultural shift in how care is delivered to and experienced by patients. Provider buy-in will be critical for successful implementation. To accomplish this transition BPHC will: (1) provide required project-specific training and technical assistance on the IMPACT model processes and protocols to primary care physicians (PCPs) and their care teams and secure an experienced training consultant to assist these sites in adopting the model over a 6-month training period. Training and technical assistance will address how PCPs, care managers, and psychiatrists can work effectively as a team. In addition, the training and technical assistance will place an emphasis on providing culturally competent care for depression, including an understanding of cultural barriers to care and health literacy and stigma among the patient population; (2) provide technical assistance for those organizations seeking to introduce PC into BH sites or BH into PC sites. BPHC will pair organizations that have successfully co-located PC and BH with those who are newly implementing these interventions in order to provide technical assistance and coaching to PC and BH staff. BPHC will also seek ways to incentivize physician participation: e.g., offering access to care management services and connectivity through BPHC's care planning tool to minimize the time burden of implementing the new evidence-based standards. Technical assistance will include an emphasis on providing culturally competent care for BH issues; (3) address regulatory and reimbursement barriers currently in place that discourage effectively integrating PC and BH through co-location due to cost, paperwork, and length of approval process. BPHC requested and received the following waivers from the State that will facilitate implementation of this project: Article 28 (SDOH) facilities may provide mental health or substance abuse services so long as those services comprise no more than 49% of a facility's annual visits and the facility complies with various provisions of the new integrated services regulations; Article 31 (OMH) and 32 (OASAS) facilities may provide physical health services so long as those services comprise no more than 49% of a facility's annual visits and the facility complies with various provisions of the new integrated services regulations; Article 28 and Article 32 facilities may treat their patients in the home, but there is no system yet for them to be reimbursed for such visits. (Article 31 facilities cannot provide care in their patients' homes.). However, SDOH, OMH, and OASAS have yet to grant any waivers that would allow two different providers licensed by different agencies to share space (for example, a common waiting room used by an Article 28 and Article 31 facility). BPHC will continue to advocate to the State on these waivers to ensure that we meet project goals and milestones; and (4) identify solutions to the shortage of psychiatrists in our PPS, as noted by our CNA. BPHC will explore use of tele-psychiatry to increase the PPS's psychiatric capacity as implementation begins. Staff recruitment efforts will focus on identifying additional psychiatrists, but the PPS will also launch a recruitment program targeted towards attracting and retaining nurses, licensed clinical social workers (LCSWs), psychologists, and psychiatric NPs and PAs to perform the roles of therapist and depression care managers at participating sites. We will also consider recruiting for licensed master social workers (LMSWs) with the expectation that they pass the LCSW exam within a year of hire, and contracting with 1199 Training and Employment Funds to provide training. BPHC will also reach out to other PPSs in the region to collaborate on workforce issues that may impact recruitment strategies, including compensation.

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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**
DY3,Q4	91,800

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
0	5,665	41.14%	8,105	6.17%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (13,770)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
zstopak	Baseline or Performance Documentation	36_PMDL3715_1_3_20160202152820_BPHC-PATIENTLIST-3ai-Q3.xlsx	3.a.i Patient Engagement DY1 Q3	02/02/2016 03:28 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Model 1	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Behavioral health services are co-located within PCMH/APC practices and are available.		Provider	Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Finalize contract with vendor		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Finalize contracts with Primary Care and Behavioral Health Providers engaged in project.		Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Assess current state, including physical health services , current PCMH level if applicable, IT infrastructure, interoperability, staffing, etc.		Project		In Progress	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recruit or contract for PCMH practice certification resources as needed		Project		Completed	05/01/2015	12/31/2015	05/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task		Project		In Progress	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Assess current state of PCPs engaged in project, including behavioral health service delivery capabilities, work flow, IT infrastructure, interoperability, staffing, etc										
Task Develop best practice policies and procedures, by PCBH workgroup to be reviewed by the Quality & Care Innovation Sub-committee (QCIS)		Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Educate leadership within each organization participating in project of the benefits of co located behavioral health services within a primary care setting.		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Perform gap analysis and identify key priorities to successful completion of co-located services.		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition		Project		In Progress	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Perform gap analysis by practice and identify key priorities		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.		Project		In Progress	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Develop mechanisms to monitor progress towards completion and sustainability of co-located services, evaluate barriers, and develop mechanisms for continuous quality improvement		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition		Project		Not Started	01/01/2016	11/30/2016	01/01/2016	11/30/2016	12/31/2016	DY2 Q3
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed		Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed		Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Provide support, trainings, resources and education to participating providers as needed to ensure successful completion of co-located and integrated behavioral health services.		Project		In Progress	12/01/2015	03/31/2018	12/01/2015	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	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.		Project		In Progress	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Establish regularly scheduled meetings with vendor and PCBH workgroup to choose evidence based guidelines and protocols including medication management, care engagement and processes for collaborative care meetings.		Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task In collaboration with BPHC Workforce Sub-committee, assign roles and responsibilities for practice specific implementation of evidence based guidelines and protocols and action plans to engage PCPs with behavioral health specialists		Project		In Progress	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize collaborative care practices, reviewed and approved by the QCIS		Project		In Progress	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Assess current participating providers practice models with		Project		In Progress	09/01/2015	03/31/2016	09/01/2015	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
vendors and PCBH workgroup. The PPS will begin working with approximately 60 sites and their staff, including administrators, providers, and care team staff.										
Task Complete best practice care protocols draft, including those needed for specific conditions, for QCIS review		Project		In Progress	12/01/2015	06/30/2016	12/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Finalize PPS wide evidence- based protocols with approval by QCIS		Project		On Hold	12/31/2015	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Perform Gap analysis to identify key priorities for participating providers to meet best practice standards		Project		In Progress	09/30/2015	12/31/2016	09/30/2015	12/31/2016	12/31/2016	DY2 Q3
Task Provide vendor and CSO support as needed for successful implementation of protocols.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Finalize and implement evidence- based practice guidelines		Project		In Progress	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Finalize and implement evidence- based practice guidelines		Project		In Progress	04/01/2015	03/31/2020	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Develop mechanisms for evaluation, accountability, and continuous quality improvement		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop mechanisms for regular review of project-selected Evidence Based Guidelines (by project quality councils) to assure our PPS is utilizing the most up-to-date tools and that those upadated guidelines/protocols continue to be clinically integrated across the PPS		Project		Not Started	04/01/2016	03/31/2017	04/01/2016	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	09/01/2015	03/31/2018	09/01/2015	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	09/01/2015	03/31/2016	09/01/2015	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 Screenings are documented in Electronic Health Record.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 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	09/01/2015	03/31/2018	09/01/2015	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	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Assess participating providers current rates of patient assessments		Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Educate leadership within each participating organization around benefits of providing preventative care screenings using industry standard questionnaires regularly.		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Assess participating providers current process for identifying unmet needs		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize draft policies and procedures to facilitate and document behavioral health screenings by PCBH workgroup, and approval by QCIS		Project		In Progress	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Perform gap analysis,including provider capability for documenting screenings in EMR, and identify steps to meet standards.		Project		In Progress	09/30/2015	03/31/2016	09/30/2015	03/31/2016	03/31/2016	DY1 Q4
Task Provide education/trainings needed to ensure success in conjunction with Workforce Sub-committee		Project		In Progress	12/01/2015	03/31/2018	12/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Finalize policy around timely documentation of screenings in the electronic health record.		Project		On Hold	12/31/2015	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop process to monitor progress towards completing screenings on 90% of patient population using approved		Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4

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SBH Health System (PPS ID:36)

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
screenings										
Task Assess participating providers current procedures for patients who receive a positive screening, as well as for completion of referrals.		Project		In Progress	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Create and Finalize policies on implementing "warm transfers" for patients who have a positive screening.		Project		Not Started	03/01/2016	12/31/2016	03/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Provide education/training as needed to ensure successful implementation.		Project		In Progress	12/01/2015	03/31/2018	12/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Implement "warm transfer" policies and procedures, as well as instructions on appropriate documentation in the electronic health record.		Project		On Hold	12/31/2016	12/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Monitor success and sustainability of implemented "warm transfer" protocols and engage sites in continuous quality improvement		Project		On Hold	12/31/2016	03/31/2017	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Monitor success and sustainability of implemented screening protocols		Project		Not Started	03/01/2016	03/31/2018	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor success with timely and accurate documentation in the electronic health record.		Project		Not Started	03/01/2016	03/31/2018	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor success towards completion of screenings on 90% of eligible patients engaged in project, engage sites with continuous quality improvement as needed to ensure success.		Project		Not Started	03/01/2016	03/31/2018	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Provide education and training as needed to achieve goal		Project		In Progress	12/01/2015	03/31/2018	12/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 1	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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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.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.		Project		Completed	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Develop a project specific strategy for tracking patient engagement, employing PHM tools and processes outlined below.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform gap analysis and identify priories to achieving integration of patient record.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget to build registry and acquire necessary resources		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task		Project		Not Started	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)	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
Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data										
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.		Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
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	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	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		Provider	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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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Health practices and are available.										
Task Finalize contract with vendor		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Finalize contracts with Behavioral Health and Primary Care Providers engaged in project.		Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Assess current state, including physical health and behavioral health services , current PCMH level if applicable, IT infrastructure, interoperability, staffing, etc.		Project		In Progress	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recruit or contract for PCMH practice certification resources as needed		Project		Completed	05/01/2015	12/31/2015	05/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Educate leadership within each organization participating in project of the benefits of co located primary care services within a behavioral health setting.		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Perform gap analysis and identify key priorities to successful completion of co-located services.		Project		In Progress	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition		Project		In Progress	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Perform gap analysis by practice and identify key priorities.		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.		Project		In Progress	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting		Project		Not Started	01/01/2016	11/30/2016	01/01/2016	11/30/2016	12/31/2016	DY2 Q3

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
partner efforts towards PCMH recognition										
Task Develop best practice policies and procedures by PCBH workgroup, send for review and approval by QCIS		Project		Not Started	03/31/2016	12/31/2016	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Provide support, trainings, resources and education to participating providers as needed to ensure successful completion of co-located and integrated primary care services.		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Develop mechanisms to monitor progress towards completion and sustainability of co-located services, evaluate barriers, and develop mechanisms for continuous quality improvement		Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed.		Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.		Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Assess current state of BH practices engaged in project, including Primary care service delivery capabilities, (e.g.exam room structure) work flow, IT infrastructure, interoperability, staffing, etc.		Project		Not Started	09/01/2016	03/31/2018	09/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 2	Project	N/A	In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		In Progress	12/31/2015	03/31/2017	12/31/2015	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	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)	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 Assess current participating providers practice models with vendors and PCBH workgroup		Project		In Progress	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task In collaboration with BPHC Workforce Sub-committee, assign roles and responsibilities for practice specific implementation of evidence based guidelines and protocols and action plans to engage PCPs with behavioral health specialists		Project		In Progress	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize PPS wide evidence- based protocols with approval by QCIS.		Project		In Progress	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Perform Gap analysis to identify key priorities for participating providers to meet best practice standards.		Project		In Progress	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize and implement evidence- based practice guidelines.		Project		In Progress	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish regularly scheduled meetings with vendor and PCBH workgroup to choose evidence based guidelines and protocols including medication management, care engagement and processes for collaborative care meetings.		Project		Not Started	03/31/2016	12/31/2016	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Finalization of collaborative care practices, reviewed and approved by the QCIS		Project		Not Started	03/31/2016	12/31/2016	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Complete best practice care protocols draft, including those needed for specific conditions, for QCIS review		Project		Not Started	03/31/2016	12/31/2016	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Develop mechanisms for evaluation, accountability, and continuous quality improvement		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop mechanisms for regular review of project-selected Evidence Based Guidelines (by project quality councils) to assure our PPS is utilizing the most up-to-date tools and		Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	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
that those upadated guidelines/protocols continue to be clinically integrated across the PPS.										
Task Provide vendor and CSO support as needed for successful implementation of protocols.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Model 2	Project	N/A	In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Screenings are documented in Electronic Health Record.		Project		Not Started	03/31/2016	03/31/2018	03/31/2016	03/31/2018	03/31/2018	DY3 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	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	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Educate leadership within each participating organization around benefits of providing preventative care screenings using industry standard questionnaires regularly. Recognize that BH patients with conditions other than depression still require depression screening with industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT. In this colocation model also educate around Primary Care preventive screenings including: age appropriate cancer screenings, alcohol, tobacco and substance use screenings, CVD and DM screenings, vaccinations, etc.		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 Assess participating providers current process for identifying unmet physical needs of patients, The PPS will begin working with approximately 50 sites and their staff, including administrators, providers, and care team staff.		Project		Not Started	03/31/2016	12/31/2016	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Develop process to monitor progress towards completing industry standard questionnaires/screening (such as PHQ-2 or 9 for those screening positive, SBIRT) on 90% of patient population.		Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Assess participating providers' current procedures for patients who receive a positive screening, as well as for completion of referrals, and adapt to include screenings performed by PCP.		Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize draft policies and procedures to facilitate and document behavioral health and primary care screenings by PCBH workgroup, approval by QCIS		Project		In Progress	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Perform gap analysis,including provider capability for documenting screenings in EMR, and identify steps to meet standards.		Project		In Progress	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize policy around timely documentation of screenings in the electronic health record.		Project		In Progress	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Monitor success with timely and accurate documentation in the electronic health record.		Project		Not Started	03/01/2016	03/31/2018	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor success and sustainability of implemented screening protocols.		Project		Not Started	03/01/2016	03/31/2018	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Assess participating providers current rates of patient assessments.		Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Monitor success towards completion of screenings on 90% of patients engaged in project, as needed to ensure		Project		Not Started	03/01/2016	03/31/2018	03/01/2016	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
success.										
Task Create and Finalize policies on implementing "warm transfers" back to BH specialist for patients who have a positive screening.		Project		Not Started	03/01/2016	12/31/2016	03/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Implement "warm transfer" policies and procedures, as well as instructions on appropriate documentation in the electronic health record.		Project		Not Started	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Monitor success and sustainability of implemented "warm transfer" protocols and engage sites in continuous quality improvement		Project		Not Started	12/31/2016	12/31/2017	12/31/2016	12/31/2017	12/31/2017	DY3 Q3
Task Provide education/training as needed to ensure success in conjunction with Workforce Sub-committee		Project		In Progress	12/01/2015	03/31/2018	12/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Provide education and training as needed to achieve goal.		Project		In Progress	12/01/2015	03/31/2018	12/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Provide education/training as needed to ensure successful implementation.		Project		In Progress	12/01/2015	03/31/2018	12/01/2015	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	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.		Project		Completed	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Develop a project specific strategy for tracking patient engagement, employing PHM tools and processes outlined below.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform gap analysis and identify priories to achieving integration of patient record.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget to build registry and acquire necessary resources		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1

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SBH Health System (PPS ID:36)

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 Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.		Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Milestone #9 Implement IMPACT Model at Primary Care Sites.	Model 3	Project	N/A	In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has implemented IMPACT Model at Primary Care Sites.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Asses the current state of participating primary care sites, including behavioral health service delivery capabilities, IT infrastructure, staffing, etc.		Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Educate senior leadership of participating providers regarding IMPACT Model and requirements.		Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Finalize contracts with providers participating in IMPACT collaborative care model and vendor		Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Perform gap analysis by practice to identify key changes required for successful transition to an IMPACT collaborative care model incorporating behavioral health.		Project		In Progress	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize and implement strategy for moving provider networks towards an IMPACT Model.		Project		In Progress	12/31/2015	03/31/2016	12/31/2015	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 Establish PCBH workgroup to integrate IMPACT model standards into best practice protocol design. Utilize the IMPACT manual.		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Monitor provider transformation sustainability and success with implementation of IMPACT Model through continuous quality improvement		Project		Not Started	03/31/2016	03/31/2018	03/31/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Model 3	Project	N/A	In Progress	09/01/2015	03/31/2017	09/01/2015	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	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures include process for consulting with Psychiatrist.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Assess current participating providers practice models with vendors and PCBH workgroup, The PPS will begin working with approximately 75 sites and their staff, including administrators, providers, and care team staff.		Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop best practice care protocols draft, integrating IMPACT model standards into best practice protocol design. Utilize the IMPACT manual.		Project		In Progress	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize PPS wide evidence- based protocols with approval by QCIS		Project		In Progress	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Perform Gap analysis to identify key priorities for participating providers to meeting best practice standards.		Project		In Progress	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provide support as needed to ensure successful		Project		In Progress	12/01/2015	03/31/2017	12/01/2015	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
implementation.										
Task Finalize and implement evidence- based practice guidelines.		Project		In Progress	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Monitor success of developed protocols, updates made as needed with approval by QCIS		Project		In Progress	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Assess current participating providers' practice to begin to formulate implementable policies and procedures for psychiatric consultation.		Project		In Progress	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Develop draft evidence-based policies and procedures for consulting with a psychiatrist case review		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Finalize policies, procedures and protocols with approval by the QCIS.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provide education, training and resources as needed for successful implementation of policies and procedures.		Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Implement policies, procedures and protocols for successful consultation with psychiatrist.		Project		In Progress	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Monitor success of developed policies, procedures and protocol, as well as sustainability for consulting with psychiatrist.		Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Establish mechanisms for continuous quality improvement		Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Model 3	Project	N/A	In Progress	09/01/2015	03/31/2017	09/01/2015	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	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Depression care manager meets requirements of IMPACT		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4

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model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.										
Task Determine the type of DCM needed for each participating provider to meet the DCM role requirements, in conjunction with Workforce Sub-Committee, .		Project		In Progress	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Update policies, protocols, procedures, and organizational structure as necessary to implement and/or formally create the role of DCM with Workforce Sub-committee		Project		Not Started	03/31/2016	12/31/2016	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Finalize the formal hiring and creation of DCM role with Workforce Sub-committee		Project		Not Started	03/31/2016	12/31/2016	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Ensure that this staff member is identified as such in the Electronic Health Record (E.H.R.).		Project		Not Started	03/31/2016	12/31/2016	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Establish requirements of IMPACT Model DCM role by PCBH workgroup and approval by QCIS		Project		Not Started	03/31/2016	12/31/2016	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Perform gap analysis to identify key priorities for participating providers to be successful with implementation of the role for the DCM with the IMPACT model with Workforce Sub-committee		Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Create/provide training protocols and procedures for DCM role to ensure they are proficient in all required IMPACT interventions		Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Implement IMPACT model policies, procedures and protocols.		Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provide resources, training, education as needed, assuring that DCM meets role requirements according to the IMPACT model.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Task Continuously monitor and re-evaluate the effectiveness of the individual/individuals in the DCM position to ensure that the requirements of IMPACT model continue to be met into the future.		Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Establish continuous quality improvement. Develop mechanisms for evaluation, accountability, and continuous quality improvement		Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	Model 3	Project	N/A	In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task All IMPACT participants in PPS have a designated Psychiatrist.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Draft policies and procedures regarding the psychiatrists' responsibilities around treatment and follow-up care with patients.		Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Finalize job-related policies and procedures regarding psychiatrists' responsibilities for approval by QCIS		Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Provide assistance with resources for hiring designated psychiatrists, as needed.		Project		In Progress	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop mechanisms for evaluation, accountability, and continuous quality improvement		Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provide training of designated psychiatrists to ensure they are able to adequately perform the requirements of the position		Project		In Progress	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task Provide training for IMPACT collaborative care teams, including collaborative care case consultation		Project		In Progress	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task Provide training for care teams on IMPACT model and designated psychiatrist's role.		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #13 Measure outcomes as required in the IMPACT Model.	Model 3	Project	N/A	In Progress	09/01/2015	03/31/2018	09/01/2015	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	12/31/2015	03/31/2018	12/31/2015	03/31/2018	03/31/2018	DY3 Q4
Task Assess participating providers current rates of patient assessments.		Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Provide education and training as needed to achieve goal.		Project		In Progress	12/31/2015	03/31/2018	12/31/2015	03/31/2018	03/31/2018	DY3 Q4
Task Develop process to monitor, via EHRs/RHIO/CCMS, progress towards completing screenings on 90% of patient population using approved screenings		Project		In Progress	12/31/2015	03/31/2018	12/31/2015	03/31/2018	03/31/2018	DY3 Q4
Task Monitor success towards completion of screenings on 90% of patients engaged in project, engage sites with continuous quality improvement as needed to ensure success.		Project		Not Started	03/01/2016	03/31/2018	03/01/2016	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	12/31/2015	03/31/2018	12/31/2015	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	12/31/2015	03/31/2018	12/31/2015	03/31/2018	03/31/2018	DY3 Q4
Task Draft protocols to adjust treatment according to evidence-based algorithm if a patient is not improving, within 10-12 weeks of the start of the treatment plan. Align with IMPACT model.		Project		In Progress	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Evidence Based Protocols for stepped care, as aligned with IMPACT model, are approved by QCIS		Project		In Progress	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task Implement IMPACT model aligned protocols related to		Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
stepped care across practices using the IMPACT model										
Task Develop mechanisms for evaluating successful stepped care, accountability, and continuous quality improvement		Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	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 EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Develop a project specific strategy for tracking patient engagement, employing PHM tools and processes outlined below.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform gap analysis and identify priories to achieving integration of patient record.		Project		Completed	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Engage IT Subcommittee to identify technology and		Project		Not Started	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)	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
resource requirements for registry, including technical platform for hosting registry.										
Task Create budget to build registry and acquire necessary resources		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.		Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, with an emphasis on tracking patient engagement with primary care.		Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.	0	0	0	0	0	0	0	0	0	0
Task Behavioral health services are co-located within PCMH/APC practices and are available.	0	0	0	0	0	0	0	0	0	0
Task Finalize contract with vendor										
Task Finalize contracts with Primary Care and Behavioral Health Providers engaged in project.										
Task Assess current state, including physical health services , current PCMH level if applicable, IT infrastructure, interoperability, staffing, etc.										
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices										
Task Recruit or contract for PCMH practice certification resources as needed										
Task Assess current state of PCPs engaged in project, including behavioral health service delivery capabilities, work flow, IT infrastructure, interoperability, staffing, etc										
Task Develop best practice policies and procedures, by PCBH workgroup to be reviewed by the Quality & Care Innovation Sub-committee (QCIS)										
Task Educate leadership within each organization participating in project of the benefits of co located behavioral health services within a primary care setting.										
Task Perform gap analysis and identify key priorities to successful completion of co-located services.										
Task Establish BPHC program to educate on the benefits of, 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
encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition										
Task Perform gap analysis by practice and identify key priorities										
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.										
Task Develop mechanisms to monitor progress towards completion and sustainability of co-located services, evaluate barriers, and develop mechanisms for continuous quality improvement										
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition										
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed										
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed										
Task Provide support, trainings, resources and education to participating providers as needed to ensure successful completion of co-located and integrated behavioral health services.										
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 Establish regularly scheduled meetings with vendor and PCBH workgroup to choose evidence based guidelines and protocols including medication management, care engagement and processes for collaborative care meetings.										

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Task In collaboration with BPHC Workforce Sub-committee, assign roles and responsibilities for practice specific implementation of evidence based guidelines and protocols and action plans to engage PCPs with behavioral health specialists										
Task Finalize collaborative care practices, reviewed and approved by the QCIS										
Task Assess current participating providers practice models with vendors and PCBH workgroup. The PPS will begin working with approximately 60 sites and their staff, including administrators, providers, and care team staff.										
Task Complete best practice care protocols draft, including those needed for specific conditions, for QCIS review										
Task Finalize PPS wide evidence- based protocols with approval by QCIS										
Task Perform Gap analysis to identify key priorities for participating providers to meet best practice standards										
Task Provide vendor and CSO support as needed for successful implementation of protocols.										
Task Finalize and implement evidence- based practice guidelines										
Task Finalize and implement evidence- based practice guidelines										
Task Develop mechanisms for evaluation, accountability, and continuous quality improvement										
Task Develop mechanisms for regular review of project-selected Evidence Based Guidelines (by project quality councils) to assure our PPS is utilizing the most up-to-date tools and that those upadated guidelines/protocols continue to be clinically integrated across the PPS										
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.										

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Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	0	0	0	0	0	0	0	0	0	0
Task Assess participating providers current rates of patient assessments										
Task Educate leadership within each participating organization around benefits of providing preventative care screenings using industry standard questionnaires regularly.										
Task Assess participating providers current process for identifying unmet needs										
Task Finalize draft policies and procedures to facilitate and document behavioral health screenings by PCBH workgroup, and approval by QCIS										
Task Perform gap analysis,including provider capability for documenting screenings in EMR, and identify steps to meet standards.										
Task Provide education/trainings needed to ensure success in conjunction with Workforce Sub-committee										
Task Finalize policy around timely documentation of screenings in the electronic health record.										
Task Develop process to monitor progress towards completing screenings on 90% of patient population using approved screenings										
Task Assess participating providers current procedures for patients who receive a positive screening, as well as for completion of referrals.										
Task Create and Finalize policies on implementing "warm transfers" for										

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SBH Health System (PPS ID:36)

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
patients who have a positive screening.										
Task Provide education/training as needed to ensure successful implementation.										
Task Implement "warm transfer" policies and procedures, as well as instructions on appropriate documentation in the electronic health record.										
Task Monitor success and sustainability of implemented "warm transfer" protocols and engage sites in continuous quality improvement										
Task Monitor success and sustainability of implemented screening protocols										
Task Monitor success with timely and accurate documentation in the electronic health record.										
Task Monitor success towards completion of screenings on 90% of eligible patients engaged in project, engage sites with continuous quality improvement as needed to ensure success.										
Task Provide education and training as needed to achieve goal										
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 Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.										
Task Develop a project specific strategy for tracking patient engagement, employing PHM tools and processes outlined below.										
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff										

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SBH Health System (PPS ID:36)

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 Perform current state assessment of E.H.R. capabilities										
Task Perform gap analysis and identify priories to achieving integration of patient record.										
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)										
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.										
Task Create budget to build registry and acquire necessary resources										
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries										
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data										
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care										
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.										
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.										
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.										

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SBH Health System (PPS ID:36)

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 #5 Co-locate primary care services at behavioral health sites.										
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.	0	0	0	0	0	0	0	0	0	0
Task Primary care services are co-located within behavioral Health practices and are available.	0	0	0	0	0	0	0	0	0	0
Task Primary care services are co-located within behavioral Health practices and are available.	0	0	0	0	0	0	0	0	0	0
Task Finalize contract with vendor										
Task Finalize contracts with Behavioral Health and Primary Care Providers engaged in project.										
Task Assess current state, including physical health and behavioral health services , current PCMH level if applicable, IT infrastructure, interoperability, staffing, etc.										
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices										
Task Recruit or contract for PCMH practice certification resources as needed										
Task Educate leadership within each organization participating in project of the benefits of co located primary care services within a behavioral health setting.										
Task Perform gap analysis and identify key priorities to successful completion of co-located services.										
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition										
Task Perform gap analysis by practice and identify key priorities.										
Task Finalize strategy to support primary care physicians with										

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SBH Health System (PPS ID:36)

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
achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.										
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition										
Task Develop best practice policies and procedures by PCBH workgroup, send for review and approval by QCIS										
Task Provide support, trainings, resources and education to participating providers as needed to ensure successful completion of co-located and integrated primary care services.										
Task Develop mechanisms to monitor progress towards completion and sustainability of co-located services, evaluate barriers, and develop mechanisms for continuous quality improvement										
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed.										
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.										
Task Assess current state of BH practices engaged in project, including Primary care service delivery capabilities, (e.g.exam room structure) work flow, IT infrastructure, interoperability, staffing, etc.										
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 Assess current participating providers practice models with vendors and PCBH workgroup										
Task In collaboration with BPHC Workforce Sub-committee, assign roles and responsibilities for practice specific implementation of										

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SBH Health System (PPS ID:36)

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
evidence based guidelines and protocols and action plans to engage PCPs with behavioral health specialists										
Task Finalize PPS wide evidence- based protocols with approval by QCIS.										
Task Perform Gap analysis to identify key priorities for participating providers to meet best practice standards.										
Task Finalize and implement evidence- based practice guidelines.										
Task Establish regularly scheduled meetings with vendor and PCBH workgroup to choose evidence based guidelines and protocols including medication management, care engagement and processes for collaborative care meetings.										
Task Finalization of collaborative care practices, reviewed and approved by the QCIS										
Task Complete best practice care protocols draft, including those needed for specific conditions, for QCIS review										
Task Develop mechanisms for evaluation, accountability, and continuous quality improvement										
Task Develop mechanisms for regular review of project-selected Evidence Based Guidelines (by project quality councils) to assure our PPS is utilizing the most up-to-date tools and that those upadated guidelines/protocols continue to be clinically integrated across the PPS.										
Task Provide vendor and CSO support as needed for successful implementation of protocols.										
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.										

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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 (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	0	0	0	0	0	0	0	0	0	0
Task Educate leadership within each participating organization around benefits of providing preventative care screenings using industry standard questionnaires regularly. Recognize that BH patients with conditions other than depression still require depression screening with industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT. In this colocation model also educate around Primary Care preventive screenings including: age appropriate cancer screenings, alcohol, tobacco and substance use screenings, CVD and DM screenings, vaccinations, etc.										
Task Assess participating providers current process for identifying unmet physical needs of patients, The PPS will begin working with approximately 50 sites and their staff, including administrators, providers, and care team staff.										
Task Develop process to monitor progress towards completing industry standard questionnaires/screening (such as PHQ-2 or 9 for those screening positive, SBIRT) on 90% of patient population.										
Task Assess participating providers' current procedures for patients who receive a positive screening, as well as for completion of referrals, and adapt to include screenings performed by PCP.										
Task Finalize draft policies and procedures to facilitate and document behavioral health and primary care screenings by PCBH workgroup, approval by QCIS										
Task Perform gap analysis,including provider capability for documenting screenings in EMR, and identify steps to meet standards.										
Task Finalize policy around timely documentation of screenings in the electronic health 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 Monitor success with timely and accurate documentation in the electronic health record.										
Task Monitor success and sustainability of implemented screening protocols.										
Task Assess participating providers current rates of patient assessments.										
Task Monitor success towards completion of screenings on 90% of patients engaged in project, as needed to ensure success.										
Task Create and Finalize policies on implementing "warm transfers" back to BH specialist for patients who have a positive screening.										
Task Implement "warm transfer" policies and procedures, as well as instructions on appropriate documentation in the electronic health record.										
Task Monitor success and sustainability of implemented "warm transfer" protocols and engage sites in continuous quality improvement										
Task Provide education/training as needed to ensure success in conjunction with Workforce Sub-committee										
Task Provide education and training as needed to achieve goal.										
Task Provide education/training as needed to ensure successful implementation.										
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 Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.										
Task										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Develop a project specific strategy for tracking patient engagement, employing PHM tools and processes outlined below.										
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff										
Task Perform current state assessment of E.H.R. capabilities.										
Task Perform gap analysis and identify priories to achieving integration of patient record.										
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)										
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.										
Task Create budget to build registry and acquire necessary resources										
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries										
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data										
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care										
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.										
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security										

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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
requirements across the system.										
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.										
Milestone #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	0	0	0	0	0	0	0	0	0	0
Task Asses the current state of participating primary care sites, including behavioral health service delivery capabilities, IT infrastructure, staffing, etc.										
Task Educate senior leadership of participating providers regarding IMPACT Model and requirements.										
Task Finalize contracts with providers participating in IMPACT collaborative care model and vendor										
Task Perform gap analysis by practice to identify key changes required for successful transition to an IMPACT collaborative care model incorporating behavioral health.										
Task Finalize and implement strategy for moving provider networks towards an IMPACT Model.										
Task Establish PCBH workgroup to integrate IMPACT model standards into best practice protocol design. Utilize the IMPACT manual.										
Task Monitor provider transformation sustainability and success with implementation of IMPACT Model through continuous quality improvement										
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.										

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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 Policies and procedures include process for consulting with Psychiatrist.										
Task Assess current participating providers practice models with vendors and PCBH workgroup, The PPS will begin working with approximately 75 sites and their staff, including administrators, providers, and care team staff.										
Task Develop best practice care protocols draft, integrating IMPACT model standards into best practice protocol design. Utilize the IMPACT manual.										
Task Finalize PPS wide evidence- based protocols with approval by QCIS										
Task Perform Gap analysis to identify key priorities for participating providers to meeting best practice standards.										
Task Provide support as needed to ensure successful implementation.										
Task Finalize and implement evidence- based practice guidelines.										
Task Monitor success of developed protocols, updates made as needed with approval by QCIS										
Task Assess current participating providers' practice to begin to formulate implementable policies and procedures for psychiatric consultation.										
Task Develop draft evidence-based policies and procedures for consulting with a psychiatrist case review										
Task Finalize policies, procedures and protocols with approval by the QCIS.										
Task Provide education, training and resources as needed for successful implementation of policies and procedures.										
Task Implement policies, procedures and protocols for successful consultation with psychiatrist.										
Task Monitor success of developed policies, procedures and protocol, as well as sustainability for consulting with psychiatrist.										

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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 Establish mechanisms for continuous quality improvement										
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 Determine the type of DCM needed for each participating provider to meet the DCM role requirements, in conjunction with Workforce Sub-Committee, .										
Task Update policies, protocols, procedures, and organizational structure as necessary to implement and/or formally create the role of DCM with Workforce Sub-committee										
Task Finalize the formal hiring and creation of DCM role with Workforce Sub-committee										
Task Ensure that this staff member is identified as such in the Electronic Health Record (E.H.R.).										
Task Establish requirements of IMPACT Model DCM role by PCBH workgroup and approval by QCIS										
Task Perform gap analysis to identify key priorities for participating providers to be successful with implementation of the role for the DCM with the IMPACT model with Workforce Sub-committee										
Task Create/provide training protocols and procedures for DCM role to ensure they are proficient in all required IMPACT interventions										
Task Implement IMPACT model policies, procedures and protocols.										
Task Provide resources, training, education as needed, assuring that DCM meets role requirements according to the IMPACT model.										

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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 Continuously monitor and re-evaluate the effectiveness of the individual/individuals in the DCM position to ensure that the requirements of IMPACT model continue to be met into the future.										
Task Establish continuous quality improvement. Develop mechanisms for evaluation, accountability, and continuous quality improvement										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Task Draft policies and procedures regarding the psychiatrists' responsibilities around treatment and follow-up care with patients.										
Task Finalize job-related policies and procedures regarding psychiatrists' responsibilities for approval by QCIS										
Task Provide assistance with resources for hiring designated psychiatrists, as needed.										
Task Develop mechanisms for evaluation, accountability, and continuous quality improvement										
Task Provide training of designated psychiatrists to ensure they are able to adequately perform the requirements of the position										
Task Provide training for IMPACT collaborative care teams, including collaborative care case consultation										
Task Provide training for care teams on IMPACT model and designated psychiatrist's role.										
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										

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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
Assess participating providers current rates of patient assessments.										
Task Provide education and training as needed to achieve goal.										
Task Develop process to monitor, via EHRs/RHIO/CCMS, progress towards completing screenings on 90% of patient population using approved screenings										
Task Monitor success towards completion of screenings on 90% of patients engaged in project, engage sites with continuous quality improvement as needed to ensure success.										
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 Draft protocols to adjust treatment according to evidence-based algorithm if a patient is not improving, within 10-12 weeks of the start of the treatment plan. Align with IMPACT model.										
Task Evidence Based Protocols for stepped care, as aligned with IMPACT model, are approved by QCIS										
Task Implement IMPACT model aligned protocols related to stepped care across practices using the IMPACT model										
Task Develop mechanisms for evaluating successful stepped care, accountability, and continuous quality improvement										
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 Develop a project specific strategy for tracking patient engagement, employing PHM tools and processes outlined below.										

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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 Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff										
Task Perform current state assessment of E.H.R. capabilities.										
Task Perform gap analysis and identify priories to achieving integration of patient record.										
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.										
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)										
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.										
Task Create budget to build registry and acquire necessary resources										
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries										
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data										
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care										
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.										
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security										

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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
requirements across the system.										
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, with an emphasis on tracking patient engagement with primary care.										

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.	78	158	318	796	796	796	796	796	796	796
Task Behavioral health services are co-located within PCMH/APC practices and are available.	19	39	78	195	195	195	195	195	195	195
Task Finalize contract with vendor										
Task Finalize contracts with Primary Care and Behavioral Health Providers engaged in project.										
Task Assess current state, including physical health services , current PCMH level if applicable, IT infrastructure, interoperability, staffing, etc.										
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices										
Task Recruit or contract for PCMH practice certification resources as needed										
Task Assess current state of PCPs engaged in project, including behavioral health service delivery capabilities, work flow, IT infrastructure, interoperability, staffing, etc										
Task Develop best practice policies and procedures, by PCBH										

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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
workgroup to be reviewed by the Quality & Care Innovation Sub-committee (QCIS)										
Task Educate leadership within each organization participating in project of the benefits of co located behavioral health services within a primary care setting.										
Task Perform gap analysis and identify key priorities to successful completion of co-located services.										
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition										
Task Perform gap analysis by practice and identify key priorities										
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.										
Task Develop mechanisms to monitor progress towards completion and sustainability of co-located services, evaluate barriers, and develop mechanisms for continuous quality improvement										
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition										
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed										
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed										
Task Provide support, trainings, resources and education to participating providers as needed to ensure successful completion of co-located and integrated behavioral health services.										
Milestone #2 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 medication management and care engagement processes.										
Task Establish regularly scheduled meetings with vendor and PCBH workgroup to choose evidence based guidelines and protocols including medication management, care engagement and processes for collaborative care meetings.										
Task In collaboration with BPHC Workforce Sub-committee, assign roles and responsibilities for practice specific implementation of evidence based guidelines and protocols and action plans to engage PCPs with behavioral health specialists										
Task Finalize collaborative care practices, reviewed and approved by the QCIS										
Task Assess current participating providers practice models with vendors and PCBH workgroup. The PPS will begin working with approximately 60 sites and their staff, including administrators, providers, and care team staff.										
Task Complete best practice care protocols draft, including those needed for specific conditions, for QCIS review										
Task Finalize PPS wide evidence- based protocols with approval by QCIS										
Task Perform Gap analysis to identify key priorities for participating providers to meet best practice standards										
Task Provide vendor and CSO support as needed for successful implementation of protocols.										
Task Finalize and implement evidence- based practice guidelines										
Task Finalize and implement evidence- based practice guidelines										
Task Develop mechanisms for evaluation, accountability, and continuous quality improvement										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Develop mechanisms for regular review of project-selected Evidence Based Guidelines (by project quality councils) to assure our PPS is utilizing the most up-to-date tools and that those upadated guidelines/protocols continue to be clinically integrated across the PPS										
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.	78	158	318	796	796	796	796	796	796	796
Task Assess participating providers current rates of patient assessments										
Task Educate leadership within each participating organization around benefits of providing preventative care screenings using industry standard questionnaires regularly.										
Task Assess participating providers current process for identifying unmet needs										
Task Finalize draft policies and procedures to facilitate and document behavioral health screenings by PCBH workgroup, and approval by QCIS										
Task Perform gap analysis,including provider capability for documenting screenings in EMR, and identify steps to meet standards.										
Task Provide education/trainings needed to ensure success in conjunction with Workforce Sub-committee										

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

DSRIP Implementation Plan Project

SBH Health System (PPS ID:36)

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 Finalize policy around timely documentation of screenings in the electronic health record.										
Task Develop process to monitor progress towards completing screenings on 90% of patient population using approved screenings										
Task Assess participating providers current procedures for patients who receive a positive screening, as well as for completion of referrals.										
Task Create and Finalize policies on implementing "warm transfers" for patients who have a positive screening.										
Task Provide education/training as needed to ensure successful implementation.										
Task Implement "warm transfer" policies and procedures, as well as instructions on appropriate documentation in the electronic health record.										
Task Monitor success and sustainability of implemented "warm transfer" protocols and engage sites in continuous quality improvement										
Task Monitor success and sustainability of implemented screening protocols										
Task Monitor success with timely and accurate documentation in the electronic health record.										
Task Monitor success towards completion of screenings on 90% of eligible patients engaged in project, engage sites with continuous quality improvement as needed to ensure success.										
Task Provide education and training as needed to achieve goal										
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										

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DSRIP Implementation Plan Project

SBH Health System (PPS ID:36)

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
PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.										
Task Develop a project specific strategy for tracking patient engagement, employing PHM tools and processes outlined below.										
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff										
Task Perform current state assessment of E.H.R. capabilities										
Task Perform gap analysis and identify priories to achieving integration of patient record.										
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)										
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.										
Task Create budget to build registry and acquire necessary resources										
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries										
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data										
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care										
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify										

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SBH Health System (PPS ID:36)

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
targeted patients and track those who are actively engaged for milestone reporting.										
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.										
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.										
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.	78	158	318	796	796	796	796	796	796	796
Task Primary care services are co-located within behavioral Health practices and are available.	78	158	318	796	796	796	796	796	796	796
Task Primary care services are co-located within behavioral Health practices and are available.	19	39	78	195	195	195	195	195	195	195
Task Finalize contract with vendor										
Task Finalize contracts with Behavioral Health and Primary Care Providers engaged in project.										
Task Assess current state, including physical health and behavioral health services , current PCMH level if applicable, IT infrastructure, interoperability, staffing, etc.										
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices										
Task Recruit or contract for PCMH practice certification resources as needed										
Task Educate leadership within each organization participating in project of the benefits of co located primary care services within a behavioral health setting.										
Task										

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SBH Health System (PPS ID:36)

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
Perform gap analysis and identify key priorities to successful completion of co-located services.										
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition										
Task Perform gap analysis by practice and identify key priorities.										
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.										
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition										
Task Develop best practice policies and procedures by PCBH workgroup, send for review and approval by QCIS										
Task Provide support, trainings, resources and education to participating providers as needed to ensure successful completion of co-located and integrated primary care services.										
Task Develop mechanisms to monitor progress towards completion and sustainability of co-located services, evaluate barriers, and develop mechanisms for continuous quality improvement										
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed.										
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.										
Task Assess current state of BH practices engaged in project, including Primary care service delivery capabilities, (e.g.exam room structure) work flow, IT infrastructure, interoperability, staffing, etc.										
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.										

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SBH Health System (PPS ID:36)

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 Assess current participating providers practice models with vendors and PCBH workgroup										
Task In collaboration with BPHC Workforce Sub-committee, assign roles and responsibilities for practice specific implementation of evidence based guidelines and protocols and action plans to engage PCPs with behavioral health specialists										
Task Finalize PPS wide evidence- based protocols with approval by QCIS.										
Task Perform Gap analysis to identify key priorities for participating providers to meet best practice standards.										
Task Finalize and implement evidence- based practice guidelines.										
Task Establish regularly scheduled meetings with vendor and PCBH workgroup to choose evidence based guidelines and protocols including medication management, care engagement and processes for collaborative care meetings.										
Task Finalization of collaborative care practices, reviewed and approved by the QCIS										
Task Complete best practice care protocols draft, including those needed for specific conditions, for QCIS review										
Task Develop mechanisms for evaluation, accountability, and continuous quality improvement										
Task Develop mechanisms for regular review of project-selected Evidence Based Guidelines (by project quality councils) to assure our PPS is utilizing the most up-to-date tools and that those upadated guidelines/protocols continue to be clinically integrated across the PPS.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Provide vendor and CSO support as needed for successful implementation of protocols.										
Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.										
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.										
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	78	158	318	796	796	796	796	796	796	796
Task Educate leadership within each participating organization around benefits of providing preventative care screenings using industry standard questionnaires regularly. Recognize that BH patients with conditions other than depression still require depression screening with industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT. In this colocation model also educate around Primary Care preventive screenings including: age appropriate cancer screenings, alcohol, tobacco and substance use screenings, CVD and DM screenings, vaccinations, etc.										
Task Assess participating providers current process for identifying unmet physical needs of patients, The PPS will begin working with approximately 50 sites and their staff, including administrators, providers, and care team staff.										
Task Develop process to monitor progress towards completing industry standard questionnaires/screening (such as PHQ-2 or 9 for those screening positive, SBIRT) on 90% of patient population.										
Task Assess participating providers' current procedures for patients										

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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
who receive a positive screening, as well as for completion of referrals, and adapt to include screenings performed by PCP.										
Task Finalize draft policies and procedures to facilitate and document behavioral health and primary care screenings by PCBH workgroup, approval by QCIS										
Task Perform gap analysis,including provider capability for documenting screenings in EMR, and identify steps to meet standards.										
Task Finalize policy around timely documentation of screenings in the electronic health record.										
Task Monitor success with timely and accurate documentation in the electronic health record.										
Task Monitor success and sustainability of implemented screening protocols.										
Task Assess participating providers current rates of patient assessments.										
Task Monitor success towards completion of screenings on 90% of patients engaged in project, as needed to ensure success.										
Task Create and Finalize policies on implementing "warm transfers" back to BH specialist for patients who have a positive screening.										
Task Implement "warm transfer" policies and procedures, as well as instructions on appropriate documentation in the electronic health record.										
Task Monitor success and sustainability of implemented "warm transfer" protocols and engage sites in continuous quality improvement										
Task Provide education/training as needed to ensure success in conjunction with Workforce Sub-committee										
Task Provide education and training as needed to achieve goal.										
Task Provide education/training as needed to ensure successful implementation.										

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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 #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 Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.										
Task Develop a project specific strategy for tracking patient engagement, employing PHM tools and processes outlined below.										
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff										
Task Perform current state assessment of E.H.R. capabilities.										
Task Perform gap analysis and identify priories to achieving integration of patient record.										
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)										
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.										
Task Create budget to build registry and acquire necessary resources										
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries										
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data										

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SBH Health System (PPS ID:36)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care										
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.										
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.										
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.										
Milestone #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	78	158	318	796	796	796	796	796	796	796
Task Asses the current state of participating primary care sites, including behavioral health service delivery capabilities, IT infrastructure, staffing, etc.										
Task Educate senior leadership of participating providers regarding IMPACT Model and requirements.										
Task Finalize contracts with providers participating in IMPACT collaborative care model and vendor										
Task Perform gap analysis by practice to identify key changes required for successful transition to an IMPACT collaborative care model incorporating behavioral health.										
Task Finalize and implement strategy for moving provider networks towards an IMPACT Model.										
Task Establish PCBH workgroup to integrate IMPACT model standards into best practice protocol design. Utilize the IMPACT manual.										

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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 Monitor provider transformation sustainability and success with implementation of IMPACT Model through continuous quality improvement										
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 Assess current participating providers practice models with vendors and PCBH workgroup, The PPS will begin working with approximately 75 sites and their staff, including administrators, providers, and care team staff.										
Task Develop best practice care protocols draft, integrating IMPACT model standards into best practice protocol design. Utilize the IMPACT manual.										
Task Finalize PPS wide evidence- based protocols with approval by QCIS										
Task Perform Gap analysis to identify key priorities for participating providers to meeting best practice standards.										
Task Provide support as needed to ensure successful implementation.										
Task Finalize and implement evidence- based practice guidelines.										
Task Monitor success of developed protocols, updates made as needed with approval by QCIS										
Task Assess current participating providers' practice to begin to formulate implementable policies and procedures for psychiatric consultation.										
Task Develop draft evidence-based policies and procedures for consulting with a psychiatrist case review										

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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 Finalize policies, procedures and protocols with approval by the QCIS.										
Task Provide education, training and resources as needed for successful implementation of policies and procedures.										
Task Implement policies, procedures and protocols for successful consultation with psychiatrist.										
Task Monitor success of developed policies, procedures and protocol, as well as sustainability for consulting with psychiatrist.										
Task Establish mechanisms for continuous quality improvement										
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 Determine the type of DCM needed for each participating provider to meet the DCM role requirements, in conjunction with Workforce Sub-Committee, .										
Task Update policies, protocols, procedures, and organizational structure as necessary to implement and/or formally create the role of DCM with Workforce Sub-committee										
Task Finalize the formal hiring and creation of DCM role with Workforce Sub-committee										
Task Ensure that this staff member is identified as such in the Electronic Health Record (E.H.R.).										
Task Establish requirements of IMPACT Model DCM role by PCBH workgroup and approval by QCIS										

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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 Perform gap analysis to identify key priorities for participating providers to be successful with implementation of the role for the DCM with the IMPACT model with Workforce Sub-committee										
Task Create/provide training protocols and procedures for DCM role to ensure they are proficient in all required IMPACT interventions										
Task Implement IMPACT model policies, procedures and protocols.										
Task Provide resources, training, education as needed, assuring that DCM meets role requirements according to the IMPACT model.										
Task Continuously monitor and re-evaluate the effectiveness of the individual/individuals in the DCM position to ensure that the requirements of IMPACT model continue to be met into the future.										
Task Establish continuous quality improvement. Develop mechanisms for evaluation, accountability, and continuous quality improvement										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Task Draft policies and procedures regarding the psychiatrists' responsibilities around treatment and follow-up care with patients.										
Task Finalize job-related policies and procedures regarding psychiatrists' responsibilities for approval by QCIS										
Task Provide assistance with resources for hiring designated psychiatrists, as needed.										
Task Develop mechanisms for evaluation, accountability, and continuous quality improvement										
Task Provide training of designated psychiatrists to ensure they are able to adequately perform the requirements of the position										
Task										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Provide training for IMPACT collaborative care teams, including collaborative care case consultation										
Task Provide training for care teams on IMPACT model and designated psychiatrist's role.										
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 Assess participating providers current rates of patient assessments.										
Task Provide education and training as needed to achieve goal.										
Task Develop process to monitor, via EHRs/RHIO/CCMS, progress towards completing screenings on 90% of patient population using approved screenings										
Task Monitor success towards completion of screenings on 90% of patients engaged in project, engage sites with continuous quality improvement as needed to ensure success.										
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 Draft protocols to adjust treatment according to evidence-based algorithm if a patient is not improving, within 10-12 weeks of the start of the treatment plan. Align with IMPACT model.										
Task Evidence Based Protocols for stepped care, as aligned with IMPACT model, are approved by QCIS										
Task Implement IMPACT model aligned protocols related to stepped care across practices using the IMPACT model										
Task Develop mechanisms for evaluating successful stepped care, accountability, and continuous quality improvement										

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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 #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 Develop a project specific strategy for tracking patient engagement, employing PHM tools and processes outlined below.										
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff										
Task Perform current state assessment of E.H.R. capabilities.										
Task Perform gap analysis and identify priories to achieving integration of patient record.										
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.										
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)										
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.										
Task Create budget to build registry and acquire necessary resources										
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries										
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care										
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.										
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.										
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, with an emphasis on tracking patient engagement with primary care.										

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.	CSO Staff, along with its vendor, Institute for Family Health, have been conducting outreach and technical assistance needs assessments to determine which providers are interested and eligible to participate in this project, including PCMH readiness. Most sites participating in this project, per PCMH gap analysis as described in task 1.6 and 1.7, are on track for 2014 PCMH recognition. This milestone is on track for completion. The CSO is executing a comprehensive plan to support our safety net providers in MU and PCMH which includes EHR support and connectivity of data captured therein. A process has been started to ensure all applicable providers meet PCMH and MU accreditation where possible and that we meet our obligation to the previously agreed tasks. Consultants have been deployed to perform detailed Gap Analysis with about 100 practices, with 60 locations already evaluated thus far. 13 practices have already submitted their PCMH 2014 attestations, with twelve achieving level 3 and one still pending NCQA ruling. Contracting is currently ongoing and is in various stages, with six consulting groups, for the work on the remaining practices. These six consulting groups are part of a Community of Practice we are organizing to share and collaborate on PCMH transformation and possibly other population health initiatives. Milestone is on track for completion.
Develop collaborative evidence-based standards of care including medication management and care engagement process.	The Clinical Operations Plans outlining policies and procedures for effective implementation of PCBH co-location have been created and finalized by the CSO and the vendor. As outlined in task 2.3, the implementation workgroup (IWG) has met and will convene approximately bi-monthly going forward in Q4. The

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	next meeting will be held in February, members will review elements of the Clinical Operations Plan (Care Planning & Coordination; Evidence-based Guidelines; staffing plans; and Stepped Care) for PCBH. The IWG will meet bi-monthly to discuss and recommend strategies for standards of care. This milestone is on track for completion.
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.	Onsite technical needs assistant visits have begun as of October 2015. These visits allow the CSO staff and vendor to identify key areas of technical assistance for each site. Patient flows and current EHR practices are being examined. Individualized, site-specific technical assistance and training plans are being developed to many implementation topics, including preventive screenings. Task 3.5 has been completed for many participating providers (Assess rates of patient assessment) through these TA needs assessments. The remainder of site assessments will be completed in Q4, as more sites are interested in participating as they are becoming more engaged in DSRIP and our PPS. This milestone is on track for completion.
Use EHRs or other technical platforms to track all patients engaged in this project.	We are executing a comprehensive plan to support our safety net providers in MU and PCMH which includes EHR support and connectivity of data captured therein. Our agreement with Bronx RHIO will serve as the foundation to achieve next quarter's tasks and those of the future to support this Milestone. This agreement is very close to being signed. We also have a strategy around funding for the adoption of the HIE by safety net providers, informed by an analysis of EMR and QE implementation and use by member organizations. Registry elements were approved by the Quality and Care Innovations Subcommittee. The IT Subcommittee reviewed the registry strategy but approval from this subcommittee of the registry elements was determined to be unnecessary and less meaningful than originally determined, given the clinical expertise required that the IT Subcommittee does not offer. It was further determined that the Executive Committee would not need to approve this level of detail in the PHM strategy, give that its Clinical Committee had already conducted a thorough review and approval process. Milestone is on track for completion.
Co-locate primary care services at behavioral health sites.	CSO Staff, along with its vendor, Institute for Family Health, have been conducting outreach and technical assistance needs assessments to determine which providers are interested and eligible to participate in this project. Further outreach is being conducted to engage a sufficient number of behavioral health providers. This milestone is on track for completion.
Develop collaborative evidence-based standards of care including medication management and care engagement process.	The Clinical Operations Plans outlining policies and procedures for effective implementation of PCBH co-location have been created and finalized by the CSO and the vendor. The next step will be to vet the documents and related attachments through the PCBH IWG (Care Planning & Coordination; Evidence-based Guidelines; staffing plans; and Stepped Care). The IWG will meet bi-monthly to discuss and recommend strategies for standards of care. This milestone is on track for completion.
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.	Onsite technical needs assistant visits have begun as of October 2015. These visits allow the CSO staff and vendor to identify key areas of technical assistance for each site. Patient flows and current EHR practices are being examined. Individualized, site-specific technical assistance and training plans are being developed to many implementation topics, including preventive screenings. This milestone is on track for completion.
Use EHRs or other technical platforms to track all patients engaged in this project.	We are executing a comprehensive plan to support our safety net providers in MU and PCMH which includes EHR support and connectivity of data captured therein. Our agreement with Bronx RHIO will serve as the foundation to achieve next quarter's tasks and those of the future to support this Milestone. This agreement is very close to being signed. We also have a strategy around funding for the adoption of the HIE by safety net providers, informed by an analysis of EMR and QE implementation and use by member organizations. Registry elements were approved by the Quality and Care Innovations Subcommittee. The IT Subcommittee reviewed the registry strategy but approval from this subcommittee of the registry elements was determined to be unnecessary and less meaningful than originally determined, given the clinical expertise required that the IT Subcommittee does not offer. It was further determined that the Executive Committee would not need to approve this level of detail in the PHM strategy, give that its Clinical Committee had already conducted a thorough review and approval process. Milestone is on track for completion.
Implement IMPACT Model at Primary Care Sites.	CSO Staff, along with the vendor, Institute for Family Health, have begun conducting technical assistance needs assessments at individual sites to determine which providers are interested and eligible to participate in this project, including PCMH readiness. During site visits, CSO staff and the vendor, IFH, are encouraging organizations to also adopt IMPACT, as it is complementary to both Model 1 and PCMH implementation. This milestone is on track for

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	completion.
Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	The Clinical Operations Plans outlining policies and procedures for effective implementation of the IMPACT model have been created and finalized by the CSO and the vendor. The next step will be to vet the documents and related attachments through the PCBH Implementation Work Group (IWG). The IWG will meet bi-monthly to discuss and recommend strategies for standards of care. This milestone is on track for completion.
Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	The CSO recently solicited funding needs through a Request for Information (RFI) to our partners who have signed MSAs with us, the results of which are being decided this month. Staffing needs were addressed through this process and allocations of funds to cover the initial hiring. Resources are being identified to develop trainings for DCM's. The DCM role has been defined in the Clinical Operations Plans, which will be vetted by the IWG. This milestone is on track for completion.
Designate a Psychiatrist meeting requirements of the IMPACT Model.	The role of the psychiatrist has been defined in the COPs and will be vetted with the PCBH IWG. The IMPACT requirements for a consulting psychiatrist were obtained from the AIMS Center at the University of Washington. The RFI process helped to identify gaps in staffing for participating organizations. This milestone is on track for completion.
Measure outcomes as required in the IMPACT Model.	The individual TA Needs Assessments currently being conducted include questions on current screening practices. Clinical Operations Plans provide information on the type of care to be provided, staffing roles, and data collection protocol as required for implementation of the IMPACT model. CSO staff are working closely with DSRIP Program Directors, who are seated at the largest PPS member organizations, to create strategies for tracking important data via EHR's. This information will provide a baseline for current screening rates and use of stepped care. Screening rates will continue to be monitored through the EHRs. The depression registry will monitor the depression care status, screening, and improvement rates. This will also include integration of patient records between the PCP and BH providers. This milestone is on track for completion.
Provide "stepped care" as required by the IMPACT Model.	The COPs include evidence-based guidance on stepped care for institutions implementing IMPACT. The needs assessment and gap analysis will inform the type of technical assistance and training that are needed by each organization. Stepped care guidance was obtained through the AIMS Center at the University of Washington. This milestone is on track for completion.
Use EHRs or other technical platforms to track all patients engaged in this project.	We are executing a comprehensive plan to support our safety net providers in MU and PCMH which includes EHR support and connectivity of data captured therein. Our agreement with Bronx RHIO will serve as the foundation to achieve next quarter's tasks and those of the future to support this Milestone. This agreement is very close to being signed. We also have a strategy around funding for the adoption of the HIE by safety net providers, informed by an analysis of EMR and QE implementation and use by member organizations. Registry elements were approved by the Quality and Care Innovations Subcommittee. The IT Subcommittee reviewed the registry strategy but approval from this subcommittee of the registry elements was determined to be unnecessary and less meaningful than originally determined, given the clinical expertise required that the IT Subcommittee does not offer. It was further determined that the Executive Committee would not need to approve this level of detail in the PHM strategy, give that its Clinical Committee had already conducted a thorough review and approval process. Milestone is on track for completion.

Milestone Review Status

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

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Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

As we begin implementation, some practitioners may resist the imposition of standard treatment protocols and new workflows. To mitigate this risk, we have brought together stakeholders to develop clinical operation plans (COPs) for all of the projects. These include evidence-based (EB) guidelines protocols for each disease-specific intervention. Implementation of these protocols will be part of contractual agreements between partners & the PPS. These COPs have been designed to align with 2014 PCMH Level 3 recognition. The CSO has committed to providing technical and financial assistance, including IT support & training, to primary care practices as they work to attain PCMH Level 3 recognition. This includes resources toward project management staff at the participating organizations, and for PCMH "coaches."
Physicians & other PCMH care team members may not currently document self-management goals in the medical record as required, &/or they may be resistant to conducting additional documentation efforts. To address this risk, BPHC is working with our partners to update their respective EHRs to better capture this information consistently. In addition, the CSO may audit medical records to ensure that documentation is occurring.
As we begin building our care teams, recruiting and training sufficient care management staff to serve the needs of the Bronx population may be challenging. Recruiting Spanish-speaking care management staff will be a particular risk. BPHC's workforce strategy will be targeted towards mitigating this risk, such as through the CSO working with community colleges & coordinating with the 1199 Job Security Fund, Montefiore CMO, & NYSNA to identify capable workers & provide training in Spanish when needed. BPHC will also use alternative employment tactics, such as flexible hours, & job sharing, where feasible to attract a broader pool of workers.
Medication adherence is a chronic problem for individuals with chronic illness including those with CVD. Organizations that could be instrumental in helping patients with medication adherence, such as home care agencies & MCOs are handicapped by policies &/or regulations. To mitigate these risks, BPHC will work with MCOs to institute policy changes that will promote medication adherence.
Enhancing patient self-management & self-efficacy is anticipated to be a particular risk to the success of Project 3.b.i. It is challenging to effectively motivate & engage chronically ill patients to embrace changes in behavior & self-manage their condition. Many patients do not grasp the effects of cardiovascular disease & unmanaged hypertension, risks that are compounded in the Bronx population by low health literacy & educational attainment. To mitigate this risk BPHC will engage Health People, a Bronx-based CBO that provides EB education, to expand its own capacity to deploy the peer-based Stanford Model & to train other PPS members on the model to disseminate it broadly.
Providers may not implement EHR systems that meet MU & PCMH Level 3 standards, interoperability challenges may present &/or providers may resist participating in the IDS. BPHC will use gap analysis to develop a program to monitor & deploy assistance to providers at risk, support practices by deploying internal community, external consulting resources and provide customized technical assistance, coaching, & training modules.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	30,800

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
0	4,122	53.53%	3,578	13.38%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (7,700)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
zstopak	Baseline or Performance Documentation	36_PMDL4215_1_3_20160202143101_BPHC-PATIENTLIST-3bi-Q3.xlsx	3.b.i Patient Engagement DY1 Q3	02/02/2016 02:31 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Project		In Progress	06/30/2015	03/31/2018	06/30/2015	03/31/2018	03/31/2018	DY3 Q4
Task Create a Transitional Work Group (CVD/DM TWG) comprised of representatives from partner organizations to support development of and approve elements of the COP	Project		Completed	04/01/2015	06/01/2015	04/01/2015	06/01/2015	06/30/2015	DY1 Q1
Task Identify DSRIP project requirements which are related to PCMH elements and incorporate into PCMH strategy and project planning documents	Project		Completed	05/15/2015	09/30/2015	05/15/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify relevant evidence-based guidelines for HTN and hyperlipidemia in conjunction with the CVD/DM TWG	Project		Completed	05/04/2015	09/30/2015	05/04/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify patient criteria for smoking cessation interventions (counsel to quit, smoking cessation medication, non-medication smoking cessation strategy)	Project		Completed	06/11/2015	09/30/2015	06/11/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify partner organizations participating in project (sites and CBOs)	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop a workplan and timeline to develop the clinical operations plan (COPs) and implement a strategy for the CV population that aligns with the patient engagement speed and scale application submission	Project		Completed	04/01/2015	10/31/2015	04/01/2015	10/31/2015	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 Develop the COP to define the program elements, define the required and suggested components of those elements, and identify relevant resources to achieve them. Elements include health information exchange and technology requirements, and evidence-based guidelines and high-value treatment protocols	Project		Completed	05/04/2015	10/31/2015	05/04/2015	10/31/2015	12/31/2015	DY1 Q3
Task Develop the project implementation budget	Project		Completed	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Design training and recruitment strategy in conjunction with workforce team and CVD/DM TWG	Project		In Progress	07/28/2015	03/31/2016	07/28/2015	03/31/2016	03/31/2016	DY1 Q4
Task Submit elements of the COP to Quality and Care Innovation Sub-Committee (QCIS) for approval	Project		Completed	07/23/2015	10/31/2015	07/23/2015	10/31/2015	12/31/2015	DY1 Q3
Task Identify clinical champions and operational leaders in each participating organization to develop and lead implementation of the program at each of their providers/sites. These facility-based champions/leaders form the Site-Specific Implementation Team	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Prepare/disseminate gap analysis tool based on COP to participating providers to determine implementaton support needs	Project		Not Started	01/15/2016	06/30/2016	01/15/2016	06/30/2016	06/30/2016	DY2 Q1
Task Hold webinar for participating partner organizations	Project		Not Started	01/15/2016	03/31/2016	01/15/2016	03/31/2016	03/31/2016	DY1 Q4
Task Create rapid deployment collaborative, comprised of representatives from partner organizations to support implementation of the COP. This group replaces the TWG and will be the implementation work group.	Project		In Progress	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop mechanisms for regular review of project-selected evidence-based guidelines (EBGs) by implementation work group to assure our PPS is utilizing the most up-to-date tools and that those upadated guidelines/protocols continue to be clinically integrated across the PPS	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information	Project	N/A	In Progress	06/30/2015	03/31/2018	06/30/2015	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
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.	Provider	Safety Net 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 EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Mental Health	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.	Project		In Progress	09/30/2015	03/31/2018	09/30/2015	03/31/2018	03/31/2018	DY3 Q4
Task Identify safety net provider data sharing requirements and assess partner and QE data sharing capabilities and current HIE participation	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Coordinate with Bronx RHIO to develop comprehensive HIE adoption program to encourage and support partner participation and integration	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Begin coordinated interface and service development with Bronx RHIO, including connectivity to the SHIN-NY.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish BPHC program to manage support for safety net providers to ensure that all are actively sharing health information, coordinating with Bronx RHIO to encourage, track and support partner participation and integration/data sharing	Project		Not Started	03/01/2016	04/25/2016	03/01/2016	04/25/2016	06/30/2016	DY2 Q1
Task Track status and manage support to ensure that all PPS safety net providers are actively sharing health information through Bronx RHIO or alternative health information exchange	Project		Not Started	03/01/2016	03/31/2018	03/01/2016	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	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Project		Not Started	01/01/2018	03/31/2018	01/01/2018	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	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Assess eligible participating partner EHR use relative to Meaningful Use and PCMH 2014 Level 3 standards	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish BPHC program to educate, encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, including potential use of incentive-based payments for implementation	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Recruit or contract for EHR implementation resources as needed	Project		In Progress	11/01/2015	06/30/2016	11/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner EHR implementation and progress towards Meaningful Use and PCMH standards	Project		Not Started	08/01/2016	12/31/2016	08/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Track status and manage support to ensure all eligible safety net providers are using certified EHR systems that meet Meaningful Use and PCMH 2014 Level 3 standards	Project		In Progress	10/15/2015	03/15/2018	10/15/2015	03/15/2018	03/31/2018	DY3 Q4
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recruit or contract for PCMH practice certification resources as needed	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition	Project		In Progress	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task	Project		In Progress	10/01/2015	04/15/2016	10/01/2015	04/15/2016	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
Perform gap analysis by practice and identify key priorities.									
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.	Project		In Progress	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition	Project		Not Started	01/01/2016	11/30/2016	01/01/2016	11/30/2016	12/31/2016	DY2 Q3
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	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	06/30/2015	03/31/2017	06/30/2015	03/31/2017	03/31/2017	DY2 Q4
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform gap analysis and identify priories to achieving integration of patient record.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.	Project		Completed	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task	Project		Not Started	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
Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.									
Task Create budget to build registry and acquire necessary resources	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
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	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate tobacco control protocols.	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify/establish the protocols for the 5A's of tobacco control and services/programs to incorporate into COP	Project		Completed	07/01/2015	03/31/2016	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify/develop member educational material and smoking cessation support tools for inclusion in COP	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Survey participants to determine capability of sites' EHR systems for providing point of care reminders	Project		Not Started	05/01/2016	09/30/2016	05/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Site-Specific Implementation Teams work with their IT teams to implement point-of-care prompts to facilitate tobacco control protocols into EHR workflows, including documentation	Project		Not Started	05/01/2016	03/31/2017	05/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Site-specific Implementation Teams establish and map interim manual processes to fulfill protocols in COP	Project		Not Started	05/01/2016	09/30/2016	05/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Establish the schedule and materials for periodic staff training to incorporate the use of the EHR to prompt the use of 5 A's of tobacco control.	Project		Not Started	08/01/2016	03/31/2017	08/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provide guidance for ongoing assesment to ensure that practices are following training requirements and protocols	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop feedback mechansims for accountability and continuous quality improvement	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	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	05/04/2015	03/31/2017	05/04/2015	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	06/30/2015	03/31/2017	06/30/2015	03/31/2017	03/31/2017	DY2 Q4
Task Define target population, select EBGs for target population and present recommmendation to Quality & Care Innovation Sub-	Project		Completed	05/04/2015	12/31/2015	05/04/2015	12/31/2015	12/31/2015	DY1 Q3

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Committee (QCIS)									
Task QCIS reviews and recommends EBGs for adoption and implementation across the PPS	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develops educational materials suitable to the needs, culture and language of the target populations in conjunction with select CBOs, PCPs, and SMEs	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Present educational materials to QCIS for review	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Identify clinical champions to drive adoption of guidelines	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Implement EBG and educational material dissemination plan across the PPS with support of RDC and site-specific implementation teams	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	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	06/30/2015	03/31/2017	06/30/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	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	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination processes are in place.	Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinate across project specific workgroups to establish the care management model/organizational structure and processes most appropriate for achieving project outcomes; include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers	Project		Completed	06/30/2015	10/31/2015	06/30/2015	10/31/2015	12/31/2015	DY1 Q3
Task Present care management model to QCIS for review and	Project		Completed	06/30/2015	10/31/2015	06/30/2015	10/31/2015	12/31/2015	DY1 Q3

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approval									
Task Working with Workforce Subcommittee, design training and recruitment strategy for care managers and care teams	Project		In Progress	06/30/2015	10/31/2015	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Begin to recruit, hire and train new and existing staff as needed.	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Site-specific implementation teams, with support from CSO and in coordination with PCMH work, establish care coordination team and implement care coordination processes (e.g., community service/program referrals and tracking, communication, PCP alerts, education materials, coordination among team members, frequency and purpose of patient contact.) Ensure these include coordination with the Health Home care manager, where applicable.	Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Develop a mechanism to gather feedback and share best practices	Project		In Progress	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task Provide guidance for ongoing assesment to ensure that practices are following requirements and protocols	Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify and document required clinical and care management protocols for priority programs, projects and interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data	Project		Completed	08/15/2015	10/15/2015	08/15/2015	10/15/2015	12/31/2015	DY1 Q3
Task Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations for how interventions will be logged, tracked and reported.	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Deploy systems to improve and promote effective care transitions	Project		Not Started	01/15/2016	02/28/2016	01/15/2016	02/28/2016	03/31/2016	DY1 Q4
Task Operationalize partner and workforce roles by providing gap analysis and appropriate training.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task	Project		Not Started	02/01/2016	06/15/2016	02/01/2016	06/15/2016	06/30/2016	DY2 Q1

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Establish data collection, survey and reporting mechanisms to enable BPHC monitoring to ensure that patients are receiving appropriate health care and community support in priority projects, based on needs identified in prior planning activities									
Task Review process for rapid cycle evaluation and continuous improvement of data collection, survey and reporting methods based on priority project experience and modify process as needed to ensure patients receive appropriate health care and community support	Project		Not Started	08/01/2016	09/01/2016	08/01/2016	09/01/2016	09/30/2016	DY2 Q2
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	Project	N/A	In Progress	05/19/2015	03/31/2019	05/19/2015	03/31/2019	03/31/2019	DY4 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	12/31/2015	03/31/2019	12/31/2015	03/31/2019	03/31/2019	DY4 Q4
Task Review Million Hearts resources and other relevant literature related to implementation of similar programs and identify documents most relevant for PPS, including strategies to ensure that Medicaid patients are not charged a co-pay for blood pressure checks	Project		In Progress	05/19/2015	03/31/2016	05/19/2015	03/31/2016	03/31/2016	DY1 Q4
Task Conduct research into current coverage for such visits by Medicaid and coding for non-billable visits, etc.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Conduct gap analysis to assess resources required to meet this requirement	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Meet with other PPSs to consider lobbying MCOs to cover such visit copays (make providers whole)	Project		In Progress	10/15/2015	03/31/2019	10/15/2015	03/31/2019	03/31/2019	DY4 Q4
Task Conduct periodic meetings/learning collaboratives with PCP practice partners to gather feedback and share best practices	Project		Not Started	09/30/2016	03/31/2019	09/30/2016	03/31/2019	03/31/2019	DY4 Q4
Task Provide guidance for ongoing assesment to ensure that practices are providing access for such visits	Project		Not Started	09/30/2016	03/31/2019	09/30/2016	03/31/2019	03/31/2019	DY4 Q4
Task Develop feedback mechansims for accountability and continuous	Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4

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
quality improvement									
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	06/30/2015	03/31/2017	06/30/2015	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	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task In conjunction with Workforce Subcommittee, identify relevant training resources and nursing competencies to create protocols (standardized across PPS) for inclusion in the COP	Project		In Progress	07/28/2015	03/31/2016	07/28/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify site-specific staff members responsible for BP measurement training and documenting training has occurred	Project		In Progress	10/15/2015	03/31/2016	10/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Provide guidance for ongoing assesment of staff competencies to ensure that practices are following training requirements and protocols	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop feedback mechansims for accountability and continuous quality improvement	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	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	07/07/2015	03/31/2017	07/07/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Using EBGs identified in the COP, determine blood pressure program parameters and stratification levels for identification,	Project		In Progress	07/07/2015	06/30/2016	07/07/2015	06/30/2016	06/30/2016	DY2 Q1

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enrollment and hypertension visit frequency									
Task Establish processes to use registry (see requirement 4), to reach out to patients and establish the process and person responsible for staff training on such processes.	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Support site-specific implementation teams to ensure that scheduling resources/technology fulfills project requirements.	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Conduct periodic meetings/learning collaboratives with PCP practice partners to gather feedback and share best practices	Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provide guidance for ongoing assesment of competencies to ensure that practices are following training requirements and protocols	Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop feedback mechansims for accountability and continuous quality improvement	Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Determine criteria/limitations for use of once-daily and single dose medication regimens based on feedback from partners, review of MCO formularies and review of clinicial literature; include recommendations in COP	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Determine current status of the above regimens in payor and provider formularies, ease of prescribing in various EHRs	Project		In Progress	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish protocols for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors for inclusion in COP	Project		In Progress	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop mechanisms for regular review of medication	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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recommondations to assure our PPS is utilizing the most up-to-date tools and that any updated guidelines/protocols continue to be clinically integrated across the PPS									
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	Project	N/A	In Progress	05/04/2015	03/31/2017	05/04/2015	03/31/2017	03/31/2017	DY2 Q4
Task Self-management goals are documented in the clinical record.	Project		In Progress	06/30/2015	03/31/2017	06/30/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.	Project		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify best practices for identification and follow-up of self-management goals into COP	Project		Completed	05/04/2015	12/31/2015	05/04/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify relevant training resources /competencies in conjuction with workforce subcommittee	Project		Completed	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish plan to integrate self-management goals into the EHR with interim manual processes as needed	Project		In Progress	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish requirements and processes to ensure documentation of the goals	Project		Not Started	04/01/2016	03/31/2017	01/15/2016	03/31/2017	03/31/2017	DY2 Q4
Task Establish the schedule and materials for periodic staff training on person-centered methods that include documentation of self-management goals	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provide guidance for ongoing assesment of competencies to ensure that practices are following training requirements and protocols	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop feedback mechansims for accountability, and continuous quality improvement, including assessment of patient adherence to self-management plan and opportunities to increase adherence.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status	Project	N/A	In Progress	05/15/2015	03/31/2017	05/15/2015	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
changes.									
Task PPS has developed referral and follow-up process and adheres to process.	Project		In Progress	06/30/2015	03/31/2017	06/30/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff on warm referral and follow-up process.	Project		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.	Project		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Define processes for referral, and access to information among providers, and feedback processes to the practices electronically with interim manual processes as needed in conjunction with IT subcommittee	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish and document referral and follow-up procedures for the sites, with a mechanism for sites to audit adherence	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify community organizations for inclusion in the initial iteration of the Community Resource Database, sign agreements with with community based organizations and establish process to facilitate feedback to and from community organizations	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Perform regular checks of Community Resource Database to ensure data is up to date and accurate and to identify additional resources to consider including	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Establish the schedule and materials for periodic staff training on the warm transfer and referral tracking	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	Project	N/A	In Progress	06/11/2015	03/31/2017	06/11/2015	03/31/2017	03/31/2017	DY2 Q4
Task	Project		In Progress	06/30/2015	03/31/2017	06/30/2015	03/31/2017	03/31/2017	DY2 Q4

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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.	Project		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff on warm referral and follow-up process.	Project		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify minimal and recommended SBPM protocols needed to satisfy project requirements, including identification of patients' needs and linkage to support	Project		Completed	06/11/2015	03/31/2016	06/11/2015	12/18/2015	12/31/2015	DY1 Q3
Task Conduct gap analysis with partners to identify implementation support needs	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Individual sites adopt protocols for at-home BP monitoring	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Identify staff member(s) at each site responsible for training patients in self-blood pressure monitoring, including equipment evaluation	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Establish workflow at each site to address patient-reported BP values that are out of range, including how are values reported and staff member(s) responsible for following up	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Conduct webinars/conference calls to ensure that all practices have protocols in place and are adhering to them	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Define training requirements in conjuction with Workforce Subcommittee	Project		In Progress	07/28/2015	09/30/2016	07/28/2015	09/30/2016	09/30/2016	DY2 Q2
Task Identify nursing competencies and training resources to support SBPM in conjuction with Workforce Subcommittee	Project		In Progress	08/15/2015	09/30/2016	08/15/2015	09/30/2016	09/30/2016	DY2 Q2
Task Create patient communication materials in coordination with the Cultural Competency/Health Literacy orkstream	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices									
Task Establish schedule and materials for periodic staff training on the warm transfer and referral follow-up process	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop feedback mechansims for accountability and continuous quality improvement	Project		Not Started	09/30/2016	03/31/2017	09/30/2016	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	Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Using EBGs identified in the COP, determine parameters for patient stratification, identification, and hypertension visit frequency	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Establish processes to use registry (see requirement 4), to reach out to patients and establish processes and person responbile for staff training on such processes.	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Support site-specific implementation teams to ensure that scheduling resources/technology fulfills projecct requirements.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Conduct periodic meetings/learning collaboratives with sites to gather feedback and share best practices	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provide guidance for ongoing assesment of competencies to ensure that sites are following training requirements and protocols	Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop feedback mechansims for accountability and continuous quality improvement	Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	Project	N/A	In Progress	07/07/2015	03/31/2017	07/07/2015	03/31/2017	03/31/2017	DY2 Q4
Task	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4

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DSRIP Implementation Plan Project

SBH Health System (PPS ID:36)

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 has developed referral and follow-up process and adheres to process.									
Task Define criteria for referral to Quitline	Project		Completed	07/07/2015	12/31/2015	07/07/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish and document process for referral to Quitline and patient follow-up	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Create culturally-competent communication materials at appropriate health literacy levels materials with the Quitline telephone number and website	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop feedback mechansims for accountability and continuous quality improvement	Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	Project	N/A	In Progress	12/31/2015	03/31/2020	12/31/2015	03/31/2020	03/31/2020	DY5 Q4
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.	Project		Not Started	06/30/2017	03/31/2020	06/30/2017	03/31/2020	03/31/2020	DY5 Q4
Task If applicable, PPS has established linkages to health homes for targeted patient populations.	Project		In Progress	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.	Project		Not Started	07/01/2016	09/30/2017	01/15/2016	09/30/2017	09/30/2017	DY3 Q2
Task Using claims data to identify "hotspot" areas/patient groups for outreach	Project		Not Started	07/01/2016	03/31/2020	07/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task Identify and mitigate service shortages to address these "hotspots" which can include mobile services and use of churches and community centers for education and blood pressure screening.	Project		Not Started	09/30/2017	03/31/2018	09/30/2017	03/31/2018	03/31/2018	DY3 Q4

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Task Implement 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, if feasible.	Project		Not Started	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Establish linkages to health homes for targeted patient populations	Project		Not Started	07/01/2016	06/30/2017	07/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task Implement the Stanford Model through partnerships with community based organizations, including Health People	Project		Not Started	07/01/2016	03/31/2020	07/01/2016	03/31/2020	03/31/2020	DY5 Q4
Milestone #18 Adopt strategies from the Million Hearts Campaign.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Practitioner - Primary Care Provider (PCP)	Not Started	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Practitioner - Non-Primary Care Provider (PCP)	Not Started	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Mental Health	Not Started	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify relevant resources and protocols earmarked as useful by Million Hearts to incorporate into COP, including noting relevance by provider type (PCP, non-PCP and behavioral health providers)	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify relevant patient tools for inclusion in COP	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Review Action Guide related to HTN and SBPM and incorporate into guidelines/protocols in COP	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify clinical champions from the Site-Specific Implementation Team in each participating organization (PCP, non-PCP and behavioral health providers) to drive adoption of	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Million Hearts strategies and materials identified in COP									
Task Develop mechanisms for regular review of Million Hearts resources to assure our PPS is utilizing the most up-to-date tools and that any updates are clinically integrated across the PPS.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	Project	N/A	In Progress	07/01/2015	03/31/2020	07/01/2015	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		Not Started	06/30/2016	03/31/2020	06/30/2016	03/31/2020	03/31/2020	DY5 Q4
Task Identify current tools and services available to members for relevant MCOs across the PPS, including telehealth, care management, and stipends for completing recommended preventive screenings.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Distribute materials regarding extant services and benefits available to members to providers participting in project	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Build prompts to these tools and services into provider EHRs	Project		Not Started	04/01/2017	03/31/2020	04/01/2017	03/31/2020	03/31/2020	DY5 Q4
Task Where feasible, make agreements with MCO related to coordination of services for high risk populations, including smoking cessation services, weight management, and other preventive services relevant to this project.	Project		Not Started	04/01/2017	03/31/2018	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task Communicate payor information and include information on availability/how to access in training programs	Project		Not Started	04/01/2017	03/31/2018	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has engaged at least 80% of their PCPs in this activity.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify sites participating in project	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)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Ensure that all participating practices have signed MSA	Project		In Progress	09/30/2015	03/31/2016	09/30/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify opportunities to coordinate processes, education and communication including incorporation of increased blood pressure identification for screening checks into PCMH workflow processes.	Project		In Progress	05/15/2015	03/31/2016	05/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Ensure that hypertension program training is incoporated/included in other care coordination training sessions.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Monitor activity/engagement and make periodic reports to QCIS / EC	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop feedback mechansims for accountability and continuous quality improvement for Site-Specific Implementation Teams.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 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 Create a Transitional Work Group (CVD/DM TWG) comprised of representatives from partner organizations to support development of and approve elements of the COP										
Task Identify DSRIP project requirements which are related to PCMH elements and incorporate into PCMH strategy and project planning documents										
Task Identify relevant evidence-based guidelines for HTN and hyperlipidemia in conjunction with the CVD/DM TWG										

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Task Identify patient criteria for smoking cessation interventions (counsel to quit, smoking cessation medication, non-medication smoking cessation strategy)										
Task Identify partner organizations participating in project (sites and CBOs)										
Task Develop a workplan and timeline to develop the clinical operations plan (COPs) and implement a strategy for the CV population that aligns with the patient engagement speed and scale application submission										
Task Develop the COP to define the program elements, define the required and suggested components of those elements, and identify relevant resources to achieve them. Elements include health information exchange and technology requirements, and evidence-based guidelines and high-value treatment protocols										
Task Develop the project implementation budget										
Task Design training and recruitment strategy in conjunction with workforce team and CVD/DM TWG										
Task Submit elements of the COP to Quality and Care Innovation Sub-Committee (QCIS) for approval										
Task Identify clinical champions and operational leaders in each participating organization to develop and lead implementation of the program at each of their providers/sites. These facility-based champions/leaders form the Site-Specific Implementation Team										
Task Prepare/disseminate gap analysis tool based on COP to participating providers to determine implementaton support needs										
Task Hold webinar for participating partner organizations										
Task Create rapid deployment collaborative, comprised of representatives from partner organizations to support implementation of the COP. This group replaces the TWG and will be the implementation work group.										
Task Develop mechanisms for regular review of project-selected evidence-based guidelines (EBGs) by implementation work										

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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
group to assure our PPS is utilizing the most up-to-date tools and that those upadated guidelines/protocols continue to be clinically integrated across the PPS										
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	180	543
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task PPS uses alerts and secure messaging functionality.										
Task Identify safety net provider data sharing requirements and assess partner and QE data sharing capabilities and current HIE participation										
Task Coordinate with Bronx RHIO to develop comprehensive HIE adoption program to encourage and support partner participation and integration										
Task Begin coordinated interface and service development with Bronx RHIO, including connectivity to the SHIN-NY.										
Task Establish BPHC program to manage support for safety net providers to ensure that all are actively sharing health information, coordinating with Bronx RHIO to encourage, track and support partner participation and integration/data sharing										
Task Track status and manage support to ensure that all PPS safety net providers are actively sharing health information through Bronx RHIO or alternative health information exchange										
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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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 Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	0	0	0	0	0	0	0	0	0
Task Assess eligible participating partner EHR use relative to Meaningful Use and PCMH 2014 Level 3 standards										
Task Establish BPHC program to educate, encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, including potential use of incentive-based payments for implementation										
Task Recruit or contract for EHR implementation resources as needed										
Task Begin actively encouraging, tracking and supporting partner EHR implementation and progress towards Meaningful Use and PCMH standards										
Task Track status and manage support to ensure all eligible safety net providers are using certified EHR systems that meet Meaningful Use and PCMH 2014 Level 3 standards										
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices										
Task Recruit or contract for PCMH practice certification resources as needed										
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition										
Task Perform gap analysis by practice and identify key priorities.										
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.										

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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 Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition										
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed.										
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.										
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 Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff										
Task Perform current state assessment of E.H.R. capabilities.										
Task Perform gap analysis and identify priories to achieving integration of patient record.										
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.										
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)										
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.										
Task Create budget to build registry and acquire necessary resources										
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries										
Task										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data										
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care										
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.										
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.										
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.										
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 Identify/establish the protocols for the 5A's of tobacco control and services/programs to incorporate into COP										
Task Identify/develop member educational material and smoking cessation support tools for inclusion in COP										
Task Survey participants to determine capability of sites' EHR systems for providing point of care reminders										
Task Site-Specific Implementation Teams work with their IT teams to implement point-of-care prompts to facilitate tobacco control protocols into EHR workflows, including documentation										

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Task Site-specific Implementation Teams establish and map interim manual processes to fulfill protocols in COP										
Task Establish the schedule and materials for periodic staff training to incorporate the use of the EHR to prompt the use of 5 A's of tobacco control.										
Task Provide guidance for ongoing assesment to ensure that practices are following training requirements and protocols										
Task Develop feedback mechansims for accountability and continuous quality improvement										
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 Define target population, select EBGs for target population and present recommmendation to Quality & Care Innovation Sub-Committee (QCIS)										
Task QCIS reviews and recommends EBGs for adoption and implementation across the PPS										
Task Develops educational materials suitable to the needs, culture and language of the target populations in conjunction with select CBOs, PCPs, and SMEs										
Task Present educational materials to QCIS for review										
Task Identify clinical champions to drive adoption of guidelines										
Task Implement EBG and educational material dissemination plan across the PPS with support of RDC and site-specific implementation teams										
Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.										

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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 Coordinate across project specific workgroups to establish the care management model/organizational structure and processes most appropriate for achieving project outcomes; include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers										
Task Present care management model to QCIS for review and approval										
Task Working with Workforce Subcommittee, design training and recruitment strategy for care managers and care teams										
Task Begin to recruit, hire and train new and existing staff as needed.										
Task Site-specific implementation teams, with support from CSO and in coordination with PCMH work, establish care coordination team and implement care coordination processes (e.g., community service/program referrals and tracking, communication, PCP alerts, education materials, coordination among team members, frequency and purpose of patient contact.) Ensure these include coordination with the Health Home care manager, where applicable.										
Task Develop a mechanism to gather feedback and share best practices										
Task Provide guidance for ongoing assesment to ensure that practices are following requirements and protocols										
Task Identify and document required clinical and care management protocols for priority programs, projects and interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data										

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Task Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations for how interventions will be logged, tracked and reported.										
Task Deploy systems to improve and promote effective care transitions										
Task Operationalize partner and workforce roles by providing gap analysis and appropriate training.										
Task Establish data collection, survey and reporting mechanisms to enable BPHC monitoring to ensure that patients are receiving appropriate health care and community support in priority projects, based on needs identified in prior planning activities										
Task Review process for rapid cycle evaluation and continuous improvement of data collection, survey and reporting methods based on priority project experience and modify process as needed to ensure patients receive appropriate health care and community support										
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.										
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	0	0	0	0	0	0	0	0	0	0
Task Review Million Hearts resources and other relevant literature related to implementation of similar programs and identify documents most relevant for PPS, including strategies to ensure that Medicaid patients are not charged a co-pay for blood pressure checks										
Task Conduct research into current coverage for such visits by Medicaid and coding for non-billable visits, etc.										
Task Conduct gap analysis to assess resources required to meet this requirement										
Task Meet with other PPSs to consider lobbying MCOs to cover such visit copays (make providers whole)										
Task Conduct periodic meetings/learning collaboratives with PCP										

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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
practice partners to gather feedback and share best practices										
Task Provide guidance for ongoing assesment to ensure that practices are providing access for such visits										
Task Develop feedback mechansims for accountability and continuous quality improvement										
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 In conjunction with Workforce Subcommittee, identify relevant training resources and nursing competencies to create protocols (standardized across PPS) for inclusion in the COP										
Task Identify site-specific staff members responsible for BP measurement training and documenting training has occurred										
Task Provide guidance for ongoing assesment of staff competencies to ensure that practices are following training requirements and protocols										
Task Develop feedback mechansims for accountability and continuous quality improvement										
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 Using EBGs identified in the COP, determine blood pressure										

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program parameters and stratification levels for identification, enrollment and hypertension visit frequency										
Task Establish processes to use registry (see requirement 4), to reach out to patients and establish the process and person responsible for staff training on such processes.										
Task Support site-specific implementation teams to ensure that scheduling resources/technology fulfills project requirements.										
Task Conduct periodic meetings/learning collaboratives with PCP practice partners to gather feedback and share best practices										
Task Provide guidance for ongoing assesment of competencies to ensure that practices are following training requirements and protocols										
Task Develop feedback mechansims for accountability and continuous quality improvement										
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 Determine criteria/limitations for use of once-daily and single dose medication regimens based on feedback from partners, review of MCO formularies and review of clinicial literature; include recommendations in COP										
Task Determine current status of the above regimens in payor and provider formularies, ease of prescribing in various EHRs										
Task Establish protocols for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors for inclusion in COP										
Task Develop mechanisms for regular review of medication recommondations to assure our PPS is utilizing the most up-to-date tools and that any updated guidelines/protocols continue to be clinically integrated across the PPS										
Milestone #12 Document patient driven self-management goals in the medical										

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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
record and review with patients at each visit.										
Task Self-management goals are documented in the clinical record.										
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.										
Task Identify best practices for identification and follow-up of self-management goals into COP										
Task Identify relevant training resources /competencies in conjuction with workforce subcommittee										
Task Establish plan to integrate self-management goals into the EHR with interim manual processes as needed										
Task Establish requirements and processes to ensure documentation of the goals										
Task Establish the schedule and materials for periodic staff training on person-centered methods that include documentation of self-management goals										
Task Provide guidance for ongoing assesment of competencies to ensure that practices are following training requirements and protocols										
Task Develop feedback mechansims for accountability, and continuous quality improvement, including assessment of patient adherence to self-management plan and opportunities to increase adherence.										
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										

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
community organizations.										
Task Define processes for referral, and access to information among providers, and feedback processes to the practices electronically with interim manual processes as needed in conjunction with IT subcommittee										
Task Establish and document referral and follow-up procedures for the sites, with a mechanism for sites to audit adherence										
Task Identify community organizations for inclusion in the initial iteration of the Community Resource Database, sign agreements with with community based organizations and establish process to facilitate feedback to and from community organizations										
Task Perform regular checks of Community Resource Database to ensure data is up to date and accurate and to identify additional resources to consider including										
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices										
Task Establish the schedule and materials for periodic staff training on the warm transfer and referral tracking										
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 Identify minimal and recommended SBPM protocols needed to satisfy project requirements, including identification of patients' needs and linkage to support										
Task Conduct gap analysis with partners to identify implementation										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
support needs										
Task Individual sites adopt protocols for at-home BP monitoring										
Task Identify staff member(s) at each site responsible for training patients in self-blood pressure monitoring, including equipment evaluation										
Task Establish workflow at each site to address patient-reported BP values that are out of range, including how are values reported and staff member(s) responsible for following up										
Task Conduct webinars/conference calls to ensure that all practices have protocols in place and are adhering to them										
Task Define training requirements in conjuction with Workforce Subcommittee										
Task Identify nursing competencies and training resources to support SBPM in conjuction with Workforce Subcommittee										
Task Create patient communication materials in coordination with the Cultural Competency/Health Literacy orkstream										
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices										
Task Establish schedule and materials for periodic staff training on the warm transfer and referral follow-up process										
Task Develop feedback mechansims for accountability and continuous quality improvement										
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 Using EBGs identified in the COP, determine parameters for patient stratification, identification, and hypertension visit frequency										

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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 Establish processes to use registry (see requirement 4), to reach out to patients and establish processes and person responbile for staff training on such processes.										
Task Support site-specific implementation teams to ensure that scheduling resources/technology fulfills projecct requirements.										
Task Conduct periodic meetings/learning collaboratives with sites to gather feedback and share best practices										
Task Provide guidance for ongoing assesment of competencies to ensure that sites are following training requirements and protocols										
Task Develop feedback mechansims for accountability and continuous quality improvement										
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task Define criteria for referral to Quitline										
Task Establish and document process for referral to Quitline and patient follow-up										
Task Create culturally-competent communication materials at appropriate health literacy levels materials with the Quitline telephone number and website										
Task Develop feedback mechansims for accountability and continuous quality improvement										
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.										

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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 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 Using claims data to identify "hotspot" areas/patient groups for outreach										
Task Identify and mitigate service shortages to address these "hotspots" which can include mobile services and use of churches and community centers for education and blood pressure screening.										
Task Implement 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, if feasible.										
Task Establish linkages to health homes for targeted patient populations										
Task Implement the Stanford Model through partnerships with community based organizations, including Health People										
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	0	0	0	0	0	0	0
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	0	0	0	0	0	0	0	180	543
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	0	0	0	0	0	0	0	0	0
Task Identify relevant resources and protocols earmarked as useful by Million Hearts to incorporate into COP, including noting relevance by provider type (PCP, non-PCP and behavioral health providers)										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Identify relevant patient tools for inclusion in COP										
Task Review Action Guide related to HTN and SBPM and incorporate into guidelines/protocols in COP										
Task Identify clinical champions from the Site-Specific Implementation Team in each participating organization (PCP, non-PCP and behavioral health providers) to drive adoption of Million Hearts strategies and materials identified in COP										
Task Develop mechanisms for regular review of Million Hearts resources to assure our PPS is utilizing the most up-to-date tools and that any updates are clinically integrated across 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 Identify current tools and services available to members for relevant MCOs across the PPS, including telehealth, care management, and stipends for completing recommended preventive screenings.										
Task Distribute materials regarding extant services and benefits available to members to providers participting in project										
Task Build prompts to these tools and services into provider EHRs										
Task Where feasible, make agreements with MCO related to coordination of services for high risk populations, including smoking cessation services, weight management, and other preventive services relevant to this project.										
Task Communicate payor information and include information on availability/how to access in training programs										
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.										

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Task PPS has engaged at least 80% of their PCPs in this activity.	0	0	0	0	0	0	0	0	0	0
Task Identify sites participating in project										
Task Ensure that all participating practices have signed MSA										
Task Identify opportunities to coordinate processes, education and communication including incorporation of increased blood pressure identification for screening checks into PCMH workflow processes.										
Task Ensure that hypertension program training is incoporated/included in other care coordination training sessions.										
Task Monitor activity/engagement and make periodic reports to QCIS / EC										
Task Develop feedback mechansims for accountability and continuous quality improvement for Site-Specific Implementation Teams.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task Create a Transitional Work Group (CVD/DM TWG) comprised of representatives from partner organizations to support development of and approve elements of the COP										
Task Identify DSRIP project requirements which are related to PCMH elements and incorporate into PCMH strategy and project planning documents										
Task Identify relevant evidence-based guidelines for HTN and hyperlipidemia in conjunction with the CVD/DM TWG										

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Task Identify patient criteria for smoking cessation interventions (counsel to quit, smoking cessation medication, non-medication smoking cessation strategy)										
Task Identify partner organizations participating in project (sites and CBOs)										
Task Develop a workplan and timeline to develop the clinical operations plan (COPs) and implement a strategy for the CV population that aligns with the patient engagement speed and scale application submission										
Task Develop the COP to define the program elements, define the required and suggested components of those elements, and identify relevant resources to achieve them. Elements include health information exchange and technology requirements, and evidence-based guidelines and high-value treatment protocols										
Task Develop the project implementation budget										
Task Design training and recruitment strategy in conjunction with workforce team and CVD/DM TWG										
Task Submit elements of the COP to Quality and Care Innovation Sub-Committee (QCIS) for approval										
Task Identify clinical champions and operational leaders in each participating organization to develop and lead implementation of the program at each of their providers/sites. These facility-based champions/leaders form the Site-Specific Implementation Team										
Task Prepare/disseminate gap analysis tool based on COP to participating providers to determine implementaton support needs										
Task Hold webinar for participating partner organizations										
Task Create rapid deployment collaborative, comprised of representatives from partner organizations to support implementation of the COP. This group replaces the TWG and will be the implementation work group.										
Task Develop mechanisms for regular review of project-selected evidence-based guidelines (EBGs) by implementation work										

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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
group to assure our PPS is utilizing the most up-to-date tools and that those upadated guidelines/protocols continue to be clinically integrated across the PPS										
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.	74	494	494	494	494	494	494	494	494	494
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	1,087	1,812	1,812	1,812	1,812	1,812	1,812	1,812	1,812	1,812
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	18	122	122	122	122	122	122	122	122	122
Task PPS uses alerts and secure messaging functionality.										
Task Identify safety net provider data sharing requirements and assess partner and QE data sharing capabilities and current HIE participation										
Task Coordinate with Bronx RHIO to develop comprehensive HIE adoption program to encourage and support partner participation and integration										
Task Begin coordinated interface and service development with Bronx RHIO, including connectivity to the SHIN-NY.										
Task Establish BPHC program to manage support for safety net providers to ensure that all are actively sharing health information, coordinating with Bronx RHIO to encourage, track and support partner participation and integration/data sharing										
Task Track status and manage support to ensure that all PPS safety net providers are actively sharing health information through Bronx RHIO or alternative health information exchange										
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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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task EHR meets 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.	74	494	494	494	494	494	494	494	494	494
Task Assess eligible participating partner EHR use relative to Meaningful Use and PCMH 2014 Level 3 standards										
Task Establish BPHC program to educate, encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, including potential use of incentive-based payments for implementation										
Task Recruit or contract for EHR implementation resources as needed										
Task Begin actively encouraging, tracking and supporting partner EHR implementation and progress towards Meaningful Use and PCMH standards										
Task Track status and manage support to ensure all eligible safety net providers are using certified EHR systems that meet Meaningful Use and PCMH 2014 Level 3 standards										
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices										
Task Recruit or contract for PCMH practice certification resources as needed										
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition										
Task Perform gap analysis by practice and identify key priorities.										
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.										

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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 Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition										
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed.										
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.										
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 Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff										
Task Perform current state assessment of E.H.R. capabilities.										
Task Perform gap analysis and identify priories to achieving integration of patient record.										
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.										
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)										
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.										
Task Create budget to build registry and acquire necessary resources										
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries										
Task										

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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
Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data										
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care										
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.										
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.										
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.										
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 Identify/establish the protocols for the 5A's of tobacco control and services/programs to incorporate into COP										
Task Identify/develop member educational material and smoking cessation support tools for inclusion in COP										
Task Survey participants to determine capability of sites' EHR systems for providing point of care reminders										
Task Site-Specific Implementation Teams work with their IT teams to implement point-of-care prompts to facilitate tobacco control protocols into EHR workflows, including documentation										

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Task Site-specific Implementation Teams establish and map interim manual processes to fulfill protocols in COP										
Task Establish the schedule and materials for periodic staff training to incorporate the use of the EHR to prompt the use of 5 A's of tobacco control.										
Task Provide guidance for ongoing assesment to ensure that practices are following training requirements and protocols										
Task Develop feedback mechansims for accountability and continuous quality improvement										
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 Define target population, select EBGs for target population and present recommmendation to Quality & Care Innovation Sub-Committee (QCIS)										
Task QCIS reviews and recommends EBGs for adoption and implementation across the PPS										
Task Develops educational materials suitable to the needs, culture and language of the target populations in conjunction with select CBOs, PCPs, and SMEs										
Task Present educational materials to QCIS for review										
Task Identify clinical champions to drive adoption of guidelines										
Task Implement EBG and educational material dissemination plan across the PPS with support of RDC and site-specific implementation teams										
Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.										

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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 Coordinate across project specific workgroups to establish the care management model/organizational structure and processes most appropriate for achieving project outcomes; include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers										
Task Present care management model to QCIS for review and approval										
Task Working with Workforce Subcommittee, design training and recruitment strategy for care managers and care teams										
Task Begin to recruit, hire and train new and existing staff as needed.										
Task Site-specific implementation teams, with support from CSO and in coordination with PCMH work, establish care coordination team and implement care coordination processes (e.g., community service/program referrals and tracking, communication, PCP alerts, education materials, coordination among team members, frequency and purpose of patient contact.) Ensure these include coordination with the Health Home care manager, where applicable.										
Task Develop a mechanism to gather feedback and share best practices										
Task Provide guidance for ongoing assesment to ensure that practices are following requirements and protocols										
Task Identify and document required clinical and care management protocols for priority programs, projects and interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data										

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Task Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations for how interventions will be logged, tracked and reported.										
Task Deploy systems to improve and promote effective care transitions										
Task Operationalize partner and workforce roles by providing gap analysis and appropriate training.										
Task Establish data collection, survey and reporting mechanisms to enable BPHC monitoring to ensure that patients are receiving appropriate health care and community support in priority projects, based on needs identified in prior planning activities										
Task Review process for rapid cycle evaluation and continuous improvement of data collection, survey and reporting methods based on priority project experience and modify process as needed to ensure patients receive appropriate health care and community support										
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.	74	494	494	494	494	494	494	494	494	494
Task Review Million Hearts resources and other relevant literature related to implementation of similar programs and identify documents most relevant for PPS, including strategies to ensure that Medicaid patients are not charged a co-pay for blood pressure checks										
Task Conduct research into current coverage for such visits by Medicaid and coding for non-billable visits, etc.										
Task Conduct gap analysis to assess resources required to meet this requirement										
Task Meet with other PPSs to consider lobbying MCOs to cover such visit copays (make providers whole)										
Task Conduct periodic meetings/learning collaboratives with PCP										

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practice partners to gather feedback and share best practices										
Task Provide guidance for ongoing assesment to ensure that practices are providing access for such visits										
Task Develop feedback mechansims for accountability and continuous quality improvement										
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 In conjunction with Workforce Subcommittee, identify relevant training resources and nursing competencies to create protocols (standardized across PPS) for inclusion in the COP										
Task Identify site-specific staff members responsible for BP measurement training and documenting training has occurred										
Task Provide guidance for ongoing assesment of staff competencies to ensure that practices are following training requirements and protocols										
Task Develop feedback mechansims for accountability and continuous quality improvement										
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 Using EBGs identified in the COP, determine blood pressure										

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
program parameters and stratification levels for identification, enrollment and hypertension visit frequency										
Task Establish processes to use registry (see requirement 4), to reach out to patients and establish the process and person responsible for staff training on such processes.										
Task Support site-specific implementation teams to ensure that scheduling resources/technology fulfills project requirements.										
Task Conduct periodic meetings/learning collaboratives with PCP practice partners to gather feedback and share best practices										
Task Provide guidance for ongoing assesment of competencies to ensure that practices are following training requirements and protocols										
Task Develop feedback mechansims for accountability and continuous quality improvement										
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 Determine criteria/limitations for use of once-daily and single dose medication regimens based on feedback from partners, review of MCO formularies and review of clinicial literature; include recommendations in COP										
Task Determine current status of the above regimens in payor and provider formularies, ease of prescribing in various EHRs										
Task Establish protocols for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors for inclusion in COP										
Task Develop mechanisms for regular review of medication recommondations to assure our PPS is utilizing the most up-to-date tools and that any updated guidelines/protocols continue to be clinically integrated across the PPS										
Milestone #12 Document patient driven self-management goals in the medical										

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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 and review with patients at each visit.										
Task Self-management goals are documented in the clinical record.										
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.										
Task Identify best practices for identification and follow-up of self-management goals into COP										
Task Identify relevant training resources /competencies in conjuction with workforce subcommittee										
Task Establish plan to integrate self-management goals into the EHR with interim manual processes as needed										
Task Establish requirements and processes to ensure documentation of the goals										
Task Establish the schedule and materials for periodic staff training on person-centered methods that include documentation of self-management goals										
Task Provide guidance for ongoing assesment of competencies to ensure that practices are following training requirements and protocols										
Task Develop feedback mechansims for accountability, and continuous quality improvement, including assessment of patient adherence to self-management plan and opportunities to increase adherence.										
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										

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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
community organizations.										
Task Define processes for referral, and access to information among providers, and feedback processes to the practices electronically with interim manual processes as needed in conjunction with IT subcommittee										
Task Establish and document referral and follow-up procedures for the sites, with a mechanism for sites to audit adherence										
Task Identify community organizations for inclusion in the initial iteration of the Community Resource Database, sign agreements with with community based organizations and establish process to facilitate feedback to and from community organizations										
Task Perform regular checks of Community Resource Database to ensure data is up to date and accurate and to identify additional resources to consider including										
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices										
Task Establish the schedule and materials for periodic staff training on the warm transfer and referral tracking										
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 Identify minimal and recommended SBPM protocols needed to satisfy project requirements, including identification of patients' needs and linkage to support										
Task Conduct gap analysis with partners to identify implementation										

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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
support needs										
Task Individual sites adopt protocols for at-home BP monitoring										
Task Identify staff member(s) at each site responsible for training patients in self-blood pressure monitoring, including equipment evaluation										
Task Establish workflow at each site to address patient-reported BP values that are out of range, including how are values reported and staff member(s) responsible for following up										
Task Conduct webinars/conference calls to ensure that all practices have protocols in place and are adhering to them										
Task Define training requirements in conjuction with Workforce Subcommittee										
Task Identify nursing competencies and training resources to support SBPM in conjuction with Workforce Subcommittee										
Task Create patient communication materials in coordination with the Cultural Competency/Health Literacy orkstream										
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices										
Task Establish schedule and materials for periodic staff training on the warm transfer and referral follow-up process										
Task Develop feedback mechansims for accountability and continuous quality improvement										
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 Using EBGs identified in the COP, determine parameters for patient stratification, identification, and hypertension visit frequency										

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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 Establish processes to use registry (see requirement 4), to reach out to patients and establish processes and person responbile for staff training on such processes.										
Task Support site-specific implementation teams to ensure that scheduling resources/technology fulfills projecct requirements.										
Task Conduct periodic meetings/learning collaboratives with sites to gather feedback and share best practices										
Task Provide guidance for ongoing assesment of competencies to ensure that sites are following training requirements and protocols										
Task Develop feedback mechansims for accountability and continuous quality improvement										
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task Define criteria for referral to Quitline										
Task Establish and document process for referral to Quitline and patient follow-up										
Task Create culturally-competent communication materials at appropriate health literacy levels materials with the Quitline telephone number and website										
Task Develop feedback mechansims for accountability and continuous quality improvement										
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.										

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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 established linkages to health homes for targeted patient populations.										
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.										
Task Using claims data to identify "hotspot" areas/patient groups for outreach										
Task Identify and mitigate service shortages to address these "hotspots" which can include mobile services and use of churches and community centers for education and blood pressure screening.										
Task Implement 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, if feasible.										
Task Establish linkages to health homes for targeted patient populations										
Task Implement the Stanford Model through partnerships with community based organizations, including Health People										
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.	74	494	494	494	494	494	494	494	494	494
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	1,087	1,812	1,812	1,812	1,812	1,812	1,812	1,812	1,812	1,812
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	18	122	122	122	122	122	122	122	122	122
Task Identify relevant resources and protocols earmarked as useful by Million Hearts to incorporate into COP, including noting relevance by provider type (PCP, non-PCP and behavioral health providers)										

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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 Identify relevant patient tools for inclusion in COP										
Task Review Action Guide related to HTN and SBPM and incorporate into guidelines/protocols in COP										
Task Identify clinical champions from the Site-Specific Implementation Team in each participating organization (PCP, non-PCP and behavioral health providers) to drive adoption of Million Hearts strategies and materials identified in COP										
Task Develop mechanisms for regular review of Million Hearts resources to assure our PPS is utilizing the most up-to-date tools and that any updates are clinically integrated across 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 Identify current tools and services available to members for relevant MCOs across the PPS, including telehealth, care management, and stipends for completing recommended preventive screenings.										
Task Distribute materials regarding extant services and benefits available to members to providers participting in project										
Task Build prompts to these tools and services into provider EHRs										
Task Where feasible, make agreements with MCO related to coordination of services for high risk populations, including smoking cessation services, weight management, and other preventive services relevant to this project.										
Task Communicate payor information and include information on availability/how to access in training programs										
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.										

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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 at least 80% of their PCPs in this activity.	74	494	494	494	494	494	494	494	494	494
Task Identify sites participating in project										
Task Ensure that all participating practices have signed MSA										
Task Identify opportunities to coordinate processes, education and communication including incorporation of increased blood pressure identification for screening checks into PCMH workflow processes.										
Task Ensure that hypertension program training is incoporated/included in other care coordination training sessions.										
Task Monitor activity/engagement and make periodic reports to QCIS / EC										
Task Develop feedback mechansims for accountability and continuous quality improvement for Site-Specific Implementation Teams.										

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.	The Central Services Organization (CSO) continued development and finalized the CVD Clinical Operations Plan (COP) in December. The COP is based on the DSRIP Domain 1 and 3 measures, using input from the CVD-Diabetes Transitional Work Group (TWG). It includes chapters on target population, evidence-based guidelines, guidance for at-home blood pressure monitoring, aspirin use, flu shots, patient-driven self-management goals, preferred drugs, referral protocols, patient flows, care team roles, patient/caregiver education and engagement, and practitioner engagement tools.
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.	BPHC plans to use the RHIO/SHIN-NY for population health and reporting and these topics are included in the COP. There is a regular weekly meeting between stakeholders from the Bronx RHIO and BPHC to formulate the strategy for use and implementation of the RHIO and SHIN-NY. Additionally, the four Bronx PPS's meet monthly to discuss shared efforts and are working unified strategy for QE Engagement, including communications, operations and training. Improving RHIO consent penetration is a focus area for BPHC in DY2.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	PCMH consultants have been hired by BPHC to support our member organizations achievement of PCMH 2014 Level 3 certification and Meaningful Use. This quarter, they began conducting site-specific gap analyses with BPHC PCPs which includes assessing current EHR capabilities/standards at the sites and formulating a plan to meet Meaningful use and PCMH Level 3 standards by the end of DY3. BPHC has developed a comprehensive plan to support MU and PCMH which includes use of targeted patient registries in conjunctions with our clinical projects.
Use EHRs or other technical platforms to track all patients engaged in this project.	The four tasks under this milestone concerning, variously, assessing the capabilities and requirements of EHRs and other technical platforms for tracking actively engaged patients, e.g., patient registry, have been completed in DY 1, Q3. The CVD/Diabetes Transitional Work Group (TWG) finalized their recommendation regarding the data elements for patient registries for project 3.b.i. Along with feedback from other project-specific workgroups, this work was used to draft a PPS-wide strategy which was presented to and approved by QCIS (Quality and Care Innovation Subcommittee) this quarter. The IT Subcommittee reviewed the registry strategy but approval from this subcommittee of the registry elements was determined to be unnecessary and less meaningful than originally determined, given the clinical expertise required that the IT Subcommittee does not offer. It was further determined that the Executive Committee would not need to approve this level of detail in the PHM strategy, given that its Clinical Committee had already conducted a thorough review and approval process.
Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	The COP includes a chapter on this topic, written in policy & procedure (P&P) format as well as suggested resources. Sites will kick off work on milestone following our launch in February by conducting a current state assessment and gap analysis with their IT departments.
Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	The Quality and Care Innovation Subcommittee adopted the recommended clinical evidence-based guidelines (EBGs) and home-based services for hypertension (including at-home blood-pressure monitoring) and elevated cholesterol developed by the CVD/Diabetes Transitional Work Group (TWG). They were incorporated into the COP, which was finalized this quarter. Following our launch in February, DPDs are expected to begin organization-specific processes to adopt evidence-based guidelines from COPs. The development of mechanisms for regular review of the EBGs is scheduled to begin in DY 1, Q4.
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.	The model for care coordination teams was finalized this quarter and included in the COP for the Health Home at Risk program (referenced in other project sections). Since the implementation of team-based care is foundational to BPHC's primary care projects, this program launched this January to allow sites time to begin building their teams and making selected hires. The requirements of the CVD (and other primary care projects) were included in the assessment of need for additional staff members to prevent silo-ing and to build capacity for PCMH and Domain 3 DSRIP requirements.
Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	The COP includes a chapter on this topic, written in policy & procedure (P&P) format. It also includes Million Hearts resources, case studies of successful implementation and strategies to ensure that Medicaid patients are not charged a co-pay for blood pressure checks. The work will continue into this year, as part of the work of the CVD/Diabetes Implementation Workgroup.
Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	The COP includes a chapter on this topic. Education in correct blood pressure measurement has been identified as one of the elements of the consolidated training curriculum being developed by the Workforce Subcommittee. The Workforce subcommittee is prioritizing training of medical assistants and will incorporate BPHC's evidence based practices in the curriculum. This was also a topic of the cross-PPS CVD learning consortium (a monthly call of 7 PPS participating in the CVD project) and selected resources were exchanged. Following the launch of this project in February, sites will be asked to identify any training currently conducted at their organization around this topic.
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.	As part of their work, the CVD/Diabetes TWG considered and recommended that the CVD component of the PPS-wide, cross-project registry being developed should be used to fulfill this requirement. As such, the data elements required to fulfill this task were considered and included in the data elements recommended for inclusion in the draft a PPS-wide strategy which was presented to and approved by the QCIS this quarter. Additionally, the COP includes a chapter on this specific activity (which should be fulfilled with the cross-project registry), written in policy & procedure (P&P) format.
Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	The COP includes a chapter on this topic, written in policy & procedure (P&P) format, based on the TWG's recommendation that where patients' insurance status allows and it is medically appropriate, PCPs will preferentially prescribe combination drugs, once-daily formulations, and 90-day supplies. Additionally,

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	the COP included the recommendation by the TWG that where adherence is an issue, BPHC will assist patients in finding pharmacies that offer blister packs, and pill boxes, etc. QCIS approved this for adoption this quarter.
Document patient driven self-management goals in the medical record and review with patients at each visit.	The COP includes a chapter on this topic, written in policy & procedure (P&P) format, based on the CVD/Diabetes TWG's recommendation. The recommendations were based / aligned with NCQA PCMH 2013 guidance on patient self-management goals. As part of patient engagement data collection, BPHC conducted meetings with SBH and Montefiore to identify the current documentation for such goals and identify methods to allow for structured, consistent data collection in the future.
Follow up with referrals to community based programs to document participation and behavioral and health status changes.	The COP includes a chapter on this topic in the project "cross-cutting" section. Operationalizing this requirement will be a key activity for the CSO over the next two quarter, with input from the all of the clinical workgroups, QCIS and IT Subcommittee.
Develop and implement protocols for home blood pressure monitoring with follow up support.	The COP includes a chapter on this topic, written in Policy & Procedure (P&P) format, based on the CVD/Diabetes TWG's recommendation. The COP identifies the Million Hearts guidelines for Self-Measured Blood Pressure Monitoring as the minimum SBPM program. All patients with hypertension must be prescribed a self-blood pressure monitor (SBPM). Practices are also strongly recommended (but not required) to carry out telephonic titration of blood pressure medications by a non-traditional provider (RN or Pharmacist) via standing orders or titration algorithms, which can be standardized for the practice or customized by the PCP for the specific patient. The COP will be distributed in Q4 to the participating member organizations of our PPS.
Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	The COP includes a chapter on this topic, written in policy & procedure (P&P) format, based on the CVD/Diabetes TWG's recommendation. The COP will be distributed in Q4 to the participating member organizations of our PPS.
Facilitate referrals to NYS Smoker's Quitline.	The COP includes a chapter on this topic, written in policy & procedure (P&P) format, based on the CVD/Diabetes TWG's recommendation. The COP will be distributed in Q4 to the participating member organizations of our PPS.
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.	The COP includes a chapter on this topic, written in policy & procedure (P&P) format, based on the CVD/Diabetes TWG's recommendation. The COP will be distributed in Q4 to the participating member organizations of our PPS. BPHC has begun contracting with "HealthPeople" to provide training and implementation of the Stanford Model for chronic diseases.
Adopt strategies from the Million Hearts Campaign.	The CSO has written and finalized the COP based on the CVD/Diabetes TWG's approved selected patient educational materials and provider tools from the Million Hearts Patient Tools and Educational materials for inclusion as recommended resources. These tools include algorithms for BP treatment, nontraditional visits, self-management and motivational interviewing. Million Hearts resources were also included in the COP chapters on home blood pressure monitoring, and No Co-Pay Drop-In BP Checks. These recommendations have been approved by QCIS.
Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	BPHC had initial conversations with HealthFirst this quarter around the topic of the Stanford model, with continuing discussions planned for Q4. Additionally, BPHC's CMO has made the topic of partnership/agreements with Medicaid MCOs a priority topic at the regularly-scheduled cross-PPS meetings hosted by GNYHA.
Engage a majority (at least 80%) of primary care providers in this project.	This quarter, BPHC confirmed participation in the CVD project for its 7 largest member organizations, who encompass the majority of our PCPs and more than 90% of our primary care visits. Practices must commit to participating in the CVD project in order to qualify for PCMH coach funding. In our second wave of provider engagement with smaller organizations, project participation materials continue to emphasize that 3.b.i is required for all adult primary care practices.

Milestone Review Status

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

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Milestone Review Status

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

As we begin implementation, some practitioners may resist the imposition of standard treatment protocols and new workflows. It will also be challenging to implement 2014 PCMH Level 3 recognition . To mitigate these risks, we have brought together stakeholders to develop clinical operation plans (COPs) for all of the projects. These include evidence-based (EB) guidelines protocols for each disease-specific intervention. Implementation of these protocols will be part of contractual agreements between partners & the PPS. These COPs have been designed to align with the 2014 PCMH elements. The CSO has committed to providing technical and financial assistance, including IT support & training, to primary care practices as they work to attain PCMH Level 3 recognition. This includes resources toward project management staff at the participating organizations, and for PCMH "coaches."

Physicians & other PCMH care team members may not currently document self-management goals in the medical record as required, &/or they may be resistant to conducting additional documentation efforts. To address this risk, BPHC is working with our partners to update their respective EHRs to better capture this information consistently. In addition, the CSO may audit medical records to ensure that documentation is occurring.

As we begin building our care teams, recruiting and training sufficient care management staff to serve the needs of the Bronx population may be challenging. Recruiting Spanish-speaking care management staff will be a particular risk. BPHC's workforce strategy will be targeted towards mitigating this risk, such as through the CSO working with community colleges & coordinating with the 1199 Job Security Fund, Montefiore CMO, & NYSNA to identify capable workers & provide training in Spanish when needed. BPHC will also use alternative employment tactics, such as flexible hours, & job sharing, where feasible to attract a broader pool of workers.

Medication adherence is a chronic problem for individuals with chronic illness including those with CVD. Organizations that could be instrumental in helping patients with medication adherence, such as home care agencies & MCOs are handicapped by policies &/or regulations. To mitigate these risks, BPHC will work with MCOs to institute policy changes that will promote medication adherence.

Enhancing patient self-management & self-efficacy is anticipated to be a particular risk to the success of Project 3.c.i. It is challenging to effectively motivate & engage chronically ill patients over the long term to embrace changes in behavior & self-manage their condition, risks that are compounded in the Bronx population by low health literacy & educational attainment. Among its mitigation tactics, is working with Health People, a CBO that is a certified Stanford Model trainer.In addition, Project 3.c.i in conjunction with Projects 2.a.iii & 3.b.i will enable BPHC to invest in more peer educators, care managers, & certified diabetes educators to educate patients & promote self-management. Hard-to-reach patients require dedicated staff to bond with the patient, & consistency is important. Health Homes will provide valuable long-term follow up to promote engagement.

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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**
DY2,Q4	25,800

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
4,501	15,192	117.77%	-2,292	58.88%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
zstopak	Baseline or Performance Documentation	36_PMDL4415_1_3_20160202154219_BPHC-PATIENTLIST-3ci-Q3.xlsx	3.c.i Patient Engagement DY1 Q3	02/02/2016 03:43 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 3.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	06/30/2015	03/31/2018	06/30/2015	03/31/2018	03/31/2018	DY3 Q4
Task Create a Transitional Work Group (CVD/Diabetes TWG) comprised of representatives from partner organizations to support development of and approve elements of the COP	Project		Completed	04/01/2015	06/01/2015	04/01/2015	06/01/2015	06/30/2015	DY1 Q1
Task Identify DSRIP project requirements which are related to PCMH elements and incorporate into PCMH strategy and project planning documents	Project		Completed	05/15/2015	09/30/2015	05/15/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify relevant evidence-based guidelines for diabetes	Project		Completed	05/04/2015	09/30/2015	05/04/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify partner organizations participating in project (sites and CBOs)	Project		Completed	04/01/2015	11/01/2015	04/01/2015	11/01/2015	12/31/2015	DY1 Q3
Task Develop a workplan and timeline to develop the clinical operations plan (COPs) and implement a strategy for the diabetes population that aligns with the patient engagement speed and scale application submission	Project		Completed	04/01/2015	10/31/2015	04/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Develop the COP to define the program elements, define the required and suggested components of those elements, and identify relevant resources to achieve them. Elements include	Project		Completed	05/04/2015	10/31/2015	05/04/2015	10/31/2015	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
health information exchange and technology requirements, and evidence-based guidelines and high-value treatment protocols									
Task Develop the project implementation budget	Project		Completed	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Design training and recruitment strategy in conjunction with workforce team and CVD/DM TWG	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Submit elements of the COP to Quality and Care Innovation Sub-Committee (QCIS) for approval	Project		Completed	07/23/2015	10/31/2015	07/23/2015	10/31/2015	12/31/2015	DY1 Q3
Task Identify clinical champions and operational leaders in each participating organization to develop and lead implementation of the program at each of their providers/sites. These facility-based champions/leaders form the Site-Specific Implementation Team	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Prepare/disseminate gap analysis tool based on COP to participating providers to determine implementaton support needs	Project		Not Started	01/15/2016	06/30/2016	01/15/2016	06/30/2016	06/30/2016	DY2 Q1
Task Hold webinar for participating partner organizations	Project		Not Started	01/15/2016	03/31/2016	01/15/2016	03/31/2016	03/31/2016	DY1 Q4
Task Create a rapid deployment collaborative, comprised of representatives from partner organizations to support implementation of the COP and to provide updates to QCIS. and to update the COP annually.	Project		In Progress	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop mechanisms for regular review of project-selected Evidence Based Guidelines (by project quality councils) to assure our PPS is utilizing the most up-to-date tools and that those updated guidelines/protocols continue to be clinically integrated across the PPS.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
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	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	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)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Identify sites participating in project. In order to meet the 80% participation rate target, project participation materials distributed to sites indicate that 3.c.i is required for all adult primary care practices.									
Task Ensure that all participating practices have signed MSA	Project		In Progress	09/30/2015	03/31/2016	09/30/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify opportunities to coordinate processes, education and communication into PCMH workflow processes.	Project		In Progress	05/15/2015	03/31/2016	05/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Collaborate with other BPHC project-specific workgroups and teams to ensure that diabetes management training is incoporated/included in other care coordination training sessions.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Monitor acitivity/engagement and make periodic reports to QCIS / EC	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop methodology for evaluation, feedback and Continuous Quality Improvement.	Project		Not Started	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	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		Not Started	01/01/2017	03/31/2017	01/01/2017	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	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination processes are established and implemented.	Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinate to establish the care team and care coordination/management framework/organizational structure and processes most appropriate for achieving project outcome,	Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 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
including nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.									
Task Present care management model to QCIS for review and approval	Project		Completed	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish care coordination teams and processes; include community service and program referrals and tracking, communication, PCP alerts, education materials, coordination among team members, frequency and purpose of patient contact. Ensure these include coordination with the Health Home care manager, where applicable.	Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Working with Workforce Subcommittee, design training and recruitment strategy for care coordinators/managers and care teams with a training focus on improving health literacy, patient self-efficacy.	Project		Completed	06/30/2015	12/31/2015	06/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify site-specific implementation teams.	Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Launch recruitment and training programs with participating providers	Project		Not Started	04/01/2016	10/31/2016	04/01/2016	10/31/2016	12/31/2016	DY2 Q3
Task Identify and document required clinical and care management protocols for priority programs, projects and interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data	Project		Completed	08/15/2015	10/15/2015	08/15/2015	10/15/2015	12/31/2015	DY1 Q3
Task Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations for how interventions will be logged, tracked and reported.	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Deploy systems to improve and promote effective care transitions, include protocols for tracking and follow-up	Project		Not Started	01/15/2016	02/28/2016	01/15/2016	02/28/2016	03/31/2016	DY1 Q4
Task Operationalize partner and workforce roles by providing gap	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
analysis and appropriate training.									
Task Establish data collection, survey and reporting mechanisms to enable BPHC monitoring to ensure that patients are receiving appropriate health care and community support in priority projects, based on needs identified in prior planning activities	Project		Not Started	02/01/2016	06/15/2016	02/01/2016	06/15/2016	06/30/2016	DY2 Q1
Task Review process for rapid cycle evaluation and continuous improvement of data collection, survey and reporting methods based on priority project experience and modify process as needed to ensure patients receive appropriate health care and community support	Project		Not Started	08/01/2016	09/01/2016	08/01/2016	09/01/2016	09/30/2016	DY2 Q2
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.	Project	N/A	In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.	Project		In Progress	12/31/2015	03/31/2017	12/31/2015	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	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.	Project		Not Started	06/30/2016	03/31/2017	01/15/2016	03/31/2017	03/31/2017	DY2 Q4
Task Using claims data identify "hotspot" areas/patient groups for outreach	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify and mitigate service shortages to address these "hotspots" which can include mobile services and use of churches and community centers for education and blood pressure screening.	Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Implement 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	Project		In Progress	12/31/2015	03/31/2017	12/31/2015	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
disparities, if feasible.									
Task Establish linkages to health homes for targeted patient populations	Project		In Progress	12/31/2015	03/31/2017	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Implement the Stanford Model through partnerships with community based organizations, including Health People	Project		Not Started	04/30/2016	03/31/2017	01/15/2016	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	07/01/2015	03/31/2020	07/01/2015	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		Not Started	06/30/2016	03/31/2020	06/30/2016	03/31/2020	03/31/2020	DY5 Q4
Task Identify current tools and services available to members for relevant MCOs across the PPS, including telehealth, care management, stipend for completing recommended preventive screenings.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Distribute materials regarding extant services and benefits available to members to providers participting in project	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Build prompts to these tools and services into provider EHRs	Project		Not Started	04/01/2017	03/31/2020	04/01/2017	03/31/2020	03/31/2020	DY5 Q4
Task Where feasible, make agreements with MCO related to coordination of services for high risk populations, including smoking cessation services, weight management, and other preventive services relevant to this project.	Project		Not Started	04/01/2017	03/31/2018	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task Communicate payor information and include information on availability/how to access in training programs	Project		Not Started	04/01/2017	03/31/2018	04/01/2017	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	06/30/2015	03/31/2017	06/30/2015	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 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		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform gap analysis and identify priories to achieving integration of patient record.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.	Project		Completed	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget to build registry and acquire necessary resources	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care	Project		Not Started	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
coordination and patient engagement with primary care									
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Site-specific implementation teams establish processes to use PHM tools/registry, to identify, reach out and track patients due for preventive services.	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Ensure that IT solutions (within registry or other) allow for "closed loop processing" e.g., tracking of patient through completion of any given preventive service.	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Conduct training around closed loop processing/referral and preventive service tracking.	Project		Not Started	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Provide guidance for ongoing assesment to ensure that practices are following requirements and protocols, and offer guidance to develop mechanisms for continuous quality improvement.	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify safety net provider data sharing requirements and assess partner and QE data sharing capabilities and current HIE participation	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Coordinate with Bronx RHIO to develop comprehensive HIE adoption program to encourage and support partner participation	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
and integration									
Task Begin coordinated interface and service development with Bronx RHIO	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish BPHC program to manage support for safety net providers to ensure that all are actively sharing health information, coordinating with Bronx RHIO to encourage, track and support partner participation and integration/data sharing	Project		Not Started	03/01/2016	04/25/2016	03/01/2016	04/25/2016	06/30/2016	DY2 Q1
Task Track status and manage support to ensure that all PPS safety net providers are actively sharing health information through Bronx RHIO or alternative health information exchange	Project		Not Started	03/01/2016	03/31/2017	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Identify community organizations for inclusion in the initial iteration of the Community Resource Database, sign agreements with with community based organizations and establish process to facilitate feedback to and from community organizations	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Perform regular checks of Community Resource Database to ensure data is up to date and accurate and to identify additional resources to consider including	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices	Project		In Progress	04/01/2016	03/31/2017	11/02/2015	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		Not Started	01/01/2018	03/31/2018	01/01/2018	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	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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		(PCP)							
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	Provider	Safety Net Mental Health	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Assess eligible participating partner EHR use relative to Meaningful Use and PCMH 2014 Level 3 standards	Project		Completed	06/30/2015	12/31/2015	06/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish BPHC program to educate, encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, including potential use of incentive-based payments for implementation	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Recruit or contract for EHR implementation resources as needed	Project		In Progress	11/01/2015	06/30/2016	11/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner EHR implementation and progress towards Meaningful Use and PCMH standards	Project		Not Started	08/01/2016	12/31/2016	08/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Track status and manage support to ensure all eligible safety net providers are using certified EHR systems that meet Meaningful Use and PCMH 2014 Level 3 standards	Project		In Progress	10/15/2015	03/15/2018	10/15/2015	03/15/2018	03/31/2018	DY3 Q4
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recruit or contract for PCMH practice certification resources as needed	Project		Completed	05/01/2015	12/31/2015	05/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition	Project		In Progress	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Perform gap analysis by practice and identify key priorities.	Project		In Progress	10/01/2015	04/15/2016	10/01/2015	04/15/2016	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 Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.	Project		In Progress	10/01/2015	04/15/2016	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition	Project		Not Started	01/01/2016	11/30/2016	01/01/2016	11/30/2016	12/31/2016	DY2 Q3
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 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 Create a Transitional Work Group (CVD/Diabetes TWG) comprised of representatives from partner organizations to support development of and approve elements of the COP										
Task Identify DSRIP project requirements which are related to PCMH elements and incorporate into PCMH strategy and project planning documents										
Task Identify relevant evidence-based guidelines for diabetes										
Task Identify partner organizations participating in project (sites and CBOs)										
Task Develop a workplan and timeline to develop the clinical										

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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
operations plan (COPs) and implement a strategy for the diabetes population that aligns with the patient engagement speed and scale application submission										
Task Develop the COP to define the program elements, define the required and suggested components of those elements, and identify relevant resources to achieve them. Elements include health information exchange and technology requirements, and evidence-based guidelines and high-value treatment protocols										
Task Develop the project implementation budget										
Task Design training and recruitment strategy in conjunction with workforce team and CVD/DM TWG										
Task Submit elements of the COP to Quality and Care Innovation Sub-Committee (QCIS) for approval										
Task Identify clinical champions and operational leaders in each participating organization to develop and lead implementation of the program at each of their providers/sites. These facility-based champions/leaders form the Site-Specific Implementation Team										
Task Prepare/disseminate gap analysis tool based on COP to participating providers to determine implementaton support needs										
Task Hold webinar for participating partner organizations										
Task Create a rapid deployment collaborative, comprised of representatives from partner organizations to support implementation of the COP and to provide updates to QCIS. and to update the COP annually.										
Task Develop mechanisms for regular review of project-selected Evidence Based Guidelines (by project quality councils) to assure our PPS is utilizing the most up-to-date tools and that those updated guidelines/protocols continue to be clinically integrated across 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	0	0	0	0	0	0	0

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

DSRIP Implementation Plan Project

SBH Health System (PPS ID:36)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Identify sites participating in project. In order to meet the 80% participation rate target, project participation materials distributed to sites indicate that 3.c.i is required for all adult primary care practices.										
Task Ensure that all participating practices have signed MSA										
Task Identify opportunities to coordinate processes, education and communication into PCMH workflow processes.										
Task Collaborate with other BPHC project-specific workgroups and teams to ensure that diabetes management training is incoporated/included in other care coordination training sessions.										
Task Monitor acitivity/engagement and make periodic reports to QCIS / EC										
Task Develop methodology for evaluation, feedback and Continuous Quality Improvement.										
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 Coordinate to establish the care team and care coordination/management framework/organizational structure and processes most appropriate for achieving project outcome, including nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.										
Task Present care management model to QCIS for review and approval										

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

DSRIP Implementation Plan Project

SBH Health System (PPS ID:36)

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 Establish care coordination teams and processes; include community service and program referrals and tracking, communication, PCP alerts, education materials, coordination among team members, frequency and purpose of patient contact. Ensure these include coordination with the Health Home care manager, where applicable.										
Task Working with Workforce Subcommittee, design training and recruitment strategy for care coordinators/managers and care teams with a training focus on improving health literacy, patient self-efficacy.										
Task Identify site-specific implementation teams.										
Task Launch recruitment and training programs with participating providers										
Task Identify and document required clinical and care management protocols for priority programs, projects and interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data										
Task Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations for how interventions will be logged, tracked and reported.										
Task Deploy systems to improve and promote effective care transitions, include protocols for tracking and follow-up										
Task Operationalize partner and workforce roles by providing gap analysis and appropriate training.										
Task Establish data collection, survey and reporting mechanisms to enable BPHC monitoring to ensure that patients are receiving appropriate health care and community support in priority projects, based on needs identified in prior planning activities										
Task Review process for rapid cycle evaluation and continuous improvement of data collection, survey and reporting methods based on priority project experience and modify process as needed to ensure patients receive appropriate health care and										

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

DSRIP Implementation Plan Project

SBH Health System (PPS ID:36)

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
community support										
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 Using claims data identify "hotspot" areas/patient groups for outreach										
Task Identify and mitigate service shortages to address these "hotspots" which can include mobile services and use of churches and community centers for education and blood pressure screening.										
Task Implement 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, if feasible.										
Task Establish linkages to health homes for targeted patient populations										
Task Implement the Stanford Model through partnerships with community based organizations, including Health People										
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.										

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SBH Health System (PPS ID:36)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Identify current tools and services available to members for relevant MCOs across the PPS, including telehealth, care management, stipend for completing recommended preventive screenings.										
Task Distribute materials regarding extant services and benefits available to members to providers participting in project										
Task Build prompts to these tools and services into provider EHRs										
Task Where feasible, make agreements with MCO related to coordination of services for high risk populations, including smoking cessation services, weight management, and other preventive services relevant to this project.										
Task Communicate payor information and include information on availability/how to access in training programs										
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 Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff										
Task Perform current state assessment of E.H.R. capabilities.										
Task Perform gap analysis and identify priories to achieving integration of patient record.										
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.										
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)										

New York State Department Of Health
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DSRIP Implementation Plan Project

SBH Health System (PPS ID:36)

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 Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.										
Task Create budget to build registry and acquire necessary resources										
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries										
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data										
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care										
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.										
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.										
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.										
Task Site-specific implementation teams establish processes to use PHM tools/registry, to identify, reach out and track patients due for preventive services.										
Task Ensure that IT solutions (within registry or other) allow for "closed loop processing" e.g., tracking of patient through completion of any given preventive service.										
Task Conduct training around closed loop processing/referral and preventive service tracking.										

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SBH Health System (PPS ID:36)

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 Provide guidance for ongoing assesment to ensure that practices are following requirements and protocols, and offer guidance to develop mechanisms for continuous quality improvement.										
Task Identify safety net provider data sharing requirements and assess partner and QE data sharing capabilities and current HIE participation										
Task Coordinate with Bronx RHIO to develop comprehensive HIE adoption program to encourage and support partner participation and integration										
Task Begin coordinated interface and service development with Bronx RHIO										
Task Establish BPHC program to manage support for safety net providers to ensure that all are actively sharing health information, coordinating with Bronx RHIO to encourage, track and support partner participation and integration/data sharing										
Task Track status and manage support to ensure that all PPS safety net providers are actively sharing health information through Bronx RHIO or alternative health information exchange										
Task Identify community organizations for inclusion in the initial iteration of the Community Resource Database, sign agreements with with community based organizations and establish process to facilitate feedback to and from community organizations										
Task Perform regular checks of Community Resource Database to ensure data is up to date and accurate and to identify additional resources to consider including										
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices										
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).										

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SBH Health System (PPS ID:36)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	0	0	0	0	0	0	0	0	0
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	0	0	0	0	0	0	0	0	180	543
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task Assess eligible participating partner EHR use relative to Meaningful Use and PCMH 2014 Level 3 standards										
Task Establish BPHC program to educate, encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, including potential use of incentive-based payments for implementation										
Task Recruit or contract for EHR implementation resources as needed										
Task Begin actively encouraging, tracking and supporting partner EHR implementation and progress towards Meaningful Use and PCMH standards										
Task Track status and manage support to ensure all eligible safety net providers are using certified EHR systems that meet Meaningful Use and PCMH 2014 Level 3 standards										
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices										
Task Recruit or contract for PCMH practice certification resources as needed										
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition										
Task Perform gap analysis by practice and identify key priorities.										
Task Finalize strategy to support primary care physicians with										

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SBH Health System (PPS ID:36)

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
achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.										
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition										
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed.										
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 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 Create a Transitional Work Group (CVD/Diabetes TWG) comprised of representatives from partner organizations to support development of and approve elements of the COP										
Task Identify DSRIP project requirements which are related to PCMH elements and incorporate into PCMH strategy and project planning documents										
Task Identify relevant evidence-based guidelines for diabetes										
Task Identify partner organizations participating in project (sites and CBOs)										
Task Develop a workplan and timeline to develop the clinical operations plan (COPs) and implement a strategy for the diabetes population that aligns with the patient engagement speed and scale application submission										
Task Develop the COP to define the program elements, define the										

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SBH Health System (PPS ID:36)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
required and suggested components of those elements, and identify relevant resources to achieve them. Elements include health information exchange and technology requirements, and evidence-based guidelines and high-value treatment protocols										
Task Develop the project implementation budget										
Task Design training and recruitment strategy in conjunction with workforce team and CVD/DM TWG										
Task Submit elements of the COP to Quality and Care Innovation Sub-Committee (QCIS) for approval										
Task Identify clinical champions and operational leaders in each participating organization to develop and lead implementation of the program at each of their providers/sites. These facility-based champions/leaders form the Site-Specific Implementation Team										
Task Prepare/disseminate gap analysis tool based on COP to participating providers to determine implementaton support needs										
Task Hold webinar for participating partner organizations										
Task Create a rapid deployment collaborative, comprised of representatives from partner organizations to support implementation of the COP and to provide updates to QCIS. and to update the COP annually.										
Task Develop mechanisms for regular review of project-selected Evidence Based Guidelines (by project quality councils) to assure our PPS is utilizing the most up-to-date tools and that those updated guidelines/protocols continue to be clinically integrated across 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.	74	494	494	494	494	494	494	494	494	494
Task Identify sites participating in project. In order to meet the 80% participation rate target, project participation materials distributed to sites indicate that 3.c.i is required for all adult primary care practices.										

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SBH Health System (PPS ID:36)

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 Ensure that all participating practices have signed MSA										
Task Identify opportunities to coordinate processes, education and communication into PCMH workflow processes.										
Task Collaborate with other BPHC project-specific workgroups and teams to ensure that diabetes management training is incoporated/included in other care coordination training sessions.										
Task Monitor acitivity/engagement and make periodic reports to QCIS / EC										
Task Develop methodology for evaluation, feedback and Continuous Quality Improvement.										
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 Coordinate to establish the care team and care coordination/management framework/organizational structure and processes most appropriate for achieving project outcome, including nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.										
Task Present care management model to QCIS for review and approval										
Task Establish care coordination teams and processes; include community service and program referrals and tracking, communication, PCP alerts, education materials, coordination among team members, frequency and purpose of patient contact. Ensure these include coordination with the Health Home										

SBH Health System (PPS ID:36)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
care manager, where applicable.										
Task Working with Workforce Subcommittee, design training and recruitment strategy for care coordinators/managers and care teams with a training focus on improving health literacy, patient self-efficacy.										
Task Identify site-specific implementation teams.										
Task Launch recruitment and training programs with participating providers										
Task Identify and document required clinical and care management protocols for priority programs, projects and interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data										
Task Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations for how interventions will be logged, tracked and reported.										
Task Deploy systems to improve and promote effective care transitions, include protocols for tracking and follow-up										
Task Operationalize partner and workforce roles by providing gap analysis and appropriate training.										
Task Establish data collection, survey and reporting mechanisms to enable BPHC monitoring to ensure that patients are receiving appropriate health care and community support in priority projects, based on needs identified in prior planning activities										
Task Review process for rapid cycle evaluation and continuous improvement of data collection, survey and reporting methods based on priority project experience and modify process as needed to ensure patients receive appropriate health care and community support										
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.										

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SBH Health System (PPS ID:36)

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 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 Using claims data identify "hotspot" areas/patient groups for outreach										
Task Identify and mitigate service shortages to address these "hotspots" which can include mobile services and use of churches and community centers for education and blood pressure screening.										
Task Implement 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, if feasible.										
Task Establish linkages to health homes for targeted patient populations										
Task Implement the Stanford Model through partnerships with community based organizations, including Health People										
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 Identify current tools and services available to members for relevant MCOs across the PPS, including telehealth, care management, stipend for completing recommended preventive screenings.										
Task Distribute materials regarding extant services and benefits										

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SBH Health System (PPS ID:36)

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
available to members to providers participting in project										
Task Build prompts to these tools and services into provider EHRs										
Task Where feasible, make agreements with MCO related to coordination of services for high risk populations, including smoking cessation services, weight management, and other preventive services relevant to this project.										
Task Communicate payor information and include information on availability/how to access in training programs										
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 Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff										
Task Perform current state assessment of E.H.R. capabilities.										
Task Perform gap analysis and identify priories to achieving integration of patient record.										
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.										
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)										
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.										
Task Create budget to build registry and acquire necessary resources										

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SBH Health System (PPS ID:36)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries										
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data										
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care										
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.										
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.										
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.										
Task Site-specific implementation teams establish processes to use PHM tools/registry, to identify, reach out and track patients due for preventive services.										
Task Ensure that IT solutions (within registry or other) allow for "closed loop processing" e.g., tracking of patient through completion of any given preventive service.										
Task Conduct training around closed loop processing/referral and preventive service tracking.										
Task Provide guidance for ongoing assesment to ensure that practices are following requirements and protocols, and offer guidance to develop mechanisms for continuous quality improvement.										
Task Identify safety net provider data sharing requirements 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
assess partner and QE data sharing capabilities and current HIE participation										
Task Coordinate with Bronx RHIO to develop comprehensive HIE adoption program to encourage and support partner participation and integration										
Task Begin coordinated interface and service development with Bronx RHIO										
Task Establish BPHC program to manage support for safety net providers to ensure that all are actively sharing health information, coordinating with Bronx RHIO to encourage, track and support partner participation and integration/data sharing										
Task Track status and manage support to ensure that all PPS safety net providers are actively sharing health information through Bronx RHIO or alternative health information exchange										
Task Identify community organizations for inclusion in the initial iteration of the Community Resource Database, sign agreements with with community based organizations and establish process to facilitate feedback to and from community organizations										
Task Perform regular checks of Community Resource Database to ensure data is up to date and accurate and to identify additional resources to consider including										
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices										
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.	74	494	494	494	494	494	494	494	494	494
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	74	494	494	494	494	494	494	494	494	494

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	1,087	1,812	1,812	1,812	1,812	1,812	1,812	1,812	1,812	1,812
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	18	122	122	122	122	122	122	122	122	122
Task Assess eligible participating partner EHR use relative to Meaningful Use and PCMH 2014 Level 3 standards										
Task Establish BPHC program to educate, encourage, track and support eligible safety net providers in acquiring/implementing certified EHR systems, including potential use of incentive-based payments for implementation										
Task Recruit or contract for EHR implementation resources as needed										
Task Begin actively encouraging, tracking and supporting partner EHR implementation and progress towards Meaningful Use and PCMH standards										
Task Track status and manage support to ensure all eligible safety net providers are using certified EHR systems that meet Meaningful Use and PCMH 2014 Level 3 standards										
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices										
Task Recruit or contract for PCMH practice certification resources as needed										
Task Establish BPHC program to educate on the benefits of, and encourage, track and support PCPs and facility based senior leadership in achieving PCMH 2014 Level 3 recognition, including potential use of incentive-based payments for achieving recognition										
Task Perform gap analysis by practice and identify key priorities.										
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.										
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition										

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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 Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed.										
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.	The Central Services Organization (CSO) continued development and finalized the Diabetes Clinical Operations Plan (COP) in December. The COP is based on the DSRIP Domain 1 and 3 measures, using input from the CVD-Diabetes Transitional Work Group (TWG). It includes chapters on target population, evidence-based guidelines, referral protocols, patient flows, care team roles, and patient/caregiver education and engagement.
Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.	This quarter, BPHC confirmed participation in the Diabetes project for its 7 largest member organizations, who encompass the majority of our PCPs and more than 90% of our primary care visits. Practices must commit to participating in the Diabetes project in order to qualify for PCMH coach funding. In our second wave of provider engagement with smaller organizations, project participation materials continue to emphasize that 3.c.i is required for all adult primary care 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.	The model for care coordination teams was finalized this quarter and included in the COP for the Health Home at Risk program (referenced in other project sections). This model includes the opportunity to add additional members of the care management team needed to fulfil the care coordination requirements of the diabetes project, including certified diabetes educators (CDEs). Since the implementation of team-based care is foundational to BPHC's primary care projects, this program launched this January to allow sites time to begin building their teams and making selected hires. The requirements of the CVD (and other primary care projects) were included in the assessment of need for additional staff members to prevent silo-ing and to build capacity for PCMH and Domain 3 DSRIP requirements.
Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.	The COP includes a chapter on this topic, written in policy & procedure (P&P) format, based on the CVD/Diabetes TWG's recommendation. The COP will be distributed in Q4 to the participating member organizations of our PPS. BPHC has begun contracting with "HealthPeople" to provide training and implementation of the Stanford Model for chronic diseases.
Ensure coordination with the Medicaid Managed Care organizations serving the target population.	BPHC's CMO has continued to make the topic of partnership/agreements with Medicaid MCOs a priority topic at the regularly-scheduled cross-PPS meetings hosted by GNYHA. BPHC had initial conversations with HealthFirst this quarter around the topic of the Stanford model, with continuing discussions planned for Q4. BPHC plans to collect information on selected initiatives (e.g. LEAP classes) to potentially support coverage of such programs by MCOs in the future.
Use EHRs or other technical platforms to track all patients engaged in this project.	BPHC plans to use the RHIO/SHIN-NY for population health and reporting and these topics are included in the COP. There is a regular weekly meeting between stakeholders from the Bronx RHIO and BPHC to formulate the strategy for use and implementation of the RHIO and SHIN-NY. Additionally, the four Bronx PPS's meet monthly to discuss shared efforts and are working unified strategy for QE Engagement, including communications, operations and training.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	Improving RHIO consent penetration is a focus area for BPHC in DY2. The IT Subcommittee reviewed the registry strategy but approval from this subcommittee of the registry elements was determined to be unnecessary and less meaningful than originally determined, given the clinical expertise required that the IT Subcommittee does not offer. It was further determined that the Executive Committee would not need to approve this level of detail in the PHM strategy, give that its Clinical Committee had already conducted a thorough review and approval process.
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.	PCMH consultants have been hired by BPHC to support our member organizations achievement of PCMH 2014 Level 3 certification and Meaningful Use. This quarter, they began conducting site-specific gap analyses with BPHC PCPs which includes assessing current EHR capabilities/standards at the sites and formulating a plan to meet Meaningful Use and PCMH Level 3 2014 standards by the end of DY3. BPHC has developed a comprehensive plan to support MU and PCMH which includes use of targeted patient registries in conjunctions with our clinical projects.

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 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

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

Instructions :

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

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

Instructions :

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

Throughout DSRIP, BPHC will seek to address risks to the implementation of Project 3.d.ii using the mitigation strategies described below. (1) Parents and caregivers are unaware of symptoms that can lead to exacerbations and do not act fast enough to prevent an incident resulting in an ED visit. During home visits, community health workers (CHWs) will emphasize the importance of consistent medication use to control asthma and will demonstrate use of medication delivery devices. (2) This project is heavily reliant on CHWs being able to conduct home visits to inspect homes and engage and educate the target population. The experience of our primary vendor for this project, a.i.r nyc, indicates that 50% of affected individuals that they reach out to do not initially accept a home visit. This risk is most acute among the undocumented immigrant population. Trust building will require time, persistence, and tactics that are culturally sensitive and address the specific concerns of each family. To tackle this challenge, a.i.r nyc recruits CHWs from the geographic and ethnic communities to be served. CHW training focuses on building client trust, cultural competency, and positive impact of persistence as key to overcoming patients' fear. Additionally, we plan to "market" a.i.r. nyc services and to elevate their "brand" as a trusted partner to physicians, schools, and community organizations that have earned a high degree of community trust. As part of establishing this link, a.i.r. nyc will conduct an orientation on its services for sites identified as key referral sources to the project. A tactic may include incorporating logos of trusted PPS partners, including CBOs, on outreach and educational materials disseminated to patients. (3) Another challenge this project will face is integrating CHWs into two critical asthma patient contact points: hospital emergency departments (EDs) and discharge planning units. The experience of a.i.r nyc strongly suggests that effective integration will require a communication plan, including a clinician orientation, that educates ED and discharge planning staff on the goals, strategies, tactics and proven value of the intervention. (4) Capacity building will be a challenge for this project. a.i.r. nyc, our partner and vendor for this project, currently has a small staff and is planning to scale up its work to meet the needs of our PPS's patient population. To mitigate the risks associated with a.i.r. nyc's rapid expansion, BPHC's CSO will work with the organization to ensure that staff support and funding is available to rapidly plan, recruit, train and deploy CHWs to the field on a schedule that aligns with the patient engagement speed goals we have established. (5) Most providers do not have asthma registries or electronic care plan tools and do not participate in the RHIO to permit information sharing across providers. BPHC's CSO will address these issues by adding new IT capabilities, including a care planning and management platform and patient registries, and promoting RHIO participation. (6) Lifestyle choices could pose a challenge to patient compliance (e.g., passive smoking, environmental factors acting as asthma triggers such as pests, molds, etc.). Mitagation will include Comminuty Health Workers referring patients and families to Quitline, for integrated pest managment (IPM) services, etc.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	15,500

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
0	0		0	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
zstopak	Baseline or Performance Documentation	36_PMDL4715_1_3_20160201162541_3.d.ii_-_Patient_Engagement_DY1_Q3.docx	Patient Engagement	02/01/2016 04:26 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	Project	N/A	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has developed a strategy for the collaboration of community medical and social services providers to assess a patient's home and provide self-management education for the appropriate control of asthma.	Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Contract with a.i.r. nyc to provide home-based services for clients/families with asthma to develop and disseminate patient education materials and create rosters demonstrating that patients have received home-based interventions.	Project		In Progress	04/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Contract with a.i.r. nyc to perform home environment assessment for environmental factors acting as asthma triggers, e.g., pests, molds, etc.	Project		In Progress	04/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify key stakeholders and subject matter experts (SMEs) among PPS members and convene representative individuals to establish work group to develop Clinical Operations Plan (COP) for participating members to use as project implementation manual.	Project		Completed	04/01/2015	06/01/2015	04/01/2015	06/01/2015	06/30/2015	DY1 Q1
Task Develop workplan and time line to develop COP.	Project		Completed	06/01/2015	08/03/2015	06/01/2015	08/03/2015	09/30/2015	DY1 Q2
Task Develop comprehensive provider/participant engagement, education and communication plan to engage community medical and social services providers in the project and establish	Project		Completed	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 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
productive collaborative relationships and linkages among them.									
Task Develop and finalize Asthma Action Plan form	Project		Completed	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Develop systems to populate Asthma Actions Plans for dissemination to patients and PCPs.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify and establish relationship(s) with legal services in the community that provide pro bono legal services for community members, including dealing with landlords who fail to address/mitigate building environment factors that are known triggers of asthma problems	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Identify PPS members who will participate in project.	Project		Completed	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Use Master Services Agreement (MSA) to contract with PPS members who participate in the project and receive DSRIP funds	Project		Completed	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define target population.	Project		Completed	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify Site-Specific Implementation Teams to facilitate referrals to a.i.r. nyc and coordinate Asthma Action Plan and report distribution to care teams.	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Develop methodology evaluation, feedback and Continuous Quality Improvement (CQI) for Site-Specific Implementation Teams.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence-based trigger reduction interventions.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify integrated pest management (IPM) vendors who provide	Project		Completed	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
services in the Bronx.									
Task Develop policies, procedures and workflows for engaging IPM vendors when needed, including responsible resources at each stage of the workflow.	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task a.i.r. nyc has partnership with NYCDOHMH's Healthy Homes programs for linking patients to IPM vendors. Meet with a.i.r. nyc and Healthy Homes Program adminstrator to develop plan for scaling up linking patients with IPM vendors/resources and other community based services as needed.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish a.i.r nyc's Action Plan for Remediation as tool for monitoring and tracking delivery of IPM services to patients to ensure services are delivered.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task In conjunction with the Workforce Subcommittee, develop training materials for Community Health Workers (CHWs) on 1) how to conduct home environmental assessmentswith establishment of asthma action plan for remediation; and 2) the protocols for engaging IPM vendors for trigger reduction interventions.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop patient educational materials on indoor asthma triggers and availability of IPM resources to reduce exposure to the triggers.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #3 Develop and implement evidence-based asthma management guidelines.	Project	N/A	In Progress	06/29/2015	03/31/2017	06/29/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS incorporates evidence-based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management.	Project		In Progress	06/29/2015	03/31/2017	06/29/2015	03/31/2017	03/31/2017	DY2 Q4
Task Global Initiative for Asthma (GINA) guidelines for Asthma Management and Prevention in combination with EPR 3 national guidelines will serve as basis for implementing evidence-based asthma management care together with The Community	Project		Completed	06/29/2015	08/03/2015	06/29/2015	08/03/2015	09/30/2015	DY1 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
Preventative Service Task Force evidence-based recommendations for Home-Based Multi-Trigger, Multicomponent Environmental Interventions for Asthma Control: http://www.thecommunityguide.org/asthma/multicomponent.html									
Task Quality and Care Innovation Sub-Committee (QCIS) will review and revise the evidence-based guidelines for clinical practice, as needed, and approve.	Project		Completed	08/04/2015	10/31/2015	08/04/2015	10/31/2015	12/31/2015	DY1 Q3
Task Once approved, the guidelines will be incorporated into protocols and implemented by medical providers and care teams at sites of participating member organizations.	Project		Completed	11/01/2015	12/31/2015	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop mechanisms for regular review of project-selected evidence-based guidelines (EBGs) to assure our PPS is utilizing the most up-to-date tools and that those updated guidelines/protocols continue to be clinically integrated across the PPS.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed training and comprehensive asthma self-management education, to include basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task a.i.r. nyc and Asthma work group will review the National Standards for asthma self-management to ensure that training is comprehensive and utilizes national guidelines for asthma self-management : (Gardner A., Kaplan B., Brown W., et al. (2015). National standards for asthma self-management education. Ann Allergy Asthma Immunol. 114 (3). doi:	Project		Completed	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
10.1016/j.anai.2014.12.014.)									
Task Select/develop new or additional culturally/linguistically and literacy appropriate patient/caregiver educational materials as needed that improve asthma health literacy and improve self-efficacy and self-management.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Disseminate/embed (in EHR/PHR, where feasible) patient/caregiver educational information and materials across participating PPS providers.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Conduct ongoing education/training to introduce/update/refresh care teams' knowledge of new patient educational materials and evidence-based guidelines	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Establish protocols and methods that promote medication adherence, including local participating pharmacists to support patient education, especially on inhaler/spacer use.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone #5 Ensure coordinated care for asthma patients includes social services and support.	Project	N/A	In Progress	08/03/2015	09/30/2017	08/03/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has developed and conducted training of all providers, including social services and support.	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task All practices in PPS have a Clinical Interoperability System in place for all participating providers.	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has assembled a care coordination team that includes use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Project		In Progress	08/03/2015	09/30/2017	08/03/2015	09/30/2017	09/30/2017	DY3 Q2
Task In conjunction with the Workforce Subcommittee, develop training that includes social services reports and develop training calendars.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Conduct educational sessions/webinar and ongoing training as	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	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
needed for providers on use of Asthma Project COP.									
Task Develop and implement provider-specific technical assistance program to facilitate use of various interoperable IT systems.	Project		Not Started	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Identify and document required clinical and care management protocols for priority programs, projects and interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data	Project		Completed	08/15/2015	10/15/2015	08/15/2015	10/15/2015	12/31/2015	DY1 Q3
Task Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations for how interventions will be logged, tracked and reported.	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Deploy systems to improve and promote effective care transitions, include protocols for tracking and follow-up	Project		Not Started	01/15/2016	02/28/2016	01/15/2016	02/28/2016	03/31/2016	DY1 Q4
Task Operationalize partner and workforce roles by providing gap analysis and appropriate training.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Establish data collection, survey and reporting mechanisms to enable BPHC monitoring to ensure that patients are receiving appropriate health care and community support in priority projects, based on needs identified in prior planning activities	Project		Not Started	02/01/2016	06/15/2016	02/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Review process for rapid cycle evaluation and continuous improvement of data collection, survey and reporting methods based on priority project experience and modify process as needed to ensure patients receive appropriate health care and community support	Project		Not Started	08/01/2016	09/01/2016	08/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task In conjunction with Workforce Subcommittee, describe roles and responsibilities of care coordination team that includes clinical practice care team (e.g., PCPs, nurses, medical assistants), dietitians, pharmacists and community health workers.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task a.i.r. nyc will present its current intake and assessment process	Project		Completed	08/03/2015	09/30/2015	08/03/2015	09/30/2015	09/30/2015	DY1 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
and assessment tools to Asthma Project Work Group for review and inclusion in COP.									
Task a.i.r. nyc will present its current referral protocols to Asthma work groups for review, modification (if needed) and inclusion in COP.	Project		Completed	08/03/2015	09/30/2015	08/03/2015	09/30/2015	09/30/2015	DY1 Q2
Task a.i.r. nyc will present its current patient flow chart to Asthma work group for review, modification (if needed) and inclusion in COP. The flow chart plots the inter-relationships among a.i.r. nyc staff, referral sources, PCPs and CBOs and the multiple protocols and process workflows.	Project		Completed	08/03/2015	09/30/2015	08/03/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify community organizations for inclusion in the initial iteration of the Community Resource Database, sign agreements with with community based organizations and establish process to facilitate feedback to and from community organizations	Project		In Progress	10/15/2015	03/31/2017	10/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task Perform regular checks of Community Resource Database to ensure data is up to date and accurate and to identify additional resources to consider including	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	Project	N/A	In Progress	08/03/2015	03/31/2017	08/03/2015	03/31/2017	03/31/2017	DY2 Q4
Task Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's family.	Project		In Progress	08/03/2015	03/31/2017	08/03/2015	03/31/2017	03/31/2017	DY2 Q4
Task Establish protocols for frequency of follow-up services	Project		Completed	08/03/2015	12/31/2015	08/03/2015	12/31/2015	12/31/2015	DY1 Q3
Task Establish processes and timelines for additional follow-up to ensure root causes have been sustainably eliminated.	Project		Completed	08/03/2015	12/31/2015	08/03/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify patients with ED or hospital visits for an asthma	Project		Not Started	03/31/2016	06/30/2016	03/31/2016	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
diagnosis, via interoperable systems, e.g., RHIO, CCMS, registry									
Task Establish processes to identify the root causes of the "outpatient failure," e.g., problems with medication refills, prior authorization of meds, proper inhaler use, education about triggers, pest control issues	Project		In Progress	08/03/2015	03/31/2016	08/03/2015	12/31/2016	12/31/2016	DY2 Q3
Task Establish processes to share root causes with family/care givers and to provide support to eliminate/rectify root causes, as needed	Project		In Progress	08/03/2015	03/31/2016	08/03/2015	12/31/2016	12/31/2016	DY2 Q3
Task Develop mechanisms for ongoing evaluation of the above processes and follow up to assure accountability and continuous quality improvement.	Project		Not Started	01/03/2016	03/31/2017	01/03/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	Project	N/A	In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers.	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Meet with MCOs to identify triggers and processes for payer care coordination and asthma services to ensure coordination of care and prevent gaps in care and/or redundant services.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task PPS has agreement in place with MCOs to address coverage of patients with asthma health issues	Project		Not Started	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Meet with health home managers, PCPs and specialty providers of participating organizations in Asthma project to review project Clinical Operations Plan, inlcuding, but limited to evidence-based guidelines; patient flow charts plotting inter-relationship among a.i.r. nyc staff, referral sources, PCPs home health managers and specialty providers; referral protocols to medical, behavioral health, home care and social support services including PCPs,	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	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
Health Homes, mental health/behavioral health providers, and CBOs.									
Task Using Master Services Agreements and schedules, develop partnership agreements with participating health home managers, PCPs and speciality providers that define services they will provide and their responsibilities to adopt and use the Clinical Operations Plan for the project.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop partnership agreements with MCOs affirming coverage and coordination of asthma service benefits.	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	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	08/03/2015	03/31/2017	08/03/2015	03/31/2017	03/31/2017	DY2 Q4
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform gap analysis and identify priories to achieving integration of patient record.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project	Project		Completed	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task	Project		Not Started	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
Create budget to build registry and acquire necessary resources									
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, with an emphasis on tracking patient engagement with primary care	Project		Not Started	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 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.										
Task PPS has developed a strategy for the collaboration of community medical and social services providers to assess a patient's home										

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 provide self-management education for the appropriate control of asthma.										
Task Contract with a.i.r. nyc to provide home-based services for clients/families with asthma to develop and disseminate patient education materials and create rosters demonstrating that patients have received home-based interventions.										
Task Contract with a.i.r. nyc to perform home environment assessment for environmental factors acting as asthma triggers, e.g., pests, molds, etc.										
Task Identify key stakeholders and subject matter experts (SMEs) among PPS members and convene representative individuals to establish work group to develop Clinical Operations Plan (COP) for participating members to use as project implementation manual.										
Task Develop workplan and time line to develop COP.										
Task Develop comprehensive provider/participant engagement, education and communication plan to engage community medical and social services providers in the project and establish productive collaborative relationships and linkages among them.										
Task Develop and finalize Asthma Action Plan form										
Task Develop systems to populate Asthma Actions Plans for dissemination to patients and PCPs.										
Task Identify and establish relationship(s) with legal services in the community that provide pro bono legal services for community members, including dealing with landlords who fail to address/mitigate building environment factors that are known triggers of asthma problems										
Task Identify PPS members who will participate in project.										
Task Use Master Services Agreement (MSA) to contract with PPS members who participate in the project and receive DSRIP funds										
Task Define target population.										
Task Identify Site-Specific Implementation Teams to facilitate referrals to a.i.r. nyc and coordinate Asthma Action Plan and 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
distribution to care teams.										
Task Develop methodology evaluation, feedback and Continuous Quality Improvement (CQI) for Site-Specific Implementation Teams.										
Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.										
Task PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence-based trigger reduction interventions.										
Task Identify integrated pest management (IPM) vendors who provide services in the Bronx.										
Task Develop policies, procedures and workflows for engaging IPM vendors when needed, including responsible resources at each stage of the workflow.										
Task a.i.r. nyc has partnership with NYCDOHMH's Healthy Homes programs for linking patients to IPM vendors. Meet with a.i.r. nyc and Healthy Homes Program adminstrator to develop plan for scaling up linking patients with IPM vendors/resources and other community based services as needed.										
Task Establish a.i.r nyc's Action Plan for Remediation as tool for monitoring and tracking delivery of IPM services to patients to ensure services are delivered.										
Task In conjunction with the Workforce Subcommittee, develop training materials for Community Health Workers (CHWs) on 1) how to conduct home environmental assessmentswith establishment of asthma action plan for remediation; and 2) the protocols for engaging IPM vendors for trigger reduction interventions.										
Task Develop patient educational materials on indoor asthma triggers and availability of IPM resources to reduce exposure to the triggers.										

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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 Develop and implement evidence-based asthma management guidelines.										
Task PPS incorporates evidence-based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management.										
Task Global Initiative for Asthma (GINA) guidelines for Asthma Management and Prevention in combination with EPR 3 national guidelines will serve as basis for implementing evidence-based asthma management care together with The Community Preventative Service Task Force evidence-based recommendations for Home-Based Multi-Trigger, Multicomponent Environmental Interventions for Asthma Control: http://www.thecommunityguide.org/asthma/multicomponent.html										
Task Quality and Care Innovation Sub-Committee (QCIS) will review and revise the evidence-based guidelines for clinical practice, as needed, and approve.										
Task Once approved, the guidelines will be incorporated into protocols and implemented by medical providers and care teams at sites of participating member organizations.										
Task Develop mechanisms for regular review of project-selected evidence-based guidelines (EBGs) to assure our PPS is utilizing the most up-to-date tools and that those updated guidelines/protocols continue to be clinically integrated across the PPS.										
Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.										
Task PPS has developed training and comprehensive asthma self-management education, to include basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.										
Task a.i.r. nyc and Asthma work group will review the National										

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Standards for asthma self-management to ensure that training is comprehensive and utilizes national guidelines for asthma self-management : (Gardner A., Kaplan B., Brown W., et al. (2015). National standards for asthma self-management education. Ann Allergy Asthma Immunol. 114 (3). doi: 10.1016/j.anai.2014.12.014.)										
Task Select/develop new or additional culturally/linguistically and literacy appropriate patient/caregiver educational materials as needed that improve asthma health literacy and improve self-efficacy and self-management.										
Task Disseminate/embed (in EHR/PHR, where feasible) patient/caregiver educational information and materials across participating PPS providers.										
Task Conduct ongoing education/training to introduce/update/refresh care teams' knowledge of new patient educational materials and evidence-based guidelines										
Task Establish protocols and methods that promote medication adherence, including local participating pharmacists to support patient education, especially on inhaler/spacer use.										
Milestone #5 Ensure coordinated care for asthma patients includes social services and support.										
Task PPS has developed and conducted training of all providers, including social services and support.										
Task All practices in PPS have a Clinical Interoperability System in place for all participating providers.										
Task PPS has assembled a care coordination team that includes use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.										
Task In conjunction with the Workforce Subcommittee, develop training that includes social services reports and develop training calendars.										
Task Conduct educational sessions/webinar and ongoing training as needed for providers on use of Asthma Project COP.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Develop and implement provider-specific technical assistance program to facilitate use of various interoperable IT systems.										
Task Identify and document required clinical and care management protocols for priority programs, projects and interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data										
Task Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations for how interventions will be logged, tracked and reported.										
Task Deploy systems to improve and promote effective care transitions, include protocols for tracking and follow-up										
Task Operationalize partner and workforce roles by providing gap analysis and appropriate training.										
Task Establish data collection, survey and reporting mechanisms to enable BPHC monitoring to ensure that patients are receiving appropriate health care and community support in priority projects, based on needs identified in prior planning activities										
Task Review process for rapid cycle evaluation and continuous improvement of data collection, survey and reporting methods based on priority project experience and modify process as needed to ensure patients receive appropriate health care and community support										
Task In conjunction with Workforce Subcommittee, describe roles and responsibilities of care coordination team that includes clinical practice care team (e.g., PCPs, nurses, medical assistants), dietitians, pharmacists and community health workers.										
Task a.i.r. nyc will present its current intake and assessment process and assessment tools to Asthma Project Work Group for review and inclusion in COP.										
Task a.i.r. nyc will present its current referral protocols to Asthma work groups for review, modification (if needed) and inclusion in COP.										
Task a.i.r. nyc will present its current patient flow chart to Asthma work										

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
group for review, modification (if needed) and inclusion in COP. The flow chart plots the inter-relationships among a.i.r. nyc staff, referral sources, PCPs and CBOs and the multiple protocols and process workflows.										
Task Identify community organizations for inclusion in the initial iteration of the Community Resource Database, sign agreements with with community based organizations and establish process to facilitate feedback to and from community organizations										
Task Perform regular checks of Community Resource Database to ensure data is up to date and accurate and to identify additional resources to consider including										
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices										
Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.										
Task Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's family.										
Task Establish protocols for frequency of follow-up services										
Task Establish processes and timelines for additional follow-up to ensure root causes have been sustainably eliminated.										
Task Identify patients with ED or hospital visits for an asthma diagnosis, via interoperable systems, e.g., RHIO, CCMS, registry										
Task Establish processes to identify the root causes of the "outpatient failure," e.g., problems with medication refills, prior authorization of meds, proper inhaler use, education about triggers, pest control issues										
Task Establish processes to share root causes with family/care givers and to provide support to eliminate/rectify root causes, as needed										
Task Develop mechanisms for ongoing evaluation of the above processes and follow up to assure accountability and continuous										

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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
quality improvement.										
Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.										
Task PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers.										
Task Meet with MCOs to identify triggers and processes for payer care coordination and asthma services to ensure coordination of care and prevent gaps in care and/or redundant services.										
Task PPS has agreement in place with MCOs to address coverage of patients with asthma health issues										
Task Meet with health home managers, PCPs and specialty providers of participating organizations in Asthma project to review project Clinical Operations Plan, inlcuding, but limited to evidence-based guidelines; patient flow charts plotting inter-relationship among a.i.r. nyc staff, referral sources, PCPs home health managers and specialty providers; referral protocols to medical, behavioral health, home care and social support services including PCPs, Health Homes, mental health/behavioral health providers, and CBOs.										
Task Using Master Services Agreements and schedules, develop partnership agreements with participating health home managers, PCPs and speciality providers that define services they will provide and their responsibilities to adopt and use the Clinical Operations Plan for the project.										
Task Develop partnership agreements with MCOs affirming coverage and coordination of asthma service benefits.										
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Define population health management (PHM) requirements,										

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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
establish PHM function and recruit or contract with partner for PHM staff										
Task Perform current state assessment of E.H.R. capabilities.										
Task Perform gap analysis and identify priories to achieving integration of patient record.										
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project										
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)										
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.										
Task Create budget to build registry and acquire necessary resources										
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries										
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data										
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care										
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.										
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.										

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Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, with an emphasis on tracking patient engagement with primary care										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.										
Task PPS has developed a strategy for the collaboration of community medical and social services providers to assess a patient's home and provide self-management education for the appropriate control of asthma.										
Task Contract with a.i.r. nyc to provide home-based services for clients/families with asthma to develop and disseminate patient education materials and create rosters demonstrating that patients have received home-based interventions.										
Task Contract with a.i.r. nyc to perform home environment assessment for environmental factors acting as asthma triggers, e.g., pests, molds, etc.										
Task Identify key stakeholders and subject matter experts (SMEs) among PPS members and convene representative individuals to establish work group to develop Clinical Operations Plan (COP) for participating members to use as project implementation manual.										
Task Develop workplan and time line to develop COP.										
Task Develop comprehensive provider/participant engagement, education and communication plan to engage community medical and social services providers in the project and establish productive collaborative relationships and linkages among them.										
Task Develop and finalize Asthma Action Plan form										
Task Develop systems to populate Asthma Actions Plans for dissemination to patients and PCPs.										

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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 Identify and establish relationship(s) with legal services in the community that provide pro bono legal services for community members, including dealing with landlords who fail to address/mitigate building environment factors that are known triggers of asthma problems										
Task Identify PPS members who will participate in project.										
Task Use Master Services Agreement (MSA) to contract with PPS members who participate in the project and receive DSRIP funds										
Task Define target population.										
Task Identify Site-Specific Implementation Teams to facilitate referrals to a.i.r. nyc and coordinate Asthma Action Plan and report distribution to care teams.										
Task Develop methodology evaluation, feedback and Continuous Quality Improvement (CQI) for Site-Specific Implementation Teams.										
Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.										
Task PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence-based trigger reduction interventions.										
Task Identify integrated pest management (IPM) vendors who provide services in the Bronx.										
Task Develop policies, procedures and workflows for engaging IPM vendors when needed, including responsible resources at each stage of the workflow.										
Task a.i.r. nyc has partnership with NYCDOHMH's Healthy Homes programs for linking patients to IPM vendors. Meet with a.i.r. nyc and Healthy Homes Program adminstrator to develop plan for scaling up linking patients with IPM vendors/resources and other community based services as needed.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Establish a.i.r nyc's Action Plan for Remediation as tool for monitoring and tracking delivery of IPM services to patients to ensure services are delivered.										
Task In conjunction with the Workforce Subcommittee, develop training materials for Community Health Workers (CHWs) on 1) how to conduct home environmental assessmentswith establishment of asthma action plan for remediation; and 2) the protocols for engaging IPM vendors for trigger reduction interventions.										
Task Develop patient educational materials on indoor asthma triggers and availability of IPM resources to reduce exposure to the triggers.										
Milestone #3 Develop and implement evidence-based asthma management guidelines.										
Task PPS incorporates evidence-based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management.										
Task Global Initiative for Asthma (GINA) guidelines for Asthma Management and Prevention in combination with EPR 3 national guidelines will serve as basis for implementing evidence-based asthma management care together with The Community Preventative Service Task Force evidence-based recommendations for Home-Based Multi-Trigger, Multicomponent Environmental Interventions for Asthma Control: http://www.thecommunityguide.org/asthma/multicomponent.html										
Task Quality and Care Innovation Sub-Committee (QCIS) will review and revise the evidence-based guidelines for clinical practice, as needed, and approve.										
Task Once approved, the guidelines will be incorporated into protocols and implemented by medical providers and care teams at sites of participating member organizations.										
Task Develop mechanisms for regular review of project-selected evidence-based guidelines (EBGs) to assure our PPS is utilizing the most up-to-date tools and that those updated guidelines/protocols continue to be clinically integrated across the PPS.										

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Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.										
Task PPS has developed training and comprehensive asthma self-management education, to include basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.										
Task a.i.r. nyc and Asthma work group will review the National Standards for asthma self-management to ensure that training is comprehensive and utilizes national guidelines for asthma self-management : (Gardner A., Kaplan B., Brown W., et al. (2015). National standards for asthma self-management education. Ann Allergy Asthma Immunol. 114 (3). doi: 10.1016/j.anai.2014.12.014.)										
Task Select/develop new or additional culturally/linguistically and literacy appropriate patient/caregiver educational materials as needed that improve asthma health literacy and improve self-efficacy and self-management.										
Task Disseminate/embed (in EHR/PHR, where feasible) patient/caregiver educational information and materials across participating PPS providers.										
Task Conduct ongoing education/training to introduce/update/refresh care teams' knowledge of new patient educational materials and evidence-based guidelines										
Task Establish protocols and methods that promote medication adherence, including local participating pharmacists to support patient education, especially on inhaler/spacer use.										
Milestone #5 Ensure coordinated care for asthma patients includes social services and support.										
Task PPS has developed and conducted training of all providers, including social services and support.										

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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 practices in PPS have a Clinical Interoperability System in place for all participating providers.										
Task PPS has assembled a care coordination team that includes use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.										
Task In conjunction with the Workforce Subcommittee, develop training that includes social services reports and develop training calendars.										
Task Conduct educational sessions/webinar and ongoing training as needed for providers on use of Asthma Project COP.										
Task Develop and implement provider-specific technical assistance program to facilitate use of various interoperable IT systems.										
Task Identify and document required clinical and care management protocols for priority programs, projects and interventions, based on Community Needs Assessment, clinical planning to-date and further analysis of attributed patient population, using MAPP and PPS partner patient-level data										
Task Define partner and workforce roles in delivering care based on protocols and planned interventions in priority projects, including expectations for how interventions will be logged, tracked and reported.										
Task Deploy systems to improve and promote effective care transitions, include protocols for tracking and follow-up										
Task Operationalize partner and workforce roles by providing gap analysis and appropriate training.										
Task Establish data collection, survey and reporting mechanisms to enable BPHC monitoring to ensure that patients are receiving appropriate health care and community support in priority projects, based on needs identified in prior planning activities										
Task Review process for rapid cycle evaluation and continuous improvement of data collection, survey and reporting methods based on priority project experience and modify process as										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
needed to ensure patients receive appropriate health care and community support										
Task In conjunction with Workforce Subcommittee, describe roles and responsibilities of care coordination team that includes clinical practice care team (e.g., PCPs, nurses, medical assistants), dietitians, pharmacists and community health workers.										
Task a.i.r. nyc will present its current intake and assessment process and assessment tools to Asthma Project Work Group for review and inclusion in COP.										
Task a.i.r. nyc will present its current referral protocols to Asthma work groups for review, modification (if needed) and inclusion in COP.										
Task a.i.r. nyc will present its current patient flow chart to Asthma work group for review, modification (if needed) and inclusion in COP. The flow chart plots the inter-relationships among a.i.r. nyc staff, referral sources, PCPs and CBOs and the multiple protocols and process workflows.										
Task Identify community organizations for inclusion in the initial iteration of the Community Resource Database, sign agreements with with community based organizations and establish process to facilitate feedback to and from community organizations										
Task Perform regular checks of Community Resource Database to ensure data is up to date and accurate and to identify additional resources to consider including										
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices										
Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.										
Task Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's family.										
Task Establish protocols for frequency of follow-up services										
Task Establish processes and timelines for additional follow-up to										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
ensure root causes have been sustainably eliminated.										
Task Identify patients with ED or hospital visits for an asthma diagnosis, via interoperable systems, e.g., RHIO, CCMS, registry										
Task Establish processes to identify the root causes of the "outpatient failure," e.g., problems with medication refills, prior authorization of meds, proper inhaler use, education about triggers, pest control issues										
Task Establish processes to share root causes with family/care givers and to provide support to eliminate/rectify root causes, as needed										
Task Develop mechanisms for ongoing evaluation of the above processes and follow up to assure accountability and continuous quality improvement.										
Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.										
Task PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers.										
Task Meet with MCOs to identify triggers and processes for payer care coordination and asthma services to ensure coordination of care and prevent gaps in care and/or redundant services.										
Task PPS has agreement in place with MCOs to address coverage of patients with asthma health issues										
Task Meet with health home managers, PCPs and specialty providers of participating organizations in Asthma project to review project Clinical Operations Plan, inlcuding, but limited to evidence-based guidelines; patient flow charts plotting inter-relationship among a.i.r. nyc staff, referral sources, PCPs home health managers and specialty providers; referral protocols to medical, behavioral health, home care and social support services including PCPs, Health Homes, mental health/behavioral health providers, and CBOs.										

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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 Using Master Services Agreements and schedules, develop partnership agreements with participating health home managers, PCPs and speciality providers that define services they will provide and their responsibilities to adopt and use the Clinical Operations Plan for the project.										
Task Develop partnership agreements with MCOs affirming coverage and coordination of asthma service benefits.										
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff										
Task Perform current state assessment of E.H.R. capabilities.										
Task Perform gap analysis and identify priories to achieving integration of patient record.										
Task Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project										
Task Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)										
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.										
Task Create budget to build registry and acquire necessary resources										
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries										
Task Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure										

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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
frequent automated updates of registry data										
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care										
Task Execute registry testing plan and training program for providers and care managers on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.										
Task Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.										
Task Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, with an emphasis on tracking patient engagement with primary care										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	Update: BPHC continued to develop the strategy for this project with the support of its partner a.i.r nyc, a CBO with 10 years' experience in providing asthma home-based services. In this quarter, a.i.r nyc and BPHC finalized the the clinical operations plan (COP) that will be used by participating member organizations as the implementation guide for the project. All the Milestone 1 tasks that were in progress to be completed by the end of Q3 were completed, except that we are pushing the delivery deadline for the next contract with a.i.r. nyc, for the actual delivery of home-based asthma services (Tasks 1.2 and 1.3) to Q3. The timeline for Tasks 1.13 and 1.14 is also being adjusted. (See justification below). Justification: We need to push the completion quarter of tasks 1.2 and 1.3 to Q4 because the main focus of the Asthma project to date has been the development and completion of the Clinical Operations Plan (COP), and this process took longer than expected due to a very intensive development and review and approval process involving the Asthma Transitional Work Group, whose membership included several physicians. That work needed to be

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	completed before contracting with a.i.r. nyc for the actual delivery of home-based services to clients/families as described in tasks 1.2 and 1.3. At present we are well into the process of negotiating the budget and contract with a.i.r. nyc to deliver these services as we implement the project and we will have the contract in place within the next several weeks (before the end of Q4). The timeline for completion of Tasks 1.13 and 1.14 are being extended due to the "ramp up" nature of a.i.r. nyc's proposed approach of scaling hiring over the first year. Given a.i.r. nyc's capacity, engagement of site-specific orientation teams will also likely scale up over time.
Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	Update: The Central Services Organization (CSO) continued development and finalized the Asthma Clinical Operations Plan (COP) in December. The COP includes the the evidence-based recommendations of the Task Force on Community Preventive Services for home-based, multi-trigger, multi-component, interventions with an environmental focus. The COP also includes procedures for the referral of patients to a.i.r. nyc, as well the training a.i.r. nyc's community health workers receive to perform such an assessment and the template for the Asthma Action plan which outlines steps to be taken to reduce exposure. The timing of task 4.6 around medication adherence and role of pharmacists in patient education is being pushed out by two quarters to collaborate with a similar initiative for the CVD project.
Develop and implement evidence-based asthma management guidelines.	Clinical evidence-based guidelines (EBGs) and home-based services for asthma care and management were developed by our Asthma Transitional Workgroup and recommended to the Quality and Care Innovation Subcommittee for adoption. The Subcommittee approved both sets of guidelines, and were incorporated into the Clinical Operations Plan. Following our launch in March, DPDs are expected to begin organization-specific processes to adopt evidence-based guidelines from COPs. The development of mechanisms for regular review of the EBGs is scheduled to begin in DY 1, Q4.
Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	a.i.r. nyc completed a comprehensive "Training & Practicum for Asthma Care Delivery in the Home Setting" this quarter. This guide contains thorough references to peer-reviewed literature to support its training and education strategy and comples with the National Standards for Asthma self-management. The other five tasks will be initiated and completed as scheduled. We expect excellent results for this milestone as a.i.r nyc has 10 years experience in the field and is recognized across the city as a leader in the area of training and comprehensive asthma self-management education.
Ensure coordinated care for asthma patients includes social services and support.	Update: The three tasks scheduled for DY 1, Q3 were initiated and completed on time. The COP includes chapters on clinical and care management protocols. The model for care coordination was finalized this quarter and included in the COP for the Health Home at Risk program (referenced in the asthma COP). Asthma was identified as one of the priority areas for this work. Since the implementation of team-based care is foundational to BPHC's primary care projects, this program launched this January to allow sites time to begin building their teams and making selected hires to build capacity for PCMH and Domain 3 DSRIP requirements. The COP also includes chapters on the roles and responsibilities of a.i.r. nyc and workforce at sites, including tracking and reporting. Based on this strategy, the deadlines for tasks 5.9-5.11 is being extended to DY1Q3, as hiring for the care coordinator roles will likely not be able to begin until March 2016, and sites will need time to finalize and train teams. The implementation of systems to support care coordination will also be staged. This timing is reflected in the new deadline for 5.8
Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	Update: The COP includes chapters on root cause analyses after ED visits to avoid future events, including protocols on follow-up services. As part of their Q2 work, the Asthma TWG identified the data elements required to identify patients with ED or hospital visits and their diagnosis status. These components will be included in the PPS-wide, cross-project registry being developed by BPHC. As such, the asthma data elements referenced above were included in the data elements recommended for inclusion in the draft a PPS-wide strategy which was presented to and approved by the QCIS this quarter The deadlines for tasks 6.5 and 6.6 will extend to DY1Q3 in order to reflect the timeline for all care coordination teams to be finalized and begin the asthma work (rationale described in greater detail in Milestone 5).
Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	Update: The model for care coordination was finalized this quarter and included in the COP for the Health Home at Risk program (referenced in the asthma COP). Additionally, BPHC is developing a cross-project strategy for referrals to and communication between Health Home care managers and other DSRIP stakeholders. Independent of the DSRIP work, HealthFirst has begun a pilot program with a.i.r. nyc recently to fund home-based asthma care, which may

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Milestone Name	Narrative Text
	serve an impetus for other MCOs to similar fund these services. BPHC has begun discussion around identification of BPHC Health First patients and will continue this work in future quarters. Due to these foundational discussions and the staggered approach of BPHC's projects (which led to a later initiation of the asthma work than originally anticipated), we pushing the deadline for task 7.4 (agreements with MCOs for asthma services) to DY3Q2. BPHC's CMO has made the topic of partnership/agreements with Medicaid MCOs a priority topic at the regularly-scheduled cross-PPS meetings hosted by GNYHA, so some of these agreements may be a collaboration with other PPSs.
Use EHRs or other technical platforms to track all patients engaged in this project.	Update: The four tasks under this milestone concerning, variously, assessing the capabilities and requirements of EHRs and other technical platforms for tracking actively engaged patients, e.g., patient registry, were completed in DY 1, Q3 as scheduled. The Asthma TWG finalized their recommendation regarding the data elements for tracking patients in Q2. Along with feedback from other project-specific workgroups, this work was used to draft a PPS-wide strategy which was presented to and approved by QCIS (Quality and Care Innovation Subcommittee) this quarter. Tracking of actively engaged patients will be a coordinated effort between referring sites and a.i.r. nyc. Actively engaged patients will be tracked and reported based on a.i.r. nyc's care management system. Practices making a referral are expected to enter that patient into the registry. The IT Subcommittee reviewed the registry strategy but approval from this subcommittee of the registry elements was determined to be unnecessary and less meaningful than originally determined, given the clinical expertise required that the IT Subcommittee does not offer. It was further determined that the Executive Committee would not need to approve this level of detail in the PHM strategy, give that its Clinical Committee had already conducted a thorough review and approval process.

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.d.ii.4 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

The primary risk associated with this project is that substance abuse and mental health services are siloed. The CNA identified pronounced silos in care, despite the co-morbidities in MH and SA. Further, various evidence-based trainings focus exclusively on mental health concerns. To mitigate this risk, BPHC and its MHSA Collaborative Workgroup PPS partners – Community Care of Brooklyn, OneCity Health, and Bronx Health Access – will include content experts and substance abuse trainings/materials that address prevention of overdose and unprotected sex and other risky behaviors into core programming. Another risk is that PPS partners will be challenged in collaborating with NYC Department of Education (DOE). The PPSs have identified strong synergies between this project and DOE programming, such as DOE's investments in mental health infrastructure in approximately 100 community/renewal schools City-wide, but they will need to actively engage DOE to succeed in DSRIP-related transformations. The Workgroup has already been addressing this risk by engaging the Director of School Mental Health Services with the City's Office of School Health and individuals with the New York City Department of Health and Mental Hygiene (DOHMH) as advisory members of the Workgroup. The PPS partners will continue to engage both DOE and DOHMH in developing their approach to programming and staffing. Additional risks are that PPSs will lack the robust data set required to measure progress against goals and serve as an evidence base to demonstrate the cost-effectiveness of the activities and, relatedly, that MHSA activities will not be sustainable beyond the demonstration period. The intervention aims to develop long-standing, sustainable school-based infrastructure to address MHSA needs. Specifically, rather than engage in any direct delivery of care, the PPSs will enhance schools' resources to manage MHSA needs for current and future students. The project design utilizes cost-effective staffing plans and trainings to prepare non-MD school-based staff to serve as effective coaches. Further, the PPSs have committed to working together to build an evidence-base to document results and cost-effectiveness. The PPSs have identified certain performance metrics, such as reductions in schools suspensions and 911 calls, that will be tracked. MCOs, SDOH, and DOE will be engaged in discussions regarding the program's cost-effectiveness and how to finance DSRIP staff and their related school-based activities under a value based payment system post-DSRIP. Another possible risk is that school-based staff will be disengaged, based on their own biases or misunderstanding of MHSA-related disease, or fears of being held responsible for individual student outcomes related to MHSA issues. To mitigate this risk, partnerships with teachers and school staff will be established at the ground level. Staff trainings will address issues like bias and stigma and will educate staff on the nature of MHSA conditions. The PPSs will also train school-based staff on when to refer students with potentially more serious problems to available referral channels and help to ensure warm handoffs to appropriate community-based MHSA services. Another possible risk is that BPHC will not be able to sustain a high level of commitment towards the project over the demonstration period. To mitigate this risk, the PPSs have made commitments, memorialized in a joint charter, to engage the MHSA Collaborative Workgroup over the entire demonstration period to spearhead programming. The Workgroup's experience to date reflects a high level of engagement and interest that the PPSs intend to sustain.

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Participate in citywide MHSA Workgroup meetings	In Progress	BPHC will join and contribute to a cross-PPS workgroup to develop, implement, and monitor the collaborative MHSA interventions.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Participate in cross-PPS workgroup	Completed	Contribute to the formation of an MHSA Work Group composed of representatives of the four collaborating PPSs, including community-based representatives	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify subject matter experts for workgroup	Completed	Identify PPS subject matter experts to join cross-PPS Work Group	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Invite city agency representatives for workgroup	Completed	Invite representatives from DOE-affiliated Office of School Health and DOHMH to join Workgroup as advisory members	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Attend regular meetings for cross-PPS workgroup	In Progress	Particpate in cross-PPS MHSA Workgroup meetings under the standing structure	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone Establish cross-PPS Collaboration structure	In Progress	In collaboration with cross-PPS workgroup and participating subject matter experts and City agencies, establish formalized structure for cross-PPS collaboration on governance and implementation of MHSA project	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Confirm commitment to cross-PPS collaboration	Completed	BPHC will confirm its commitment to partner in City-wide implementation of MHSA Project	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Develop governance structure	Completed	Develop governance structure and process among collaborating PPSs to oversee the implementation and ongoing operation of the MHSA project, and document functions, roles, and responsibilities for parties including Workgroup	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone Review of existing programs	In Progress	A critical component of successful implementation will be to identify effective means to adapt the collaborative care model among the	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
		adolescent population. The PPSs will work together to conduct research and adapt evidence-based models of collaborative care for adolescents.						
Task Conduct baseline analysis	Completed	A baseline analysis of existing programs and CBOs providing MHSA services to adolescents in schools will be conducted. Special focus will be on screening for depression and drug/alcohol abuse.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Review of evidence based interventions	Completed	Review evidence-based adaptations of Collaborative Care (CC) model that have targeted adolescents	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Draft findings and integrate into plans	In Progress	Findings from analysis and review of evidence based interventions on MHSA for adolescent populations will be integrated into MHSA project concept document	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone Develop operations plan	In Progress	An operations plan detailed MHSA project operational plan for Collaborative Care Adaptation in schools will be created	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Develop concept paper	In Progress	Engage MHSA Workgroup to develop concept paper describing the approach to strengthening the MHSA infrastructure in schools	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop selection process for lead agency	Completed	Design/implement process to select well qualified Lead agency to manage detailed program planning and implementation of the MHSA cross-PPS initiative	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Contract with selected Lead Agency	Completed	Contract with selected Lead Agency to manage all aspects of the MHSA project including developing operational plan, selection of community mental/behavioral health agencies, selection of target schools, project staffing structure, and training curriculum	07/31/2015	12/31/2015	07/31/2015	12/31/2015	12/31/2015	DY1 Q3
Task Draft operational plan	In Progress	Develop draft operational plan for MHSA Workgroup review that incorporates development of culturally and linguistically sensitive MEB health promotion and prevention resources, data-collection and evaluation, staffing, training, and referral planning, as needed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize operational plan	Not Started	Finalize draft operational plan and budget; share with MHSA Collaborative cross-PPS Governance body for approval	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone Implement Collaborative Care (CC) Adaptation in schools	In Progress	Implementation will encompass details on contracting, collaboration with NYCDOE, school selection, and launch of intervention in schools.	07/01/2015	09/30/2017	07/01/2015	09/30/2017	09/30/2017	DY3 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 Implement process for community agency selection	Not Started	Design and implement process to select and contract with community mental/behavioral agencies to implement programs in the schools	01/31/2016	06/30/2016	01/31/2016	06/30/2016	06/30/2016	DY2 Q1
Task Solicit DOE input on school selection methodology	Not Started	DOE will provide input and feedback on proposed process for community mental/behavioral health agency selection	01/31/2016	09/30/2017	01/31/2016	09/30/2017	09/30/2017	DY3 Q2
Task Identify target schools	Not Started	Identify target schools for implementation of CC adaptation	04/01/2016	06/30/2017	04/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task Develop project activities schedule	Not Started	Develop schedule for MHSA project activities, including activities preparatory to launch of CC adaptation in schools such as contracting, staff recruitment and deployment, training	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Launch MHSA project in schools	Not Started	Launch implementation of MHSA Project CC adaptation in schools	10/01/2016	09/30/2017	10/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone Design programs for young adults	Not Started	Adult-interfacing programs will be implemented to reach young people who are out of grade school. These programs will target young people though relevant community-based locations, including, but not limited to community colleges.	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Identify target young adult groups	Not Started	Identify target young adult groups, including, but not limited to, community college students	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Refine MHSA intervention	Not Started	Refine MHSA intervention to integrate programming to reach these young adult groups, including by developing culturally and linguistically sensitive MEB health promotion and prevention resources, data-collection and evaluation plan, and staffing and training plans	07/01/2017	03/31/2018	07/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task Launch young adult programs	Not Started	Launch young adult programs	04/01/2017	03/31/2018	04/01/2017	03/31/2018	03/31/2018	DY3 Q4

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Participate in citywide MHSA Workgroup meetings	Bronx Partners for Healthy Communities (BPHC) staff have participated in all meetings of the cross-PPS collaborative. The cross-PPS workgroup has selected and finalized the contract with the lead agency, Jewish Board for Family and Children Services (JBFCS), who will manage the implementation of this shared project. The cross-PPS workgroup will continue to meet regularly to vet plans and provide input on project implementation, and also connections to individual PPS connections to schools and local experts. Milestone is on track for completion.
Establish cross-PPS Collaboration structure	BPHC has committed to the cross-PPS collaborative, including agreeing to the 'DSRIP MHSA Collaboration Agreement,' which outlines the governance structure of the cross-PPS workgroup. The agreement also outlines the scope and deliverables for this project, as well as Project roles and responsibilities are also definedfor the lead agency, the PPS partners, and the subcontractors. Milestone is complete ahead of schedule.
Review of existing programs	BPHC completed an analysis of the existing programs and community-based organizations (CBOs) that are providing MHSA services to adolescents in schools. There was special attention paid to programs and CBOs that focus on screening for depression and drug/alcohol abuse. Separately, Collaborative Care plans were reviewed; BPHC will recommend to the cross-PPS Montefiore Medical Center's Behavioral Health Integration Programto inform the development of this project. The Montefiore integrated program is the largest program for youth/adolescents in the country, which offers mental health services to more than 90,000 children across 19 clinics. Milestone is on track for completion.
Develop operations plan	The lead agency, Jewish Board for Family and Children Services (JBFCS), was selected based on their application in response to the Request for Proposals (RFP). The contract was fully executed. The concept paper describing this project has been drafted and will be vetted with the lead agency and through the PPSs respective workgroups before final approval. The BPHC MHSA Implementation Work Group met and identified concerns around school selection and project sustainabilityand will provide recommendations on this to the cross-PPS workgroup. The BPHC workgroup will continue to provide expert consult on r the development of an operations plan for review by the cross-PPS collaborative and JBFCS. JBFCS submitted an addendum to their original proposal based on this plan. The operational plan will cover many components of this project including staffing, sub-contracting, training, evidence-based guidelines, and other relevant topics related to implementation. Milestone is on track for completion.
Implement Collaborative Care (CC) Adaptation in schools	The scope of work outlined in the RFP detailed that JBFCS will be responsible for coordinating the process of identifying evidence-based guidelines, training plans, integration of NYDOE into planning and implementation (they have also been included in cross-PPS meetings), school recruitment, staff recruitment, and project launch. The cross-PPS collaborative has met monthly and each PPS will be contributing to the development of the process for school selection. The final decision for this process will be with the cross-PPS collaborative, facilitated by the lead agency, JBFCS. Milestone is on track for completion.
Design programs for young adults	The cross-PPS workgroup has discussed this milestone with the lead agency (JBFCS). Initial project outlines have been created, but further planning is tabled until this milestone begins.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

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

Instructions :

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

The first major risk for this project is that the target population, HIV-positive individuals within the PPS service area, can be difficult to locate. HIV patients have a high prevalence of substance use disorder, homelessness, chronic trauma, behavioral health diagnoses and other chronic co-morbid conditions (e.g., diabetes, heart disease). Moreover, HIV disproportionately impacts ethnic/racial and gender minorities who often face stigma both in their communities and by providers. As a result, they may have to travel far from their community to receive culturally responsive care, which is not always feasible. To mitigate this risk, we plan to work closely with BPHC partners to identify HIV-positive individuals wherever they currently access services. We will ensure that partners have information about how to link these patients to appropriate care, not only for HIV services but to manage other conditions as well. We will also develop and provide training in cultural competency for providers and support staff, to expand the number of welcoming care delivery sites for HIV-positive individuals. Finally, we intend to establish peer support programs, particularly in ethnic/racial minority communities, as peers are often more effective in helping patients overcome cultural barriers to care. The second major risk for this project is that the demographics of the populations most in need of linkages to HIV services may change over time. To mitigate this risk, we intend to continue working with the Domain IV HIV Collaborative Workgroup which was formed by the PPSs during the Application Planning phase. Through this group we will continue to share information about new hotspots in local communities in order to recognize new trends early on. Once new sub-populations are identified, we will work together to adapt interventions and outreach strategies accordingly. The third major risk for this project is that PPSs will work in silos, creating a duplication of efforts and confusion for downstream providers. To mitigate this risk, the cross-PPS HIV Workgroup will continue collaborating to ensure that the PPSs effectively share knowledge, experience, and perspectives, to avoid service duplication, and improve project design and implementation. To be most effective we will need to ensure coordination across organizations and initiatives. This will entail breaking down silos between healthcare and supportive service providers as well as silos between providers offering the same services. For example, there are a number of community-based organizations that are instrumental in HIV care, but silos often lead to ineffective working relationships, lack of care coordination, and gaps in care. Organizations providing the same type of services (e.g., HIV testing) are also often unaware of how peer organizations provide the same services, therefore missing opportunities to share best practices and identify potential areas of collaboration. This is not efficient and can be confusing and detrimental to patients. We have a number of actions planned to break down silos. First, we plan to meet with all BPHC partners providing HIV services to get a better sense of current HIV work happening across the PPS. We will also continue meeting with the citywide cross-PPS HIV workgroup to foster continued collaboration and sharing of promising practices. Throughout the next five years, we will continue meeting with providers, colleagues and stakeholders to ensure that we remain coordinated, sharing challenges and best practices across all providers. Finally, we will leverage the workgroup to make progress toward alignment on common language and best practices whenever possible, in order to promote a standard for HIV-providers across the city.

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Implement evidence based best practices for disease management, specific to HIV and viral load suppression, in community and ambulatory care settings.	In Progress	evidence-based interventions will address the seven sectors selected by the cross-PPS workgroup, addressing: HIV morbidity and disparities and retention to care; peer-led interventions; educational campaigns targeting high-risk populations; Interventions addressing co-factors (e.g., homelessness); training in cultural competency for providers; empowerment of patient population; and interventions for high-risk patients, such as therapy for depression.	08/01/2015	06/30/2017	08/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Create the BPHC HIV Work Group	Completed	BPHC workgroup will be comprised of representatives from partner organizations, including Health Homes (HH), Care Management (CM) agencies, and HIV supportive housing providers to support development of and approve elements of the implementation plan.	08/01/2015	09/30/2015	08/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify evidence-based guidelines	Completed	Identify relevant evidence-based guidelines for HIV and Viral Load Suppression (VLS)	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify DSRIP project requirements related to PCMH elements	Completed	Identify DSRIP project requirements which are related to PCMH elements and incorporate into PCMH strategy and project planning documents	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop budget	Completed	Develop the project implementation budget	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop evidence-based strategies for disease management and control	Completed	Develop evidence-based strategies for the management and control of HIV in the PPS designated area.	10/31/2015	12/31/2015	10/31/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify clinical champions and operational leaders in each participating organization	In Progress	Clinical champions and operational leaders from participating organization will develop and lead implementation of the program at each of their providers/sites. These facility-based champions/leaders form the Site-Specific Implementation Team	09/01/2015	12/31/2015	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Create detailed implementation workplan and	In Progress	Develop a workplan and timeline to guide implementation of strategies for the HIV population	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
timelines								
Task Design culturally competent training and recruitment strategy	In Progress	In conjunction with workforce subcommittee, evaluate staffing needs to design culturally competent training and recruitment strategy	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Obtain approval of implementation workplan and timelines	Not Started	Submit elements of implementation plan to Quality and Care Innovation Sub-Committee (QCIS) for approval	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Disseminate gap analysis tool to providers	In Progress	PPrepare and disseminate gap analysis tool based on Clinical Operations Plan to participating providers to determine implementaton support needs	10/30/2015	03/31/2016	10/30/2015	03/31/2016	03/31/2016	DY1 Q4
Task Hold informational webinar	Not Started	Hold webinar for participating partner organizations	01/15/2016	03/31/2016	01/15/2016	03/31/2016	03/31/2016	DY1 Q4
Task Identify partner and target organizations for project implementation	In Progress	Identify partner organizations participating in project (sites and CBOs) and target organizations addressing co-existing burdens of high-needs populations, including but not limited to housing, substance abuse, Mental, Emotional and Behavioral health (MEBH), domestic violence, food access, etc.	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Define program elements	In Progress	Develop the implementation plan to define the program elements, define the required and suggested components of those elements, and identify relevant resources to achieve them. Elements include health information exchange and technology requirements, and evidence-based guidelines and high-value treatment protocols	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Create a rapid deployment collaborative	Not Started	The rapid deployment collaborative, or implementation workgroup, will be comprised of representatives from partner organizations to support implementation of the implementation plan.	02/01/2016	03/31/2017	02/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop and implement plans for CQI	Not Started	Develop feedback mechansims for accountability and continuous quality improvement and implement in appropriate settings	01/01/2016	06/30/2017	01/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task Regular review of evidence-based guidelines	Not Started	Develop mechanisms for regular review of project-selected evidence-based guidelines to assure our PPS is utilizing the most up-to-date tools and that those updated guidelines/protocols continue to be clinically integrated across the PPS.	04/01/2016	06/30/2017	04/01/2016	06/30/2017	06/30/2017	DY3 Q1
Milestone Participate in a NYC cross-PPS Collaborative	In Progress	Due to the collaborative nature of the HIV interventions, 7 NYC PPSs have convened and aligned sectors of focus for their projects	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
		and will continue to collaborate throughout implementation.						
Task Identify cross-PPS convener	Completed	Participate in contract negotiations with DOHMH to house the cross-PPS collaborative	08/01/2015	09/30/2015	08/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Convener contract Development	Completed	Participate in drafting shared contract with DOHMH	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Convener contract execution	Completed	Participate in getting contract with DOHMH approved and signed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify data sharing needs	Completed	Identify data sharing needs and the resources to support effective data sharing	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Create cross-PPS workplan	In Progress	Contribute to development of cross-PPS workplan in alignment with internal BPHC project implementation	10/20/2015	03/31/2016	10/20/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish cross-PPS milestones	Not Started	Establish agreed upon milestones for cross-PPS project implementation	01/15/2016	03/31/2016	01/15/2016	03/31/2016	03/31/2016	DY1 Q4
Task Collaborate with NYCDOHMH to develop and implement broad-based education campaigns	Not Started	Collaborate with NYCDOHMH to develop and implement broad-based education campaigns	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Identify population health and data management tools	Not Started	Identify existing population health management tools and data interfacing tools within the PPSs	02/01/2016	06/30/2016	02/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Conduct gap analysis	Not Started	Conduct gap analysis on available data and needed data to meet project requirements	03/01/2016	09/30/2016	03/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Conduct gap analysis on available data and needed data to meet project requirements	Not Started	Conduct gap analysis on available data and needed data to meet project requirements	03/01/2016	09/30/2016	03/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Leverage existing capacities	Not Started	As part of overall IT approach, identify strategies, including RHIO use and NYC DOHMH HIV syndromic surveillance data, to leverage existing capacities and resources that will support project requirements and meet population needs	06/01/2016	09/30/2016	06/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Vet cross-PPS projects with rapid deployment	Not Started	Vet agreed upon project commonalities and shared resources with relevant BPHC sub-committees and Executive Committee	02/01/2016	03/31/2017	02/01/2016	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
collaborative and Executive Committee								
Task Vet cross-PPS data sharing proposal with BPHC sub-committees and Executive Committee	Not Started	Vet agreed-upon data sharing system to address reporting and implementation needs with relevant BPHC sub-committees and Executive Committee	02/01/2016	03/31/2017	02/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Participate in a cross-PPS HIV Learning Collaborative	In Progress	Participate in a cross-PPS HIV Learning Collaborative	12/01/2015	03/31/2020	12/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone Develop adherence protocol and staffing plans	In Progress	Engage with HHs and CM agencies to develop plans for PHM to improve retention in care and medication adherence to support VLS	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Develop workplan for Retention to Care Unit	In Progress	Retention to Care Unit will be comprised of Care Managers and peer workers to reach clients who have not achieved VLS, to supplement the care coordination that HHs and their partnering CM agencies are doing.	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Review and develop protocols for evidence-based guidelines	In Progress	Engage HHs and CM agencies in HIV workgroup (from milestone 1) to review evidence-based guidelines and develop protocols	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish partnerships	Not Started	Establish partnerships with and participation of needed social service agencies and community resources that cover issues such as housing, substance abuse, Mental, Emotional and Behavioral health (MEBH), domestic violence, food access, etc.	02/01/2016	03/31/2016	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Identify sites for VLS intervention implementation	Not Started	Identify HHs and CM agencies to implement VLS interventions	04/15/2016	06/30/2016	04/15/2016	06/30/2016	06/30/2016	DY2 Q1
Task Conduct a gap analysis	In Progress	Conduct a gap analysis on staffing and resource needs	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Hire and train staff	Not Started	In conjuction with Workforce Subcommittee, recruit, hire and train existing and new staff. Include cultural competence around LGBTQ community and SUD.	05/01/2016	12/31/2016	05/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Recruit peer leaders	Not Started	Identify peer leaders who have achieved VLS to co-facilitate support groups, assist with education and outreach, and act as escorts for apointments	07/01/2016	03/31/2017	07/01/2016	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
Task Establish Retention to Care Unit.	Not Started	Establish Retention to Care Unit with trained staff and peer supports	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Implement interventions	Not Started	Identify and implement interventions targeting high-needs populations	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop and implement plans for CQI	Not Started	Develop feedback mechansims for accountability and continuous quality improvement	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone Utlize EHR and other IT platforms for population health management	In Progress	Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Define population health management requirements	Completed	Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Assess EHR capabilities	Completed	Perform current state assessment of EHR capabilities among participating safety net providers	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform gap analysis	Completed	Perform gap analysis and identify priorities to achieving integration of patient record.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define requirements and elements for patient registry	Completed	Define business requirements and data elements for patient registry to stratify and track all patients engaged in this project.	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Vet patient registry proposal with BPHC sub-committees and Executive Committee	Completed	Recommend registry business requirements and data elements to governance committees for review and approval (Quality and Care Innovation Subcommittee, Information Technology Subcommittee and Executive Committee)	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify technology and resource requirements for registry	Not Started	Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget	Not Started	Create budget to build registry and acquire necessary resources	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Secure Care Coordination Management Solution	Not Started	Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries	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
Task Develop project implementation and testing for registry	Not Started	Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop training plan and curriculum on registry use	Not Started	Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers, emphasizing use of registries and CCMS to increase care coordination and patient engagement with primary care	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Execute registry testing plan and training program	Not Started	The registry testing plan and training program will target providers and care managers and train them on systems use and on how to identify targeted patients and track those who are actively engaged for milestone reporting.	04/02/2016	06/30/2016	04/02/2016	06/30/2016	06/30/2016	DY2 Q1
Task Issue user credentials and provide trainings on CCMS	Not Started	Issue CCMS user credentials and train designated/delegated PPS partner workforce in use of the coordinated/ integrated solution. Disseminate standardized IT protocols and data security requirements across the system.	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Launch and monitor registry	Not Started	Launch registry and monitor its use and performance, evaluate success of patient tracking, and participating provider utilization patterns, , with an emphasis on tracking patient engagement with primary care.	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone Implement peer-based supports	Not Started	Develop and implement peer-based educational support and self-management programs	07/01/2016	09/30/2017	07/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Hold trainings	Not Started	Hold trainings for providers,care managers and peer support teams on cultural competency, motivational interviewing, and other adherence support strategies.	08/01/2016	12/31/2016	08/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Launch support programs	Not Started	Launch peer educator support programs that focus on adherence to HIV management	02/01/2017	03/31/2017	02/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Provide complementary resources to reinforce trainings	Not Started	Provide follow up support and materials to reinforce training objectives, including connecting clients with case managers/ retention to care unit and screening for barriers to adherence.	03/31/2017	06/30/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1
Task Develop and implement plans for CQI	Not Started	Develop feedback mechanisms for continuous quality improvement	03/03/2017	06/30/2017	03/03/2017	06/30/2017	06/30/2017	DY3 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 Execute educational campaigns	Not Started	Execute educational campaigns developed in collaboration with cross-PPS collaborative and NYCDOHMH	08/01/2016	06/30/2017	08/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task Identify training curricula	Not Started	In conjunction with BPHC Workforce Subcommittee, identify curricula for training providers, including care managers and peer support teams, on cultural competency, motivational interviewing, and other adherence support strategies. Include cultural competence around LGBTQ community and SUD.	07/01/2016	09/30/2017	07/01/2016	09/30/2017	09/30/2017	DY3 Q2

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
Implement evidence based best practices for disease management, specific to HIV and viral load suppression, in community and ambulatory care settings.	Utilizing the New York State Department of Health's "Ending the Epidemic," the evidence-based strategies were developed to manage and control HIV in the PPS. This document outlines expert research on limiting the spread of HIV, along with minimizing new diagnoses. This includes utilizing intake case management triage, integrated care conferencing, and linkage to full-circle behavioral and social supports as needed. We have begun to identify champions and operational leaders in participating sites, though our list of participating sites has not been finalized. The establishment of these partnerships isn't scheduled until DY1 Q4, and this directly impacts identifying the champions and operational leaders. This task will be pushed back to DY1 Q4. Milestone is on track for completion, assuming push back of PPS Task 1.6.
Participate in a NYC cross-PPS Collaborative	The New York City Department of Health and Mental Hygiene will act as convener for the HIV workgroup. There is no payment associated with convening the PPSs; therefore an MOU was executed in lieu of a contract. Extensive investigation was completed to identify the data sharing needs. This included evaluating participating providers' electronic health records (EHRs). Also, an initial draft of registry items was presented to Quality and Care Innovation Subcommittee (QCIS) and was approved to take to the Executive Committee (EC). Milestone is on track for completion.
Develop adherence protocol and staffing plans	BPHC has mapped Health Home providers in the PPS and their downstream care management agencies (CMAs). Health Home representatives have been involved in the Health Home At-Risk and CCMS workgroups to ensure their perspective is included in the development of clinical operations planning and system development. Towards the establishment of formal partnerships, BPHC and has engaged in high-level discussions with Health Home agencies and is currently reaching out to individual CMAs to ensure all are fully integrated into the PPS.
Utlize EHR and other IT platforms for population health management	BPHC has defined the Population Health Management (PHM) requirements based on this project's projected outcomes and the data that must be addressed to meet the requirements. The assessment of EHR capabilities has been completed and identified gaps that may affect the integration of patient records. The business requirements and data elements for the registry were defined and approved by QCIS. These will be used to begin tracking data associated with the

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
	patients engaged in the project. BPHC is executing a comprehensive plan to support its safety net providers in MU and PCMH which includes use of targeted patient registries in conjunctions with our clinical projects. BPHC has a comprehensive strategy in place for care management, which includes the use of registries, EHRs and IT platforms, and the completion of all agreed upon tasks by agreed upon dates. In DY1Q3, registry elements and business requirements were developed and adopted and a PHM Gap Assessment and IT Gap Assessment were constructed. Registry elements were approved by the Quality and Care Innovations Subcommittee. The IT Subcommittee reviewed the registry strategy but approval from this subcommittee of the registry elements was determined to be unnecessary and less meaningful than originally determined, given the clinical expertise required that the IT Subcommittee does not offer. It was further determined that the Executive Committee would not need to approve this level of detail in the PHM strategy, give that its Clinical Committee had already conducted a thorough review and approval process. Consultants have been deployed to perform detailed PHM Gap Analysis. This milestone is on track for completion.
Implement peer-based supports	There is currently no narrative around this milestone and its associated tasks, as the start date is DY3 Q1.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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Attestation

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

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

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

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

☐ **I here by attest, as the Lead Representative of the 'SBH Health System', 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:	ST BARNABAS HOSPITAL
Secondary Lead PPS Provider:	
Lead Representative:	Leonard T Walsh
Submission Date:	03/16/2016 04:38 PM

Comments:	

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SBH Health System (PPS ID:36)

Status Log				
Quarterly Report (DY,Q)	**Status**	**Lead Representative Name**	**User ID**	**Date Timestamp**
DY1, Q3	Adjudicated	Leonard T Walsh	sacolema	03/31/2016 05:15 PM
DY1, Q3	Submitted	Leonard T Walsh	lwalsh22	03/16/2016 04:38 PM
DY1, Q3	Returned	Leonard Walsh	sacolema	03/01/2016 05:15 PM
DY1, Q3	Submitted	Leonard Walsh	lwalsh22	02/02/2016 04:16 PM
DY1, Q3	In Process		ETL	01/03/2016 08:01 PM

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Comments Log			
Status	**Comments**	**User ID**	**Date Timestamp**
Adjudicated	The IA has adjudicated the DY1, Q3 Quarterly Report.	sacolema	03/31/2016 05:15 PM
Returned	The IA is returning the DY1, Q3 Quarterly Report to the PPS for Remediation.	sacolema	03/01/2016 05:15 PM

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Section	Module Name	Status
Section 01	IPQR Module 1.1 - PPS Budget Report (Baseline)	Completed
	IPQR Module 1.2 - PPS Budget Report (Quarterly)	Completed
	IPQR Module 1.3 - PPS Flow of Funds (Baseline)	Completed
	IPQR Module 1.4 - PPS Flow of Funds (Quarterly)	Completed
	IPQR Module 1.5 - Prescribed Milestones	Completed
	IPQR Module 1.6 - PPS Defined Milestones	Completed
	IPQR Module 1.7 - IA Monitoring	
Section 02	IPQR Module 2.1 - Prescribed Milestones	Completed
	IPQR Module 2.2 - PPS Defined Milestones	Completed
	IPQR Module 2.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 2.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 2.5 - Roles and Responsibilities	Completed
	IPQR Module 2.6 - Key Stakeholders	Completed
	IPQR Module 2.7 - IT Expectations	Completed
	IPQR Module 2.8 - Progress Reporting	Completed
	IPQR Module 2.9 - IA Monitoring	
Section 03	IPQR Module 3.1 - Prescribed Milestones	Completed
	IPQR Module 3.2 - PPS Defined Milestones	Completed
	IPQR Module 3.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 3.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 3.5 - Roles and Responsibilities	Completed
	IPQR Module 3.6 - Key Stakeholders	Completed
	IPQR Module 3.7 - IT Expectations	Completed
	IPQR Module 3.8 - Progress Reporting	Completed
	IPQR Module 3.9 - IA Monitoring	
Section 04	IPQR Module 4.1 - Prescribed Milestones	Completed
	IPQR Module 4.2 - PPS Defined Milestones	Completed

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

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

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Section	Module Name	Status
	IPQR Module 10.8 - IA Monitoring	
Section 11	IPQR Module 11.1 - Workforce Strategy Spending	Completed
	IPQR Module 11.2 - Prescribed Milestones	Completed
	IPQR Module 11.3 - PPS Defined Milestones	Completed
	IPQR Module 11.4 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 11.5 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 11.6 - Roles and Responsibilities	Completed
	IPQR Module 11.7 - Key Stakeholders	Completed
	IPQR Module 11.8 - IT Expectations	Completed
	IPQR Module 11.9 - Progress Reporting	Completed
	IPQR Module 11.10 - Staff Impact	Completed
	IPQR Module 11.11 - IA Monitoring	

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

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

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Section	Module Name / Milestone #	Review Status	
Section 01	Module 1.1 - PPS Budget Report (Baseline)	Pass & Complete	
	Module 1.2 - PPS Budget Report (Quarterly)	Pass & Ongoing	
	Module 1.3 - PPS Flow of Funds (Baseline)	Pass & Complete	
	Module 1.4 - PPS Flow of Funds (Quarterly)	Pass (with Exception) & Ongoing	
	Module 1.5 - Prescribed Milestones		
	Milestone #1 Complete funds flow budget and distribution plan and communicate with network	Pass & Ongoing	
Section 02	Module 2.1 - Prescribed Milestones		
	Milestone #1 Finalize governance structure and sub-committee structure	Pass & Complete	
	Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Pass & Complete	
	Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	Pass & Complete	
	Milestone #4 Establish governance structure reporting and monitoring processes	Pass & Complete	
	Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	Pass & Complete	
	Milestone #6 Finalize partnership agreements or contracts with CBOs	Pass & Ongoing	
	Milestone #7 Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	Pass & Ongoing	
	Milestone #8 Finalize workforce communication and engagement plan	Pass & Ongoing	
	Milestone #9 Inclusion of CBOs in PPS Implementation.	Pass & Ongoing	
Section 03	Module 3.1 - Prescribed Milestones		
	Milestone #1 Finalize PPS finance structure, including reporting structure	Pass & Complete	
	Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	Pass & Ongoing	
	Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Pass & Complete	
	Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	Pass & Ongoing	

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

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Section	Module Name / Milestone #	Review Status	
	Milestone #1 Perform a clinical integration 'needs assessment'.	Pass & Complete	
	Milestone #2 Develop a Clinical Integration strategy.	Pass & Ongoing	
Section 11	Module 11.2 - Prescribed Milestones		
	Milestone #1 Define target workforce state (in line with DSRIP program's goals).	Pass & Ongoing	
	Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	Pass & Ongoing	
	Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	Pass & Ongoing	
	Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	Pass & Ongoing	
	Milestone #5 Develop training strategy.	Pass & Ongoing	

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

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

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

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Pass & Ongoing	
	Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	Pass & Ongoing	
	Milestone #13 Measure outcomes as required in the IMPACT Model.	Pass & Ongoing	
	Milestone #14 Provide "stepped care" as required by the IMPACT Model.	Pass & Ongoing	
	Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
3.b.i	Module 3.b.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.b.i.3 - Prescribed Milestones		
	Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Pass & Ongoing	
	Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	Pass & Ongoing	
	Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Pass & Ongoing	
	Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	Pass & Ongoing	
	Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	Pass & Ongoing	
	Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Pass & Ongoing	
	Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	Pass & Ongoing	
	Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	Pass & Ongoing	
	Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	Pass & Ongoing	
	Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	Pass & Ongoing	
	Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	Pass & Ongoing	
	Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	Pass & Ongoing	
	Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	Pass & Ongoing	
	Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	Pass & Ongoing	
	Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	Pass & Ongoing	
	Milestone #18 Adopt strategies from the Million Hearts Campaign.	Pass & Ongoing	
	Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	Pass & Ongoing	
	Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	Pass & Ongoing	
3.c.i	Module 3.c.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.c.i.3 - Prescribed Milestones		
	Milestone #1 Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.	Pass & Ongoing	
	Milestone #2 Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.	Pass & Ongoing	
	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.	Pass & Ongoing	
	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.	Pass & Ongoing	
	Milestone #5 Ensure coordination with the Medicaid Managed Care organizations serving the target population.	Pass & Ongoing	
	Milestone #6 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	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.	Pass & Ongoing	
3.d.ii	Module 3.d.ii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.d.ii.3 - Prescribed Milestones		
	Milestone #1 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	Pass & Ongoing	
	Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	Pass & Ongoing	
	Milestone #3 Develop and implement evidence-based asthma management guidelines.	Pass & Ongoing	

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	Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	Pass & Ongoing	
	Milestone #5 Ensure coordinated care for asthma patients includes social services and support.	Pass & Ongoing	
	Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	Pass & Ongoing	
	Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	Pass & Ongoing	
	Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
4.a.iii	Module 4.a.iii.2 - PPS Defined Milestones	Pass & Ongoing	
4.c.ii	Module 4.c.ii.2 - PPS Defined Milestones	Pass & Ongoing	