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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Quarterly Report - Implementation Plan for SBH Health System

Year and Quarter: DY1, Q1 **Application Status:** Submitted

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

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

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Section 01 – Budget

IPQR Module 1.1 - PPS Budget Report

Instructions :

This table contains five budget categories. Please add rows to this table as necessary in order to add your own additional categories and 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 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
Revenue Loss	**4,039,604**	**4,304,891**	**6,961,548**	**6,164,424**	**4,039,604**	25,510,071
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
Total Expenditures	**26,930,696**	**28,699,272**	**46,410,322**	**41,096,162**	**26,930,696**	**170,067,148**
Undistributed Revenue	**0**	**0**	**0**	**1**	**0**	**0**

Current File Uploads

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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IPQR Module 1.2 - PPS Flow of Funds

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
Primary Care Physicians	1,553,901	1,607,159	3,420,441	2,784,265	1,386,931	10,752,697
Non-PCP Practitioners	675,960	717,482	1,327,335	1,160,967	693,465	4,575,209
Hospitals	4,263,129	5,639,407	9,690,475	10,541,166	9,594,060	39,728,237
Clinics	1,553,901	1,607,159	3,420,441	2,784,265	1,386,931	10,752,697
Health Home / Care Management	2,738,852	3,056,472	5,833,777	4,530,852	2,433,862	18,593,815
Behavioral Health	810,614	846,628	2,093,106	1,931,520	1,151,287	6,833,155
Substance Abuse	371,105	347,261	936,560	918,499	528,515	3,101,940
Skilled Nursing Facilities / Nursing Homes	1,268,436	1,334,516	2,441,183	2,321,933	1,528,317	8,894,385
Pharmacies	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	1,678,907	3,930,954	3,400,707	1,844,753	12,476,549
All Other	10,858,457	10,733,527	11,101,349	8,589,098	5,184,159	46,466,590
Total Funds Distributed	**26,930,696**	**28,699,269**	**46,410,322**	**41,096,163**	**26,930,696**	**170,067,146**
Undistributed Revenue	**0**	**2**	**0**	**0**	**0**	**2**

Current File Uploads

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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IPQR Module 1.3 - Prescribed Milestones

Instructions :

Please enter baseline target dates and work breakdown tasks with target dates for each of the milestones below.

Milestone/Task Name	Status	Description	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	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	12/31/2015	DY1 Q3	
Task Establish schedule for flow of funds	In Progress	Define PPS baseline funding schedule and distribution plan. Present for review and approval by the Executive Committee.	06/01/2015	07/31/2015	09/30/2015	DY1 Q2	
Task Share flow of funds information with PPS members	In Progress	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	12/31/2015	DY1 Q3	
Task Develop budgets	In Progress	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	09/30/2015	DY1 Q2	
Task Finalize funding schedules	In Progress	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	12/31/2015	DY1 Q3	
Task Initiate reporting process	On Hold	Initiate quarterly reporting process for earned waiver revenue and partner payments.	08/15/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Establish annual review and update process	On Hold	Define annual review and update process for the PPS baseline funding schedule and distribution plan. Present for review and approval by the Executive Committee.	10/01/2015	11/30/2015	12/31/2015	DY1 Q3	
Task Establish criteria for bonus payments and revenue loss funds	On Hold	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	03/31/2016	DY1 Q4	

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date
Complete funds flow budget and distribution plan and communicate with network	lrobsbh	36_MDL0103_1_1_20150728065708_Revised Award Letter Transmittal_SBH Health System.pdf	Award letter, corresponds to the following task: "Obtain final attribution and valuation"	07/28/2015 06:56 AM

Prescribed Milestones Narrative Text

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

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IPQR Module 1.4 - 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	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 Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 1.5 - IA Monitoring

Instructions :

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Section 02 – Governance

IPQR Module 2.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	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	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	06/30/2015	DY1 Q1	
Task Appoint EC members	Completed	Appoint members of the Executive Committee.	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	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	06/30/2015	DY1 Q1	
Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	In Progress	This milestone must be completed by 12/31/2015. Clinical Quality Committee charter and committee structure chart	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Establish QCIS charter	Completed	Develop and finalize charter for Quality and Care Innovation 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-	04/01/2015	05/01/2015	06/30/2015	DY1 Q1	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		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	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	06/30/2015	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	06/30/2015	DY1 Q1	
Task Select membership for rapid deployment collaboratives	In Progress	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	12/31/2015	DY1 Q3	
Task Establish reporting format and schedule	On Hold	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	12/31/2015	DY1 Q3	
Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	In Progress	This milestone must be completed by 9/30/2015. Upload of bylaws and policies document or committee guidelines.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
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	06/30/2015	DY1 Q1	
Task Establish PPS polices and procedures	In Progress	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	09/30/2015	DY1 Q2	
Task Share policies and procedures	In Progress	Share policies and procedures with other Sub-Committees and partner organizations.	07/23/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Establish process for review of policies and	In Progress	Develop a process and schedule for reviewing, revising and updating policies and procedures.	07/23/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
procedures							
Milestone #4 Establish governance structure reporting and monitoring processes	In Progress	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	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	06/30/2015	DY1 Q1	
Task Establish procedures for meeting minutes	In Progress	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	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	06/30/2015	DY1 Q1	
Task Develop project tracking dashboard	In Progress	Create a dashboard to track quarterly progress of each DSRIP project.	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop MSAs with schedules	In Progress	Create Master Service Agreements with schedules to be executed with each PPS member receiving DSRIP funds that 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).	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Compile performance data for review	On Hold	Compile performance data into reports highlighting trends and gaps and submit to the appropriate subcommittee(s) for review.	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop feedback mechanisms	On Hold	Create mechanisms for feedback to members on their performance.	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish response mechanisms for underperformance	On Hold	Develop policy and procedure on how to address underperformance by member organizations.	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish milestones and metrics for organizational work streams	On Hold	Identify key milestones and metrics quarterly for organizational workstreams (finance, IT, workforce, governance and clinical).	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	06/30/2015	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	06/30/2015	DY1 Q1	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
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	09/30/2015	DY1 Q2	
Task Create and disseminate tools for quarterly reporting by partners	On Hold	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	12/31/2015	DY1 Q3	
Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	In Progress	Community engagement plan, including plans for two-way communication with stakeholders.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	NO
Task Create an inventory of CBO services.	In Progress	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	09/30/2015	DY1 Q2	
Task Recruit CBO representatives for engagement in committee work	In Progress	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	09/30/2015	DY1 Q2	
Task Develop community engagement strategy	In Progress	Identify strategies to facilitate connections with the community and develop associated time line.	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task	In Progress	Draft community engagement plan and obtain feedback from patient	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Establish community engagement plan		engagement group and Executive Committee.					
Task Develop budget for community engagement	In Progress	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	09/30/2015	DY1 Q2	
Task Finalize community engagement budget	In Progress	Obtain approval from Finance and Sustainability Subcommittee for community engagement budget.	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #6 Finalize partnership agreements or contracts with CBOs	In Progress	Signed CBO partnership agreements or contracts.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Identify partner CBOs for DY1 contracts	In Progress	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	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	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	06/30/2015	DY1 Q1	
Task Finalize MSA	Completed	Finalize MSA.	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	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	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	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	In Progress	Agency Coordination Plan.	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
health and mental hygiene, Social Services, Corrections, etc.)							
Task Identify state and local agencies	In Progress	Identify all state and local agencies in the PPS area. Initiate contacts with various agencies and programs of the New York 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.	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Identify additional agencies for engagement and participation	On Hold	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	12/31/2015	DY1 Q3	
Task Recruit agency representatives for engagement in committee work	On Hold	Director of Collaboration to recruit staff from state and local agencies to serve as liaisons to PPS.	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish agency coordination plan	On Hold	Develop a plan for coordinating agency activities and obtain feedback from agencies on draft plan.	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #8 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	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	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	06/30/2015	DY1 Q1	
Task Finalize MSA	Completed	Finalize MSA	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	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	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	03/31/2016	DY1 Q4	
Task Execute MSA with Health People	In Progress	Execute agreement and project schedules with Health People	06/30/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #9 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	03/31/2016	DY1 Q4	NO
Task Establish and convene Workforce Project Team	In Progress	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	09/30/2015	DY1 Q2	
Task Identify workforce engagement needs	In Progress	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	12/31/2015	DY1 Q3	
Task Convene Workforce Communications Workgroup	In Progress	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 engaged in the deployment of DSRIP projects.	05/22/2015	07/31/2015	09/30/2015	DY1 Q2	
Task Obtain input on workforce communication and engagement plan	In Progress	Develop workforce communication and engagement plan goals, objectives and potential barriers and obtain feedback from Workforce Communications Workgroup.	07/31/2015	10/30/2015	12/31/2015	DY1 Q3	
Task Draft workforce communication and engagement plan	In Progress	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	12/31/2015	DY1 Q3	
Task Finalize workforce communication and engagement plan	On Hold	Obtain sign-off on workforce communication and engagement plan from Workforce Sub-Committee and Executive Committee.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date
Finalize governance structure and sub-committee structure	vchibiso	36_MDL0203_1_1_20150806095122_EC Vote on Charters - Director's Desk.docx	Vote on Committee Charters, corresponds to task: "Establish committee charters"	08/06/2015 09:50 AM
	lrobsbh	36_MDL0203_1_1_20150728072958_Subcommittee Membership Rosters_SBH-BPHC.pptx	Subcommittee Rosters, corresponds to task: "Appoint Sub-Committee members"	07/28/2015 07:29 AM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date
	lrobsbh	36_MDL0203_1_1_20150728072837_EC Membership Roster_SBH-BPHC.pptx	Executive Committee roster, corresponds to task: "Appoint EC members"	07/28/2015 07:28 AM
	lrobsbh	36_MDL0203_1_1_20150728070824_EC Meeting Minutes_5.21.15_Final.docx	Executive Committee meeting minutes, May 21, 2015	07/28/2015 07:08 AM
	lrobsbh	36_MDL0203_1_1_20150728070801_EC Meeting Minutes_4.23.15_Final.docx	Executive Committee meeting minutes, April 23, 2015	07/28/2015 07:07 AM
	lrobsbh	36_MDL0203_1_1_20150728070658_BPHC Workforce Subcommittee Charter 6-24-15.docx	Workforce Subcommittee Charter, corresponds to task: "Establish committee charters"	07/28/2015 07:06 AM
	lrobsbh	36_MDL0203_1_1_20150728070629_BPHC QCI Subcommittee Charter 6-24-15.docx	QCI Sub-Committee Charter, corresponds to task: "Establish committee charters"	07/28/2015 07:06 AM
	lrobsbh	36_MDL0203_1_1_20150728070604_BPHC IT Subcommittee Charter 6-24-15.docx	IT Subcommittee Charter, corresponds to task: "Establish committee charters"	07/28/2015 07:05 AM
	lrobsbh	36_MDL0203_1_1_20150728070542_BPHC Finance & Sustainability Subcommittee Charter 6-24-15.docx	Finance & Sustainability Subcommittee Charter, corresponds to task: "Establish committee charters"	07/28/2015 07:05 AM
	lrobsbh	36_MDL0203_1_1_20150728070512_BPHC Executive Committee Charter _Final_4_14_15.docx	Executive Committee Charter, corresponds to task: "Establish committee charters"	07/28/2015 07:04 AM
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	lrobsbh	36_MDL0203_1_1_20150728074911_HH at-Risk TWG Meeting Minutes_Final_5.7.15.docx	HH at-Risk Work Group meeting minutes, May 7, 2015, corresponds to task: "Create work groups"	07/28/2015 07:48 AM
	lrobsbh	36_MDL0203_1_1_20150728074837_Asthma TWG Meeting Minutes_6.1.15.docx	Asthma Work Group meeting minutes, June 1, 2015, corresponds to task: "Create work groups"	07/28/2015 07:48 AM
	lrobsbh	36_MDL0203_1_1_20150728074808_CVD-Diabetes TWG Meeting Minutes_5.7.15.docx	CVD/Diabetes Work Group meeting minutes, May 7, 2015, corresponds to task: "Create work groups"	07/28/2015 07:47 AM
	lrobsbh	36_MDL0203_1_1_20150728074717_BPHC QCI Subcommittee Meeting Minutes_6.5.15.docx	QCI Subcommittee meeting minutes, June 5, 2015, corresponds to task: "Initiate QCIS work"	07/28/2015 07:46 AM
	lrobsbh	36_MDL0203_1_1_20150728074626_QCI Subcommittee Membership Roster_SBH-BPHC.pptx	QCI Subcommittee Roster, corresponds to task: "Establish QCIS membership"	07/28/2015 07:46 AM
	lrobsbh	36_MDL0203_1_1_20150728074552_BPHC QCI Subcommittee Charter 6-24-15.docx	QCI Subcommittee Charter, corresponds to task: "Establish QCIS charter"	07/28/2015 07:45 AM
Finalize bylaws and policies or Committee Guidelines where applicable	lrobsbh	36_MDL0203_1_1_20150728075828_EC Meeting Minutes_5.21.15_Final.docx	Corresponds to task: "Establish PPS governance by-laws"	07/28/2015 07:58 AM
	lrobsbh	36_MDL0203_1_1_20150728075813_EC Meeting Minutes_4.23.15_Final.docx	Corresponds to task: "Establish PPS governance by-laws"	07/28/2015 07:58 AM
	lrobsbh	36_MDL0203_1_1_20150728075758_BPHC_Nominating Committee Charter_Final_6-24-15.docx	Corresponds to task: "Establish PPS governance by-laws"	07/28/2015 07:57 AM
	lrobsbh	36_MDL0203_1_1_20150728075743_BPHC Workforce Subcommittee Charter 6-24-15.docx	Corresponds to task: "Establish PPS governance by-laws"	07/28/2015 07:57 AM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date
	lrobsbh	36_MDL0203_1_1_20150728075728_BPHC QCI Subcommittee Charter 6-24-15.docx	Corresponds to task: "Establish PPS governance by-laws"	07/28/2015 07:57 AM
	lrobsbh	36_MDL0203_1_1_20150728075710_BPHC IT Subcommittee Charter 6-24-15.docx	Corresponds to task: "Establish PPS governance by-laws"	07/28/2015 07:57 AM
	lrobsbh	36_MDL0203_1_1_20150728075659_BPHC Finance & Sustainability Subcommittee Charter 6-24-15.docx	Corresponds to task: "Establish PPS governance by-laws"	07/28/2015 07:56 AM
	lrobsbh	36_MDL0203_1_1_20150728075644_BPHC Executive Committee Charter _Final_4_14_15.docx	Corresponds to task: "Establish PPS governance by-laws"	07/28/2015 07:56 AM
Establish governance structure reporting and monitoring processes	lrobsbh	36_MDL0203_1_1_20150728083814_BPHC Finance & Sustainability Subcomm Planning Calendar_5.6.15.docx	Corresponds to task: "Develop DSRIP planning calendars"	07/28/2015 08:37 AM
	lrobsbh	36_MDL0203_1_1_20150728083745_CSO Planning Team Meeting Agenda_7.17.15.docx	Corresponds to task: "Establish CSO Planning Team"	07/28/2015 08:37 AM
	lrobsbh	36_MDL0203_1_1_20150728083647_EC Meeting Minutes_4.23.15_Final.docx	Corresponds to task: "Establish reporting framework across PPS governance"	07/28/2015 08:36 AM
	lrobsbh	36_MDL0203_1_1_20150728083624_BPHC_Nominating Committee Charter_Final_6-24-15.docx	Corresponds to task: "Establish reporting framework across PPS governance"	07/28/2015 08:36 AM
	lrobsbh	36_MDL0203_1_1_20150728083603_BPHC Workforce Subcommittee Charter 6-24-15.docx	Corresponds to task: "Establish reporting framework across PPS governance"	07/28/2015 08:35 AM
	lrobsbh	36_MDL0203_1_1_20150728083545_BPHC QCI Subcommittee Charter 6-24-15.docx	Corresponds to task: "Establish reporting framework across PPS governance"	07/28/2015 08:35 AM
	lrobsbh	36_MDL0203_1_1_20150728083524_BPHC IT Subcommittee Charter 6-24-15.docx	Corresponds to task: "Establish reporting framework across PPS governance"	07/28/2015 08:35 AM
	lrobsbh	36_MDL0203_1_1_20150728083504_BPHC Finance & Sustainability Subcommittee Charter 6-24-15.docx	Corresponds to task: "Establish reporting framework across PPS governance"	07/28/2015 08:34 AM
	lrobsbh	36_MDL0203_1_1_20150728083448_BPHC Executive Committee Charter _Final_4_14_15.docx	Corresponds to task: "Establish reporting framework across PPS governance"	07/28/2015 08:34 AM
Finalize partnership agreements or contracts with CBOs	lrobsbh	36_MDL0203_1_1_20150728091644_SBH DSRIP MSA Exhibit 2 (Legal Terms)_Final.docx	Corresponds with task: "Finalize MSA"	07/28/2015 09:16 AM
	lrobsbh	36_MDL0203_1_1_20150728091634_SBH DSRIP MSA Exhibit 1 (Definitions)_Final.docx	Corresponds with task: "Finalize MSA"	07/28/2015 09:16 AM
	lrobsbh	36_MDL0203_1_1_20150728091622_SBH DSRIP MSA_Final.docx	Corresponds with task: "Finalize MSA"	07/28/2015 09:16 AM
	lrobsbh	36_MDL0203_1_1_20150728091553_Final BPHC MSA Comment Matrix.pdf	Corresponds with task: "Obtain feedback on MSA"	07/28/2015 09:15 AM
	lrobsbh	36_MDL0203_1_1_20150728091506_BPHC MSA Comment Matrix.doc	Corresponds with task: "Obtain feedback on MSA"	07/28/2015 09:14 AM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date
	lrobsbh	36_MDL0203_1_1_20150728091432_SBH DSRIP MSA_Draft_Redline.docx	Corresponds with task: "Draft MSA for CBOs"	07/28/2015 09:14 AM
	lrobsbh	36_MDL0203_1_1_20150728091408_SBH DSRIP MSA Exhibit 2 (Legal Terms)_Draft_Redline.docx	Corresponds with task: "Draft MSA for CBOs"	07/28/2015 09:14 AM
	lrobsbh	36_MDL0203_1_1_20150728091354_SBH DSRIP MSA Exhibit 1 (Definitions)_Draft_Redline.docx	Corresponds with task: "Draft MSA for CBOs"	07/28/2015 09:13 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize governance structure and sub-committee structure	
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	
Finalize bylaws and policies or Committee Guidelines where applicable	
Establish governance structure reporting and monitoring processes	
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	
Finalize partnership agreements or contracts with CBOs	
Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	
Finalize workforce communication and engagement plan	
Inclusion of CBOs in PPS Implementation.	SBH will be contracting with CBOs in concert with contract negotiations with all other partner organizations. BPHC is planning to contract with Health People: Community Preventive Health Institute (HP), a Bronx CBO specializing in evidence-based patient education. HP will help BPHC strengthen the evidence-based disease management

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	models in Project 3.c.i (diabetes disease management) and Project 3.b.i (cardiovascular disease management) by training Bronx residents as peer educators who will deliver the Stanford self-management and LEAP amputation prevention patient engagement models. (Note: Both Health People and a.i.r. nyc are traditional CBOs; they do not oversee other CBOs, but will act as project leads in their respective DSRIP projects.) BPHC regularly meets with the other PPSs in the Bronx to explore ways of working together, including coordinating activities that impact overlapping CBO members. Additional contracts with CBOs will be developed and negotiated upon recommendations of EC and subcommittees to carry out specific project elements as determined necessary in the course of implementation during DY1 and DY2. All partner organizations, including CBOs, will participate in project delivery in accordance with the Master Services Agreement, which will set forth, among other things, the terms and conditions governing implementation by CBOs of DSRIP projects. Additionally, in accordance with the Master Services Agreement, all partner organizations, including CBOs, have the ability to participate in the PPS governance structure through the Project Advisory Committee. The Project Advisory Committee, including CBOs, will be responsible for advising the PPS and the formal committees of the governance structure. The process for finalizing the Master Services Agreements is described above under the "Finalize partnership agreements or contracts with CBOs" milestone. SBH expects to execute Master Services Agreements with two CBOs by DY1, Q3.

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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	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 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	Chair, Nominating Committee	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	Dr. David Collymore, Co-Chair, Quality & Care Innovation Sub-Committee Deborah Pantin, Co-Chair, Quality & Care Innovation Sub-Committee	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	TBD	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 on workforce	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
1199SEIU Labor Union	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	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)	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 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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize PPS finance structure, including reporting structure	In Progress	This milestone must be completed by 12/31/2015. PPS finance structure chart / document, signed off by PPS Board.	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	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	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	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	06/30/2015	DY1 Q1	
Task Establish policies and procedures	In Progress	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	09/30/2015	DY1 Q2	
Task Obtain EC approval of financial framework	On Hold	Obtain Executive Committee sign-off of PPS finance structure, policies and procedures.	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	On Hold	This milestone must be completed by 3/31/2016. Network financial health current state assessment (to be performed at least annually). The PPS must: - identify those providers in their network that are financially fragile, including those that have qualified as IAAF providers;	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		-- 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	On Hold	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.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Conduct assessment of current state of financial health	On Hold	Conduct financial health current state assessment utilizing assessment tool developed during the DSRIP planning phase for partners added since the first assessment was completed.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Analyze results of assessments	On Hold	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	03/31/2016	DY1 Q4	
Task Establish reporting and monitoring processes	On Hold	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.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Conduct first annual review	On Hold	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.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	In Progress	This milestone must be completed by 12/31/2015. Finalized Compliance Plan (for PPS Lead).	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
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	09/30/2015	DY1 Q2	
Task Identify Compliance Officer	In Progress	Identify a Compliance Officer who has an expertise in NYSSS Law 363-d.	07/01/2015	08/30/2015	09/30/2015	DY1 Q2	
Task Hire Compliance Officer	In Progress	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	09/30/2015	DY1 Q2	
Task Establish compliance enforcement procedures	In Progress	Establish PPS chain-of-command for compliance enforcement including relationship between the compliance function and the PPS governance	07/15/2015	09/30/2015	09/30/2015	DY1 Q2	

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		structure.					
Task Establish compliance plan	In Progress	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	12/31/2015	DY1 Q3	
Task Integrate compliance requirements into MSA	In Progress	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	12/31/2015	DY1 Q3	
Task Share compliance plan with partners	In Progress	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	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	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	06/30/2015	DY1 Q1	
Task Review VBP guidelines	In Progress	Review final state value-based payment prototype and roadmap upon release.	07/01/2015	08/31/2015	09/30/2015	DY1 Q2	
Task Establish VBP payment assessment procedures	In Progress	Develop value-based payment assessment and annual assessment process. Present to the Executive Committee for review and approval.	08/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Assess current VBP arrangements	On Hold	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	03/31/2016	DY1 Q4	
Task Engage MCOs in VBP planning	On Hold	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	12/31/2015	DY1 Q3	
Task Develop VBP education and engagement strategy	On Hold	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	08/15/2015	11/30/2015	12/31/2015	DY1 Q3	

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		arrangements.					
Task Hold regular meetings with MCOs	On Hold	Initiate monthly meetings with MCOs and engage in development of MCO strategy framework for BPHC PPS.	08/15/2015	11/30/2015	12/31/2015	DY1 Q3	
Task Engage PPS providers in VBP education and planning	On Hold	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	03/31/2016	DY1 Q4	
Task Establish methodology for estimating revenue and determining value	On Hold	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	03/31/2016	DY1 Q4	
Task Conduct first annual assessment of VBP	On Hold	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	03/31/2016	DY1 Q4	
Task Establish compensation and MCO strategy framework	On Hold	Develop preferred compensation and MCO strategy framework. Review and obtain sign-off with Executive Committee.	11/15/2016	01/31/2016	03/31/2016	DY1 Q4	
Task Establish methodology for PPS members to demonstrate value	On Hold	In coordination with Finance and Sustainability Committee, develop plan to show how PPS members will demonstrate value to MCOs.	09/01/2015	10/31/2015	12/31/2015	DY1 Q3	
Task Establish VBP sub working group within the F&S Subcommittee	On Hold	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	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Milestone #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	In Progress	This milestone must be completed by 12/31/2016. Value-based payment plan, signed off by PPS board	07/15/2015	12/31/2016	12/31/2016	DY2 Q3	YES
Task Review VBP guidelines	In Progress	Review final state value-based payment prototype and road map upon release.	07/15/2015	08/31/2015	09/30/2015	DY1 Q2	
Task Review baseline assessment of VBP current state	On Hold	Review baseline assessment of partners' value-based payment revenue to inform development of PPS value-based payment plan.	02/01/2016	04/30/2016	06/30/2016	DY2 Q1	
Task Conduct gap analysis	On Hold	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	03/31/2016	DY1 Q4	
Task Engage MCOs in creation of transition plan	On Hold	Engage MCOs in development of value-based purchasing transition plan.	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task	On Hold	Engage PPS providers in development of the value-based purchasing	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Engage providers in creation of transition plan		transition plan, provider adoption strategy, reporting requirements and procedures.					
Task Establish reporting requirements and procedures	On Hold	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	06/30/2016	DY2 Q1	
Task Determine organizational requirements for transition	On Hold	Define PPS organizational requirements necessary to support transition to value-based payment.	03/01/2016	04/30/2016	06/30/2016	DY2 Q1	
Task Establish VBP transition plan	On Hold	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	09/30/2016	DY2 Q2	
Task Finalize VBP reporting schedule	On Hold	Establish a monthly Executive Committee value based payment reporting schedule that will continue throughout DSRIP years.	06/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Begin expanding existing VBP arrangements	On Hold	SBH and MMC will expand the lives in their existing fully capitated arrangements starting in DY2	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Begin to pursue shared saving arrangements and risk-sharing	On Hold	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	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Expand VBP arrangements throughout PPS	On Hold	Expand the level of risk and capitation assumed by BPHC partners as the capabilities of PPS members increase	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
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	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	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	03/31/2020	DY5 Q4	YES

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date
Finalize PPS finance structure, including reporting structure	lrobsbh	36_MDL0303_1_1_20150728104448_Account_Holder_Information_form_St_Barnabas_Hospital_(2).pdf	Corresponds to the task: "Create PPS bank account"	07/28/2015 10:44 AM
	lrobsbh	36_MDL0303_1_1_20150728104357_FS Sub-Committee Minutes_Final_5.20.15.docx	Corresponds to task: "Initiate Sub-Committee and report to EC"	07/28/2015 10:43 AM
	lrobsbh	36_MDL0303_1_1_20150728104231_F&S Sub-Committee Agenda_5.20.15.docx	Corresponds to task: "Initiate Sub-Committee and report to EC"	07/28/2015 10:41 AM
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	lrobsbh	36_MDL0303_1_1_20150729113904_Test Document for Submission.docx	Document to allow for submission	07/29/2015 11:37 AM
Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	lrobsbh	36_MDL0303_1_1_20150728113842_Committee Memership Slides.pptx	Corresponds to task: "Identify subject matter experts for leadership positions"	07/28/2015 11:37 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize PPS finance structure, including reporting structure	
Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	SBH's compliance officer, Cassandra Jackson has been appointed as the interim compliance officer for the PPS.
Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	
Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	
Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	
>=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	

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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	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 Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

(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 PPS engages partners in clinical operational and project readiness planning, and introduces partners to the Master Services Agreement (MSA), it will educate partners on DSRIP funds flow and funding schedules contained in the MSA. By DY1,Q3 PPS plans to develop 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, will develop 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.
Interim SBH Compliance Advisor	Deborah Schneider (BPHC Compliance Officer recruitment in Progress)	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 (TBD)	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 will create 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 will expand 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 will 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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize cultural competency / health literacy strategy.	In Progress	This milestone must be completed by 12/31/2015. Cultural competency / health literacy strategy signed off by PPS Board. The strategy should: -- Identify priority groups experiencing health disparities (based on your CNA and other analyses); -- Identify key factors to improve access to quality primary, behavioral health, and preventive health care -- Define plans for two-way communication with the population and community groups through specific community forums -- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors); and -- Identify community-based interventions to reduce health disparities and improve outcomes.	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	06/30/2015	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	06/30/2015	DY1 Q1	
Task Identify priority populations and locations	In Progress	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 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.	05/18/2015	09/30/2015	09/30/2015	DY1 Q2	
Task	In Progress	Gather information from key stakeholders with expertise on CC/HL to identify	05/18/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Identify best practices in interventions to reduce health disparities		PPS and community-based interventions to reduce health disparities and improve outcomes.					
Task Develop CC/HL strategy and action plan	In Progress	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	12/31/2015	DY1 Q3	
Task Partner with CBOs	In Progress	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	12/31/2015	DY1 Q3	
Task Develop an evaluation plan	On Hold	Develop a plan for evaluating the effectiveness of the CC/HL strategy.	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Obtain approval for CC/HL strategy and action plan	On Hold	Present CC/HL plan to Quality and Care Innovation Sub-Committee then Executive Committee for approval	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 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	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES
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	06/30/2015	DY1 Q1	
Task Inventory training best practices	In Progress	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	09/30/2015	DY1 Q2	
Task Identify key features of training plans	On Hold	Based on inventory and research, identify key features of training plans, including scope of providers trained, mechanisms for delivering training	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		services, and frequency of offerings (e.g., semiannual).					
Task Obtain approval for training plan	On Hold	Vet training plan through Workforce Sub-Committee, QCIS and Executive Committee.	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	03/31/2016	DY1 Q4	
Task Communicate training strategy to providers	On Hold	Present the training strategy to PPS providers through the rapid deployment collaboratives.	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date
Finalize cultural competency / health literacy strategy.	lrobsbh	36_MDL0403_1_1_20150728121641_Star 2-BPHC Workforce Survey Cultural Competency Analysis_.docx	Corresponds to task: "Inventory existing CC/HL programs in PPS"	07/28/2015 12:16 PM
	lrobsbh	36_MDL0403_1_1_20150728121608_Star 1-BPHC Quality and Care Innovation Committee Meeting Minutes 6.5.15.docx	Corresponds to task: "Initiate QCIS to support CC/HL strategy."	07/28/2015 12:15 PM
	lrobsbh	36_MDL0403_1_1_20150728121521_Star 1 - BPHC_Quality and Care Innovation Sub-Committee Charter 6-24-15.docx	Corresponds to task: "Initiate QCIS to support CC/HL strategy."	07/28/2015 12:14 PM
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	lrobsbh	36_MDL0403_1_1_20150728122347_Star 4-BPHC Workforce Survey Cultural Competency Analysis_.docx	Corresponds to task: "Inventory training best practices"	07/28/2015 12:23 PM
	lrobsbh	36_MDL0403_1_1_20150728122320_Star 3-BPHC_Workforce Sub-Committee Charter_Final_4_14_15.docx	Corresponds to task: "Develop health disparities training strategy"	07/28/2015 12:23 PM
	lrobsbh	36_MDL0403_1_1_20150728122252_Star 3-BPHC Quality and Care Innovation Committee Meeting Minutes 6.5.15.docx	Corresponds to task: "Develop health disparities training strategy"	07/28/2015 12:22 PM
	lrobsbh	36_MDL0403_1_1_20150728122233_Star 3 Workforce Meeting Minutes 5.22.15.docx	Corresponds to task: "Develop health disparities training strategy"	07/28/2015 12:22 PM
	lrobsbh	36_MDL0403_1_1_20150728122213_Star 3 - BPHC_Quality and Care Innovation Sub-Committee Charter 6-24-15.docx	Corresponds to task: "Develop health disparities training strategy"	07/28/2015 12:21 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize cultural competency / health literacy strategy.	
Develop a training strategy focused on addressing the drivers of health disparities	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
(beyond the availability of language-appropriate material).	

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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	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 Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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.)

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,	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
	The Bronx Health Link, Albert Alvarez, BPHC Director of 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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	In Progress	Detailed IT current state assessment. Relevant QEs (RHIOs/HIEs) should be involved in performing this assessment.	04/01/2015	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	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	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	06/30/2015	DY1 Q1	
Task Additional partner IT assessment	In Progress	Conduct further data collection through partner surveys and interviews to fill gaps in partner data.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Assess current state of IT readiness	On Hold	Review partner data to assess current state readiness re: EHRs, HIE, PCMH and other use of HIT.	09/01/2015	10/15/2015	12/31/2015	DY1 Q3	
Task Share and validate findings	On Hold	Communicate/validate findings and data-sharing requirement gaps with partners and Executive Committee.	10/15/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Document current state of IT readiness	On Hold	Complete IT current state assessment supporting documentation for central PPS and partner IT.	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	03/31/2016	DY1 Q4	NO

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Milestone/Task Name	Status	Description	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	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	06/30/2015	DY1 Q1	
Task Develop processes and protocols for partners	In Progress	Create and update processes and protocols for adoption and use of IT that all partners must implement.	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop communication and training for partners	On Hold	Develop communication, education and training plans related to processes and protocols for adoption and use of IT.	08/30/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop impact and risk management strategy	On Hold	Develop an impact and risk management strategy for IT change management.	11/02/2015	12/04/2015	12/31/2015	DY1 Q3	
Task Establish workflows	On Hold	Develop and document workflows for IT change management.	12/07/2015	01/22/2016	03/31/2016	DY1 Q4	
Task Establish tracking and reporting structure	On Hold	Develop approach for tracking and reporting on IT change management implementation.	01/11/2016	02/05/2016	03/31/2016	DY1 Q4	
Task Obtain EC approval of change management strategy	On Hold	Obtain Executive Committee approval of IT governance and change management processes and policy.	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 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	04/01/2015	02/26/2016	03/31/2016	DY1 Q4	NO

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		shared and the purpose of this sharing).					
Task Survey current state of interoperability	In Progress	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	09/30/2015	DY1 Q2	
Task Develop data exchange strategy	On Hold	Establish priorities and develop plan for establishing data exchange capabilities and agreements with and among partners and vendors.	09/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Establish strategy for Care Coordination Management Solution implementation	In Progress	Select and plan implementation and method of payment for of Care Coordination Management Solution across member organizations.	06/01/2015	09/15/2015	09/30/2015	DY1 Q2	
Task Integrate standards into partner contracts	On Hold	Incorporate standards for clinical connectivity and funds flow into partner contracts.	09/15/2015	11/15/2015	12/31/2015	DY1 Q3	
Task Establish compliance strategy	On Hold	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	12/31/2015	DY1 Q3	
Task Finalize clinical connectivity roadmap	On Hold	Document clinical connectivity roadmap and obtain IT Sub-Committee approval.	11/02/2015	12/04/2015	12/31/2015	DY1 Q3	
Task Share clinical connectivity plans with partners	On Hold	Establish and communicate connectivity standards, priorities, compliance plan and partner support resources, including training plan and assistance program to partners.	12/07/2015	01/08/2015	03/31/2015	DY0 Q4	
Task Integrate standards into vendor contracts	On Hold	Incorporate standards for clinical connectivity into vendor contracts and develop solutions where needed.	08/01/2015	10/15/2015	12/31/2015	DY1 Q3	
Task Provide guidance on clinical data exchange	On Hold	Document and provide partner guidance for exchanging clinical data set, including data sharing policies and procedures.	10/01/2015	11/15/2015	12/31/2015	DY1 Q3	
Task Conduct training on clinical data sharing and interoperability	On Hold	Based on the systems implemented, in conjunction with workforce subcommittee, deploy training, i.e., on-site, in-person and web-based learning management system.	09/01/2015	12/15/2015	12/31/2015	DY1 Q3	
Task Ensure tracking of changes to data sharing agreements	On Hold	Develop approach for tracking and reporting on changes to data sharing agreements.	01/11/2016	02/26/2016	03/31/2016	DY1 Q4	
Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	In Progress	PPS plan for engaging attributed members in Qualifying Entities, signed off by PPS Board. The plan should include your approach to outreach into culturally and linguistically isolated communities.	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task Match attributed members	In Progress	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	12/31/2015	DY1 Q3	
Task Review QE processes and challenges	On Hold	Review current consent processes and lessons learned/challenges with QE consent.	09/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task	On Hold	Develop recommendations for outreach and education of members for	08/24/2015	10/02/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Finalize strategy for obtaining consent		partners, clinical, MCO, or CBO, to follow; obtain IT Sub-Committee review and Executive Committee approval.					
Task Develop subscription alert strategy	On Hold	Plan to implement subscription alerts or triggers through member touchpoints.	08/01/2015	09/15/2015	09/30/2015	DY1 Q2	
Task Establish QE engagement reporting strategy	On Hold	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	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	12/31/2015	DY1 Q3	NO
Task Assess security risks and establish controls	In Progress	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	12/31/2015	DY1 Q3	
Task Establish CSO oversight for vendor security testing	On Hold	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	12/31/2015	DY1 Q3	
Task Finalize data security and confidentiality plan	On Hold	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	12/31/2015	DY1 Q3	
Task Establish implementation tracking system	On Hold	Develop an IT approach for tracking and reporting on implementation of plan.	09/01/2015	11/01/2015	12/31/2015	DY1 Q3	
Task Communicate plan to partners and conduct trainings	On Hold	Communicate data security and confidentiality plan to partners using email, webinars and training and education learning management system.	11/01/2015	12/31/2015	12/31/2015	DY1 Q3	

Prescribed Milestones Current File Uploads

Milestone Name	User ID	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).	lrobsbh	36_MDL0503_1_1_20150728123719_Incomplete and Complete Tech Sheet from Survey.xlsx	Corresponds to task: "Assess partner IT readiness"	07/28/2015 12:37 PM
	lrobsbh	36_MDL0503_1_1_20150728123356_IT Sub-Committee Minutes 6.4.15.docx	Corresponds to task: "Assess central PPS IT capabilities"	07/28/2015 12:33 PM
Develop an IT Change Management Strategy.	lrobsbh	36_MDL0503_1_1_20150728124452_IT Sub-Committee Minutes 6.4.15.docx	Corresponds to task: Establish IT Sub-Committee	07/28/2015 12:44 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date
	lrobsbh	36_MDL0503_1_1_20150728124424_BPHC Information Technology Sub-Committee Charter.docx	Corresponds to task: Establish IT Sub-Committee	07/28/2015 12:44 PM

Prescribed Milestones Narrative Text

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

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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	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 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 planning work to-date, we feel well-prepared for managing 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 incorporate provisions for complying with them into Master DSRIP Service Agreements (MSAs) with them 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	Dr. Amanda Ascher, CMO BPHC	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 David Collymore, Acacia Eric Appelbaum, SBH Maxine Golub, IFH Fernando Oliver, Bronx United IPA Tosan Oruwariye, Morris Heights Douglas York, Union	• 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

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

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
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.
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

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 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	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	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	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	06/30/2015	DY1 Q1	
Task Define performance reporting categories	In Progress	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	09/30/2015	DY1 Q2	
Task Analyze reporting capacities across PPS	In Progress	Assess existing reporting capabilities of BPHC and its network partners to identify gaps between requirements and current capabilities.	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Analyze MCO data exchange capacity	In Progress	Assess MCO capabilities for data exchange relative to requirements for performance metric submission.	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop and test reporting mechanisms	In Progress	Identify CSO staff and network partner staff (i.e., end-users) who will participate in developing and beta-testing the functionality and technical specifications for reports.	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Hire performance reporting support staff	In Progress	Identify/recruit qualified staff to support BPHC performance reporting according to the structure in the approved strategy.	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop performance reporting strategy	On Hold	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	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	06/30/2016	DY2 Q1	NO
Task Establish PPS reporting goals	In Progress	Define clinical quality and performance reporting goals for the PPS.	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Define staff categories for training	In Progress	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	12/31/2015	DY1 Q3	
Task Establish reporting responsibilities	On Hold	Determine site-specific reporting responsibilities by role.	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish reporting goals by role	On Hold	Define goals for reporting by role, helping staff understand targets and responsibilities toward meeting targets.	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Provide technical assistance on interpreting data and reports for performance reporting	On Hold	Assist staff by role how to use data and interpret reports (as appropriate for role)	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Contract with vendor to develop performance reporting training program	On Hold	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	12/31/2015	DY1 Q3	
Task Include roles, methods and tools specifications in training program	On Hold	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	12/31/2015	DY1 Q3	
Task Further define the role of workgroups as clinical quality councils	On Hold	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	12/31/2015	DY1 Q3	
Task Obtain approval on training program	On Hold	Vet and finalize the initial training program with the Executive Committee.	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Create training materials	On Hold	Develop draft training materials.	03/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task	On Hold	Conduct set of initial trainings.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Pilot the training materials							
Task Develop orientation and training timeline	On Hold	Develop new hire orientation program and annual training schedule.	03/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Establish feedback mechanism and conduct retraining as needed	On Hold	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	06/30/2016	DY2 Q1	

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date
Establish reporting structure for PPS-wide performance reporting and communication.	lrobsbh	36_MDL0603_1_1_20150728142811_BPHC_Quality and Care Innovation Sub-Committee Charter 6-24-15.docx	Corresponds to task: Establish reporting oversight responsibilities	07/28/2015 02:27 PM
	lrobsbh	36_MDL0603_1_1_20150728142659_BPHC Finance and Sustainability Sub-Committee Charter 6-24-15.docx	Corresponds to task: Establish reporting oversight responsibilities	07/28/2015 02:26 PM
	lrobsbh	36_MDL0603_1_1_20150728142606_BPHC Executive Committee Charter _Final_4_14_15 (2).docx	Corresponds to task: Establish reporting oversight responsibilities	07/28/2015 02:25 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish reporting structure for PPS-wide performance reporting and communication.	Minutes approving the attached charters can be found in our Governance Workstream Quarterly Report.
Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	

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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	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 Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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 David Collymore, Acacia Eric Appelbaum, SBH Maxine Golub, IFH Fernando Oliver, Bronx United IPA Tosan Oruwariye, Morris Heights Douglas York, Union	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	Leadership on all performance reporting areas	Overall oversight of reporting process, including IT infrastructure, clinical quality metrics and financial issues
IT Sub-Committee members	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	Leadership over the QA team at BPHC CSO	Oversight of defining quality report requirement and logistics
Finance and Sustainability Sub-Committee members	Leadership on financial metrics	Oversight of financial reporting issues
Montefiore leadership	Accountable for integrating Montefiore quality measures with BPHC	Oversight and coordination of quality reporting to BPHC PPS
BPHC CSO clinical team staff	Accountable for timely communication and coordination with the QM team	Oversight and integration of the reporting into the QM
BPHC Executive Committee members	Leadership over the entire DY1 planning process	Oversight of quality reporting into BPHC
Partner organization providers and staff	Accountable for meeting the PPS partnership requirement	Delivery of quality reporting requirements to BPHC
External Stakeholders		
Bronx RHIO 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
Other PPSs in NYC	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.

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 one of two shared data management and analytics infrastructures already present in the PPS, from either Bronx RHIO or Montefiore Medical Center. 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. The PPS has conducted initial due diligence on the Bronx RHIO's data management capabilities and determined that it is a viable partner for DSRIP central data management and analytics. Over the course of continued implementation planning before April 2015, the PPS will continue due diligence while investigating the functionality and capability present in the Montefiore Enterprise Data Warehouse (EDW) to determine if it is a viable shared infrastructure as an alternative or complementary to Bronx RHIO. In either instance, the NYSDOH MAPP and Salient Interactive Miner (SIM) component is also being evaluated for integration into BPHC's analytics strategy.

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.
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.

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IPQR Module 6.9 - IA Monitoring

Instructions :

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Section 07 – Practitioner Engagement

IPQR Module 7.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	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	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	06/30/2015	DY1 Q1	
Task Create QCIS meeting schedule and agenda	In Progress	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	09/30/2015	DY1 Q2	
Task Select work group members	In Progress	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 collaboratives will also serve as project clinical quality councils.	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Produce a plan for practitioner communication and engagement	In Progress	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.	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish web-based practitioner	On Hold	Establish an online practitioner communication tool.	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
communication tool							
Task Finalize plan for practitioner communication and engagement	On Hold	Submit practitioner communication and engagement plan to Quality & Care Innovation Sub-Committee for review and approval.	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Create RDC meeting schedule	On Hold	Establish regular meeting schedule for convening the rapid deployment collaboratives.	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Produce standard reporting tools	On Hold	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	03/31/2016	DY1 Q4	
Task Create standard RDC meeting agenda	On Hold	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	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	06/30/2016	DY2 Q1	NO
Task Categorize practitioners for training purposes	In Progress	Review PPS practitioner listing and organize the list into provider specific types for DSRIP project training purposes.	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop training curriculum	In Progress	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	09/30/2015	DY1 Q2	
Task Obtain approval of curriculum	On Hold	Quality and Care Innovation Sub-Committee reviews/approves curriculum.	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop training timeline	On Hold	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	12/31/2015	DY1 Q3	
Task Develop plan for continuous quality improvement mechanisms	On Hold	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	03/31/2016	DY1 Q4	
Task Establish curriculum review process for quality improvement	On Hold	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	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Develop post-training tests	On Hold	Develop CME-type post-training testing/evaluation for practitioners to measure success of training.	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date
Develop Practitioners communication and engagement plan.	lrobsbh	36_MDL0703_1_1_20150728145422_BPHC_Nominating Committee Charter_Final_6.29.15_bt's comments.docx	Corresponds to task: "Select QCIS members"	07/28/2015 02:53 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop Practitioners communication and engagement plan.	
Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	

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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	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 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 application planning 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

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Instructions :

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

It is difficult to point to a DSRIP workstream 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)	Training and retraining of the work force	• Develop curriculum to support the quality agenda • Develop training materials that are project specific
Provider partners: Montefiore Medical Group, Bronx United IPA, FQHCs	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	Provide quality standards and strategy	Approve the strategy and content for communication and engagement plan
External Stakeholders		
Other PPSs	Sharing best practices	Regular communication stream
GNYHA	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)

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 will develop 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 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	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	03/31/2018	DY3 Q4	NO
Task Envision PHM for PPS future state	In Progress	Develop a population health management (PHM) vision	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Conduct gap analysis	In Progress	Conduct gap analysis between current state and future vision, including assessing the gaps and barriers to achieving the PHM vision	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop Site-Specific Implementation Teams	On Hold	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	12/31/2015	DY1 Q3	
Task Develop technical assistance mechanisms for PCMH recognition	On Hold	Develop centralized technical assistance programs to assist primary care practices in achieving NCQA Level 3 PCMH recognition	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Develop PHM roadmap	On Hold	Draft PHM roadmap informed by gap analysis and assessment of PHM capabilities throughout the PPS	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Analyze current PHM capacity	On Hold	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 embedding PHM practices and workflows that support PCMH Level 3 and their staffing infrastructure to support PHM	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	
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	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Obtain member buy-in for PHM roadmap	On Hold	Review PHM roadmap with IT Sub-Committee and Executive Committee	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	06/30/2016	DY2 Q1	
Task Develop training methodology for registry and care plan systems	On Hold	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	06/30/2016	DY2 Q1	
Task Achieve PPS-wide PCMH recognition	On Hold	Move all primary care practices to NCQA Level 3 2014 PCMH recognition by end of DY3	10/01/2015	03/31/2018	03/31/2018	DY3 Q4	
Milestone #2 Finalize PPS-wide bed reduction plan.	On Hold	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	12/31/2018	DY4 Q3	NO
Task Engage members in bed reduction strategy	On Hold	Convene Executive Committee to discuss bed reduction plan	08/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Analyze hospital utilization patterns	On Hold	Assess current inpatient hospital utilization rate trends in the Bronx	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Analyze hospital physical plants	On Hold	Assess long term viability, deferred maintenance, and efficiency of hospital physical plants	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Create bed-need projection strategy	On Hold	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	09/30/2016	DY2 Q2	
Task Refine bed-need projection strategy	On Hold	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	12/31/2016	DY2 Q3	
Task Engage SDOH in bed reduction strategy	On Hold	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	06/30/2017	DY3 Q1	
Task Project financial implications of bed reduction strategy	On Hold	Incorporate options under consideration into financial sustainability plan	07/01/2017	06/30/2017	06/30/2017	DY3 Q1	
Task Obtain approval for bed reduction strategy	On Hold	Present bed reduction plan to Executive Committee for review and approval	01/01/2018	03/31/2018	03/31/2018	DY3 Q4	
Task Monitor utilization and quality trends	On Hold	Track changes in occupancy, utilization rates overall, and discharges for PPRs, PQIs, and PDIs	04/01/2018	12/31/2018	12/31/2018	DY4 Q3	
Task Refine bed reduction projections and plans	On Hold	Reforecast bed reduction projections annually and update bed reduction plan accordingly	04/01/2018	12/31/2018	12/31/2018	DY4 Q3	

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

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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	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 Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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.
(4) Our PPS has not fully assessed the capabilities of its network, including providers and community-based organizations. To mitigate this risk, as part of developing our population health management roadmap, we will assess the current state of population health management capabilities across our PPS.

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
CSO	n/a	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	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	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 :

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

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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform a clinical integration 'needs assessment'.	In Progress	Clinical integration 'needs assessment' document, signed off by the Clinical Quality Committee, including: -- Mapping the providers in the network and their requirements for clinical integration (including clinical providers, care management and other providers impacting on social determinants of health) -- Identifying key data points for shared access and the key interfaces that will have an impact on clinical integration -- Identify other potential mechanisms to be used for driving clinical integration	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task Envision clinical integration end-state	In Progress	Define end-state clinical integration model, aligned with requirements for Project 2.a.i and IT Systems & Processes.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Identify care protocols for clinical integration	In Progress	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	09/30/2015	DY1 Q2	
Task Investigate gaps and needs across PPS related to clinical integration	In Progress	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	12/31/2015	DY1 Q3	
Task Establish definition of clinical integration for partners	In Progress	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	12/31/2015	DY1 Q3	
Task Analyze data on gaps and needs across PPS related to clinical integration	In Progress	Complete analysis of data collected to identify clinical integration needs, potential strategies/programs and priorities, based on project, partner and PPS management goals.	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Report findings on gaps and needs across PPS related to clinical integration	On Hold	Document assessment findings and recommendations, with prioritized clinical integration activities.	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
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	03/31/2016	DY1 Q4	NO
Task Create project-based work groups to develop clinical guidelines	In Progress	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	09/30/2015	DY1 Q2	
Task Identify overlaps between project and PCMH requirements	In Progress	Develop cross-walks for the project specific metrics with PCMH 2014 level 3 requirements.	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Identify overlaps between clinical project requirements	In Progress	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	09/30/2015	DY1 Q2	
Task Create mechanism for approval of workgroup recommendations by QCIS	In Progress	Establish methodology for workgroup recommendations to be vetted and approved by QCIS	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop PPS clinical integration strategy	On Hold	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	12/31/2015	DY1 Q3	
Task Develop data sharing and clinical interoperability implementation plan	On Hold	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 other protocols specific to supporting care transitions across settings.	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Foster two-way communications for transfer of clinical information	On Hold	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	12/31/2015	DY1 Q3	
Task Establish site-specific implementation teams	On Hold	Identify Provider-based Implementation Teams	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task	On Hold	Develop strategy for dissemination of recommendations, training on	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Develop dissemination strategy for implementation tools and procedures		guidelines/protocols/implementation strategies					
Task Further define the role of workgroups as clinical quality councils	On Hold	Develop methodologies for project-based workgroups to serve as project quality councils.	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Establish feedback mechanisms	On Hold	Develop feedback mechanisms for accountability and Continuous Quality Improvement	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Implement communications strategy to engage partners in clinical interoperability planning	On Hold	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	03/31/2016	DY1 Q4	
Task Create care transitions strategy	In Progress	Work with vendor to develop care transitions strategy across patient and provider types, including impementation plan.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Develop care coordination training strategy	On Hold	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	03/31/2016	DY1 Q4	
Task Identify training curricula	On Hold	Identify training curricula for providers on behavioral health assessments to identify unmet needs of patients.	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Establish regular review of and updates to evidence based guidelines	On Hold	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	03/31/2016	DY1 Q4	

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

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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	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 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 David Collymore, Acacia Eric Appelbaum, SBH Maxine Golub, IFH Fernando Oliver, Bronx United IPA Tosan Oruwariye, Morris Heights Douglas York, Union	• 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	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	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	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	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 intends to establish 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 arm will monitor the PPS and partners' progress towards meeting project metrics. 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 is establishing 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 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	TBD	• 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	TBD	• 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	TBD	• 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	TBD	• 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 - 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 - Project Implementation Speed

Instructions :

Please specify how many providers will have met all of the project requirements (as set out in the Project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.
Note: data entered into this table must represent CUMULATIVE figures.

Benchmarks
100% Total Committed By
DY4,Q4

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Primary Care Physicians	936	0	0	0	0	0	0	0	0	0	0
Non-PCP Practitioners	3,295	0	0	0	0	0	0	0	0	0	165
Hospitals	12	0	0	0	0	0	0	0	0	0	1
Clinics	58	0	0	0	0	0	0	0	0	0	3
Health Home / Care Management	17	0	0	0	0	0	0	0	0	0	0
Behavioral Health	325	0	0	0	0	0	0	0	0	0	0
Substance Abuse	32	0	0	0	0	0	0	0	0	0	2
Skilled Nursing Facilities / Nursing Homes	44	0	0	0	0	0	0	0	0	0	3
Pharmacies	8	0	0	0	0	0	0	0	0	0	1
Hospice	7	0	0	0	0	0	0	0	0	0	1
Community Based Organizations	46	0	0	0	0	0	0	0	0	0	3
All Other	1,867	0	0	0	0	0	0	0	0	0	94
Total Committed Providers	**6,647**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**273**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**4.11**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Primary Care Physicians	936	0	0	0	0	187	936	936	936	936	936
Non-PCP Practitioners	3,295	330	495	825	1,320	1,977	3,295	3,295	3,295	3,295	3,295

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Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Hospitals	12	2	3	4	7	12	12	12	12	12	12
Clinics	58	6	11	19	34	58	58	58	58	58	58
Health Home / Care Management	17	0	0	0	0	3	17	17	17	17	17
Behavioral Health	325	0	0	0	0	65	325	325	325	325	325
Substance Abuse	32	4	8	13	20	32	32	32	32	32	32
Skilled Nursing Facilities / Nursing Homes	44	6	11	17	27	44	44	44	44	44	44
Pharmacies	8	2	3	4	5	8	8	8	8	8	8
Hospice	7	2	3	4	5	7	7	7	7	7	7
Community Based Organizations	46	6	10	16	27	46	46	46	46	46	46
All Other	1,867	188	282	469	749	1,120	1,867	1,867	1,867	1,867	1,867
Total Committed Providers	**6,647**	**546**	**826**	**1,371**	**2,194**	**3,559**	**6,647**	**6,647**	**6,647**	**6,647**	**6,647**
Percent Committed Providers(%)		**8.21**	**12.43**	**20.63**	**33.01**	**53.54**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

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

Instructions :

Please enter baseline target dates and work breakdown tasks with target dates for each of the milestones below.

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	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	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	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	Project		Completed	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	06/30/2015	DY1 Q1
Task Finalize MSA agreement	Project		In Progress	07/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task Develop and finalize project schedules in concert with Clinical Operations Plans (COPs)	Project		In Progress	06/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Review and negotiate project schedules with partner organizations. The order in which project schedules will be negotiated will be based on prioritization of	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
partner organizations developed by SBH							
Task Complete first round of contracting with all PPS partners	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS produces a list of participating HHs and ACOs.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop and implement effective referral strategy to the HH/ACO, including referral tracking	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Integrate HHs and ACOs into the IT infrastructure	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Clinically Interoperable System is in place for all participating providers.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS trains staff on IDS protocols and processes.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Deploy systems to improve and promote effective care transitions, include protocols for tracking and follow-up	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	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).	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with	Project	N/A	In Progress	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.							
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Primary Care Physicians	In Progress	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 Non-PCP Practitioners	In Progress	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 Hospitals	In Progress	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 Behavioral Health	In Progress	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 Skilled Nursing Facilities / Nursing Homes	In Progress	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify safety net provider data sharing requirements and assess partner and QE data sharing capabilities and current HIE participation	Project		In Progress	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		In Progress	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Begin coordinated interface and service development with Bronx RHIO	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Project	N/A	In Progress	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	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
criteria).							
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Safety Net Primary Care Physicians	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Assess eligible participating partner EHR use relative to Meaningful Use and PCMH 2014 Level 3 standards	Project		In Progress	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Recruit or contract for EHR implementation resources as needed	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Begin actively encouraging, tracking and supporting partner EHR implementation and progress towards Meaningful Use and PCMH standards	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	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.	Project	N/A	In Progress	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	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		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.	Project		In Progress	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		In Progress	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		In Progress	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Recommend registry business requirements and data elements to governance	Project		On Hold	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project		On Hold	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget to build registry and acquire necessary resources	Project		On Hold	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		On Hold	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		On Hold	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		On Hold	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		On Hold	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		On Hold	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		On Hold	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 of DY 3.	Project	N/A	In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task	Project		On Hold	01/01/2018	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Provider	Primary Care Physicians	In Progress	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		On Hold	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		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recruit or contract for PCMH practice certification resources as needed	Project		In Progress	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		On Hold	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Perform gap analysis by practice and identify key priorities.	Project		On Hold	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		On Hold	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition	Project		On Hold	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		On Hold	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		On Hold	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Medicaid Managed Care contract(s) are in place that include value-based	Project		On Hold	01/01/2017	03/31/2017	03/31/2017	DY2 Q4

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SBH Health System (PPS ID:36)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
payments.							
Task Review final State value-based payment roadmap and PPS value-based payment plan	Project		In Progress	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		On Hold	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 PPS value-based payment revenue in accordance with State roadmap goals	Project		On Hold	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		On Hold	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		On Hold	09/15/2015	12/01/2015	12/31/2015	DY1 Q3
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		On Hold	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		On Hold	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		On Hold	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	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		On Hold	11/01/2016	11/30/2016	12/31/2016	DY2 Q3
Task	Project		On Hold	02/01/2017	03/31/2017	03/31/2017	DY2 Q4

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SBH Health System (PPS ID:36)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project		Completed	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		On Hold	08/15/2015	11/30/2015	12/31/2015	DY1 Q3
Task Assess PPS progress in meeting State roadmap value-based payment goals for DY 3 and DY 4	Project		On Hold	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	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		On Hold	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		In Progress	07/01/2015	08/31/2015	09/30/2015	DY1 Q2
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	Project		On Hold	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Establish reporting mechanisms to collect and analyze Medicaid MCO and PPS partner data relative to utilization, performance, and payment reform	Project		On Hold	10/01/2015	11/15/2015	12/31/2015	DY1 Q3
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		On Hold	08/15/2015	11/30/2015	12/31/2015	DY1 Q3
Task Collect and analyze PPS data and prepare framework for reports to Medicaid MCOs	Project		On Hold	01/15/2016	03/31/2016	03/31/2016	DY1 Q4
Milestone #10	Project	N/A	On Hold	08/15/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	Project		On Hold	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Establish reporting mechanisms and framework for collecting and analyzing data on patient outcomes by PPS partners and providers	Project		On Hold	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		On Hold	08/15/2015	11/30/2015	12/31/2015	DY1 Q3
Task Collect and analyze data on patient outcomes by PPS partners and providers	Project		On Hold	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		On Hold	03/01/2016	05/30/2016	06/30/2016	DY2 Q1
Task Present recommendation for allocation of internal PPS provider bonus payments to Executive Committee	Project		On Hold	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		On Hold	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		On Hold	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		On Hold	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		On Hold	09/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task	Project		On Hold	11/01/2015	01/31/2016	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project	N/A	In Progress	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		On Hold	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		In Progress	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
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		In Progress	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	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	06/30/2015	DY1 Q1
Task Finalize MSA.	Project		Completed	07/01/2015	07/23/2015	09/30/2015	DY1 Q2
Task	Project		On Hold	08/01/2015	09/30/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Develop and finalize CBO project schedules in concert with Clinical Operational Plans.							
Task Review and negotiate project schedules with CBOs.	Project		On Hold	08/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Execute agreements and project schedules for CBOs.	Project		On Hold	08/01/2015	09/30/2015	09/30/2015	DY1 Q2
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		On Hold	01/01/2016	03/01/2016	03/31/2016	DY1 Q4
Task Begin patient outreach, engagement, screening/assessment, navigation activation and education for high priority projects and population	Project		On Hold	10/15/2016	11/30/2016	12/31/2016	DY2 Q3
Task Define patient engagement and patient engagement metrics. Define mechanisms for evaluation, feedback and continuous quality improvement.	Project		In Progress	07/22/2015	03/01/2016	03/31/2016	DY1 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 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										

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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
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 planned assessment and planning activities in other work streams										

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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 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										
Task Operationalize partner and workforce roles by providing gap analysis and appropriate training to clinicians and care										

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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
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	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										

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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
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	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										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #6 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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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	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										

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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										

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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 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 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.										

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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 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										
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										

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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 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 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										

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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
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.										
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										

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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
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)										
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										

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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
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										
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.										

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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 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 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	330	495	825	1,320	1,977	3,295	3,295	3,295	3,295	3,295

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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
requirements.										
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										
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	0	0	0	0	0

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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 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.										
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)										

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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 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.										
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.										

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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 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										
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										

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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
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 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										

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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 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										
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										

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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 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 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.										

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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 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.										
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.										

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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 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 Name	Description	Upload Date
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.	lrobsbh	36_PMDL2003_1_1_20150729074147_SBH DSRIP MSA Exhibit 2 (Legal Terms)_Final.docx	Corresponds to task: Solicit comments on MSA from partners through distribution to members, opportunity to submit written comments, and review in Committee and Sub-Committee meetin	07/29/2015 07:41 AM
	lrobsbh	36_PMDL2003_1_1_20150729074135_SBH DSRIP MSA Exhibit 1 (Definitions)_Final.docx	Corresponds to task: Solicit comments on MSA from partners through distribution to members, opportunity to submit written comments, and review in Committee and Sub-Committee meetin	07/29/2015 07:41 AM
	lrobsbh	36_PMDL2003_1_1_20150729074123_SBH DSRIP Master Services Agreement_Final.docx	Corresponds to task: Solicit comments on MSA from partners through distribution to members, opportunity to submit written comments, and review in Committee and Sub-Committee meetin	07/29/2015 07:41 AM
	lrobsbh	36_PMDL2003_1_1_20150729074104_Final BPHC MSA Comment Matrix.pdf	Corresponds to task: Solicit comments on MSA from partners through distribution to members, opportunity to submit written comments, and review in Committee and Sub-Committee meetin	07/29/2015 07:40 AM
	lrobsbh	36_PMDL2003_1_1_20150729074030_SBH DSRIP MSA Exhibit 2 (Legal Terms).pdf	Corresponds to task: Draft Master Services Agreement (MSA) and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure	07/29/2015 07:40 AM
	lrobsbh	36_PMDL2003_1_1_20150729074012_SBH DSRIP MSA Exhibit 1 (Definitions).pdf	Corresponds to task: Draft Master Services Agreement (MSA) and exhibits, which will describe legal terms and	07/29/2015 07:39 AM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date
			conditions of partner participation in the PPS and governance structure	
	lrobsbh	36_PMDL2003_1_1_20150729073948_SBH DSRIP Master Services Agreement.pdf	Corresponds to task: Draft Master Services Agreement (MSA) and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure	07/29/2015 07:39 AM
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.	lrobsbh	36_PMDL2003_1_1_20150729082817_SBH DSRIP MSA Exhibit 2 (Legal Terms)_Final.docx	Final MSA	07/29/2015 08:28 AM
	lrobsbh	36_PMDL2003_1_1_20150729082749_SBH DSRIP MSA Exhibit 1 (Definitions)_Final.docx	Final MSA	07/29/2015 08:27 AM
	lrobsbh	36_PMDL2003_1_1_20150729082710_SBH DSRIP Master Services Agreement_Final.docx	Final MSA	07/29/2015 08:27 AM
Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	lrobsbh	36_PMDL2003_1_1_20150729090409_Committee Memership Slides.pptx	Corresponds to task: Recruit senior Medicaid MCO leadership to serve on Executive Committee. Identify and appoint HMO industry expert to F&S Sub-Committee.	07/29/2015 09:03 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.	
Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	
Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	
Ensure that all PPS safety net providers are actively sharing EHR systems with local health	

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Prescribed Milestones Narrative Text

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

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IPQR Module 2.a.i.4 - 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	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 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.5 - IA Monitoring

Instructions :

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 - Project Implementation Speed

Instructions :

Please specify how many providers will have met all of the project requirements (as set out in the project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.
Note: data entered into this table must represent CUMULATIVE figures.

Benchmarks
100% Total Committed By
DY3,Q4

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Primary Care Physicians	749	0	0	0	0	0	0	0	0	0	0
Non-PCP Practitioners	1,977	0	0	0	0	0	99	198	297	495	792
Clinics	58	0	0	0	0	0	1	4	10	19	34
Health Home / Care Management	17	0	0	0	0	0	1	2	3	5	10
Behavioral Health	244	0	0	0	0	0	0	0	0	0	48
Substance Abuse	32	0	0	0	0	0	0	0	0	0	6
Pharmacies	8	0	0	0	0	0	1	2	3	4	5
Community Based Organizations	46	0	0	0	0	0	3	6	11	16	27
All Other	214	0	0	0	0	0	10	20	30	52	85
Total Committed Providers	**3,345**	**0**	**0**	**0**	**0**	**0**	**115**	**232**	**354**	**591**	**1,007**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**3.44**	**6.94**	**10.58**	**17.67**	**30.10**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Primary Care Physicians	749	149	749	749	749	749	749	749	749	749	749
Non-PCP Practitioners	1,977	1,186	1,977	1,977	1,977	1,977	1,977	1,977	1,977	1,977	1,977
Clinics	58	58	58	58	58	58	58	58	58	58	58
Health Home / Care Management	17	17	17	17	17	17	17	17	17	17	17
Behavioral Health	244	244	244	244	244	244	244	244	244	244	244

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Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Substance Abuse	32	32	32	32	32	32	32	32	32	32	32
Pharmacies	8	8	8	8	8	8	8	8	8	8	8
Community Based Organizations	46	46	46	46	46	46	46	46	46	46	46
All Other	214	128	214	214	214	214	214	214	214	214	214
Total Committed Providers	**3,345**	**1,868**	**3,345**	**3,345**	**3,345**	**3,345**	**3,345**	**3,345**	**3,345**	**3,345**	**3,345**
Percent Committed Providers(%)		**55.84**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

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

Instructions :

Please specify how many patients will have become 'Actively Engaged' (as set out in the Project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.
Note: data entered into this table must represent CUMULATIVE figures.

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

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	0	0	5,760	7,200	14,400	21,600	28,800	14,400	28,800
Percent of Expected Patient Engagement(%)	**0.00**	**0.00**	**0.00**	**10.00**	**12.50**	**25.00**	**37.50**	**50.00**	**25.00**	**50.00**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	43,200	57,600	14,400	28,800	43,200	57,600	0	0	0	0
Percent of Expected Patient Engagement(%)	**75.00**	**100.00**	**25.00**	**50.00**	**75.00**	**100.00**	**0.00**	**0.00**	**0.00**	**0.00**

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IPQR Module 2.a.iii.4 - Prescribed Milestones

Instructions :

Please enter baseline target dates and work breakdown tasks with target dates for each of the milestones below.

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	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	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	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	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		In Progress	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		In Progress	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		In Progress	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Develop financial model to cost out CM team	Project		In Progress	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		In Progress	05/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task	Project		In Progress	05/01/2015	10/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Develop project implementation budget							
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	12/31/2015	DY1 Q3
Task Submit COP and budget to Quality and Care Innovation Sub-Committee for approval	Project		On Hold	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify site-specific implementation teams.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Launch recruitment and training programs with participating providers	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Complete assessment of CM staffing needs of each participating site	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Define metrics for rapid cycle evaluation	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Use rapid cycle evaluation to track implementation successes and shortcomings and develop corrective actions	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and APCM standards	Provider	Primary Care Physicians	In Progress	04/01/2015	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		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recruit or contract for PCMH practice certification resources as needed	Project		In Progress	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Perform gap analysis by practice and identify key priorities.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Primary Care Physicians	In Progress	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 Non-PCP Practitioners	In Progress	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 Health Home / Care Management	In Progress	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify safety net provider data sharing requirements and assess partner and QE data sharing capabilities and current HIE participation	Project		In Progress	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		In Progress	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Begin coordinated interface and service development with Bronx RHIO	Project		On Hold	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	Project		On Hold	03/01/2016	04/25/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	Project		On Hold	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	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Project		In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Safety Net Primary Care Physicians	In Progress	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		In Progress	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		On Hold	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Recruit or contract for EHR implementation resources as needed	Project		On Hold	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		On Hold	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		On Hold	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	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	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	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		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.	Project		In Progress	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		In Progress	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		In Progress	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		On Hold	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		On Hold	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget to build registry and acquire necessary resources	Project		On Hold	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		On Hold	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		On Hold	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		On Hold	04/01/2015	03/31/2020	03/31/2020	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.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task	Project		On Hold	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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		In Progress	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
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	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	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	06/30/2015	DY1 Q1
Task Identify qualified coordinated care management (CCMS) vendors	Project		In Progress	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		In Progress	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		In Progress	05/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Select/contract with CCMS system(s) that meet requirements	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop, in conjunction with Workforce Subcommittee, training curriculum for PPS provider staff	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Select metrics and use CCMS system to track if care management plan is successful in "reducing patient risk factors"	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Implement comprehensive care management plan system in all participating sites	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #7 Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles	Project	N/A	In Progress	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
and responsibilities for both parties.							
Task Each identified PCP establish partnerships with the local Health Home for care management services.	Provider	Primary Care Physicians	In Progress	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	Health Home / Care Management	In Progress	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Identify participating primary care practices	Project		In Progress	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	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Begin developing partnership agreements with HHs, their downstream Care Management Agencies (CMAs) and primary care practices	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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 departments).	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has established partnerships to medical, behavioral health, and social services.	Provider	Primary Care Physicians	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has established partnerships to medical, behavioral health, and social services.	Provider	Health Home / Care Management	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify CBO partners that can provide needed social support services to the HH at-risk population	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #9 Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.	Project	N/A	In Progress	05/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS has adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate evidence-based practice guidelines developed and process implemented.	Project		In Progress	05/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.	Project		In Progress	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		In Progress	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	03/31/2016	03/31/2016	DY1 Q4
Task	Project		In Progress	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	Project		On Hold	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		On Hold	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		On Hold	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task CSO implements EBG and educational material dissemination plan across the PPS	Project		On Hold	04/01/2016	03/31/2017	03/31/2017	DY2 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop feedback mechansims for accountability and continuous quality improvement	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Develop a 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										

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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 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										
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										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
participating 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 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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Project 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 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.										
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:										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
any/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 #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.										

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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 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.										
Milestone #6 Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.										

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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 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 participating sites										
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										

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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
to meet care management service needs of HH at-risk population										
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, 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	0	0	0	0	0
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										

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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
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 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										

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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
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										

Project 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)										

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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 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										
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.										

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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 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

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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										
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-										

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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
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 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										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Assess 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.										
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										

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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
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 participating sites										
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										
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)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,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 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	0	0	0	0	0
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										

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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
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)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Develop feedback mechansims for accountability and continuous quality improvement										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date
Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.	jpacesbh	36_PMDL2203_1_1_20150727165944_HH at Risk Meeting Workplan 7-14.docx	Health Home at Risk Meeting Workplan 7-14	07/27/2015 04:59 PM
Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.	jpacesbh	36_PMDL2203_1_1_20150728161249_HH at Risk Meeting Workplan 7-14.docx	HH at Risk Meeting Workplan 7-14.	07/28/2015 04:11 PM
	jpacesbh	36_PMDL2203_1_1_20150728161101_BPHC Overview and CCMS Demonstration Facilitation Guide.docx	BPHC Overview and CCMS Demonstration Facilitation Guide	07/28/2015 04:10 PM
	jpacesbh	36_PMDL2203_1_1_20150728160923_BPHC Care Management Functional List.docx	BPHC Care Management Functional List	07/28/2015 04:08 PM

Prescribed Milestones Narrative Text

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

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

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IPQR Module 2.a.iii.5 - 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	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 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.6 - IA Monitoring

Instructions :

Stakeholder Engagement: The PPS proposed action plans do not provide strategies on how they will engage substance use disorder (SUD) providers. No mechanisms for referrals, recruitment, payment for services render to SUD clients connected to PPS. No mention of electronic health record networking with already existing EHR used by SUD providers. In sum, SUD services are not mentioned with any specificity. There seems to be no pathway for SUD to access the benefits of belonging to the PPS. PPS should consider developing strategies to reach out to SUD providers with clear intentions of including them as part of the network thus, providing with meaningful resources, education, facilitate acquisition of EHR; create viable client medical communications through EHR and create mechanism to protect client confidentiality, while sharing pertinent information.

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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 planning to implement 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 will seek 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 will contract 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. Parachute NYC, an evidence-based alternative to the ED and inpatient admissions, is an effective program that has been challenged by low provider awareness. It reached the end of its funding from the Center for Medicare and Medicaid Innovation on June 30, 2015. Discussions with MCOs regarding a payment mechanism to sustain the program are still in progress. To mitigate these risks, 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" the program 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 - Project Implementation Speed

Instructions :

Please specify how many providers will have met all of the project requirements (as set out in the project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.
Note: data entered into this table must represent CUMULATIVE figures.

Benchmarks
100% Total Committed By
DY3,Q4

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Emergency Departments with Care Triage	5	0	0	0	0	0	0	0	0	0	0
Total Committed Providers	**5**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Emergency Departments with Care Triage	5	0	5	5	5	5	5	5	5	5	5
Total Committed Providers	**5**	**0**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**
Percent Committed Providers(%)		**0.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Current File Uploads

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

Instructions :

Please specify how many patients will have become 'Actively Engaged' (as set out in the Project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.
Note: data entered into this table must represent CUMULATIVE figures.

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

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	0	500	3,920	3,675	7,350	11,025	14,700	4,900	9,800
Percent of Expected Patient Engagement(%)	**0.00**	**0.00**	**2.55**	**20.00**	**18.75**	**37.50**	**56.25**	**75.00**	**25.00**	**50.00**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	14,700	19,600	4,900	9,800	14,700	19,600	0	0	0	0
Percent of Expected Patient Engagement(%)	**75.00**	**100.00**	**25.00**	**50.00**	**75.00**	**100.00**	**0.00**	**0.00**	**0.00**	**0.00**

Current File Uploads

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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IPQR Module 2.b.iii.4 - Prescribed Milestones

Instructions :

Please enter baseline target dates and work breakdown tasks with target dates for each of the milestones below.

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	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	03/31/2017	DY2 Q4
Task Stand up program based on project requirements	Project		In Progress	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		In Progress	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Conduct preliminary site visits to participating EDs	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Establish workflow triage model with input from task force and participating ED site-specific implementation teams	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Draft job descriptions, staffing and recruitment plan, in consultation with the Workforce Subcommittee	Project		On Hold	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		On Hold	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		On Hold	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		On Hold	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		On Hold	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 referral to CBOs, with particular attention to the complex needs of patients with co-occurring disorders, homelessness and SUD	Project		On Hold	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Develop standard procedures for notifying and sharing information with PCP / HH care manager / other provider	Project		On Hold	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		On Hold	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		On Hold	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		On Hold	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		On Hold	03/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Finalize budget for ED Care Triage for At-Risk Populations	Project		On Hold	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		On Hold	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		On Hold	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	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	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		On Hold	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		On Hold	04/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Identify community organizations for inclusion in the initial iteration of the	Project		On Hold	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	Project		On Hold	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		On Hold	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		On Hold	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Orient hospital staff and community-based partners on the project	Project		On Hold	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		On Hold	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	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	03/31/2017	DY2 Q4
Milestone #2 Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable	Project	N/A	In Progress	06/30/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	Provider	Safety Net Primary Care Physicians	In Progress	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	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	Provider	Safety Net Primary Care Physicians	In Progress	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 Hospitals	In Progress	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		In Progress	06/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recruit or contract for PCMH practice certification resources as needed	Project		In Progress	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Perform gap analysis by practice and identify key priorities.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Finalize strategy to support primary care physicians with achieving 2014 NCQA Level 3 PCMH certification by sub committees, including trainings and education.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS wide PCMH sub- committee as needed.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Assess eligible participating partner EHR use relative to Meaningful Use and PCMH 2014 Level 3 standards	Project		In Progress	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Recruit or contract for EHR implementation resources as needed	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Begin actively encouraging, tracking and supporting partner EHR implementation and progress towards Meaningful Use and PCMH standards	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	Project		In Progress	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		In Progress	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Begin coordinated interface and service development with Bronx RHIO	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Monitor the use of ENS for communications related to ED Care Triage	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3 PCMH certification, and provide support as needed.	Project		On Hold	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	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Implement ED care triage protocols, as outlined in Milestone 1	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Provide technical assistance to site-specific implementation teams	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Monitor the speed with which patients receive an appointment with PCP/specialist/BH. Troubleshoot with PCPs/others as necessary	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Modify Clinical Operations Plan procedures to reflect lessons learned, in conjunction with task force	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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	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 Hospitals	On Hold	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	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	03/31/2017	DY2 Q4
Task Perform gap analysis and identify priories to achieving integration of patient record.	Project		In Progress	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		In Progress	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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SBH Health System (PPS ID:36)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	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		On Hold	04/01/2015	03/31/2020	03/31/2020	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	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	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	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	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.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	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 Stand up program based on project requirements										
Task Identify key stakeholders and initiate regular ED care triage task force meetings										

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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 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 specific procedures and tools										
Task Finalize compilation of all documentation into a Clinical Operations Plan (COP) for ED Care Triage for At-Risk										

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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
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 the warm transfer and referral tracking										
Task Orient hospital staff and community-based partners on the										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
project										
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										
Task Recruit or contract for PCMH practice certification resources as needed										

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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 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										
Task Coordinate with Bronx RHIO to develop comprehensive HIE adoption program to encourage and support partner										

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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
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										
Task Monitor the speed with which patients receive an appointment with PCP/specialist/BH. Troubleshoot with PCPs/others as										

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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
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										
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
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										

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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 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.	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										

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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 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										

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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
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										
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.										

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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 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										
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 Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish ED care triage program for at-risk populations	
Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable	
For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	
Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)	
Use EHRs and other technical platforms to track all patients engaged in the project.	

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IPQR Module 2.b.iii.5 - 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	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 Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

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IPQR Module 2.b.iii.6 - 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 & exp& the Care Management Resource Unit (CMRU) at Montefiore as needed & assist SBH in establishing a CMRU-like function to exp& access & linkages 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 - Project Implementation Speed

Instructions :

Please specify how many providers will have met all of the project requirements (as set out in the project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.
Note: data entered into this table must represent CUMULATIVE figures.

Benchmarks
100% Total Committed By
DY3,Q2

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Primary Care Physicians	749	0	0	0	0	0	37	74	186	411	749
Non-PCP Practitioners	2,636	0	0	0	0	0	131	262	658	1,449	2,636
Hospitals	12	0	0	0	0	0	1	2	3	6	12
Health Home / Care Management	17	0	0	0	0	0	0	0	0	3	17
Community Based Organizations	46	0	0	0	0	0	0	0	0	9	46
All Other	560	0	0	0	0	0	28	56	140	308	560
Total Committed Providers	**4,020**	**0**	**0**	**0**	**0**	**0**	**197**	**394**	**987**	**2,186**	**4,020**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**4.90**	**9.80**	**24.55**	**54.38**	**100.00**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Primary Care Physicians	749	749	749	749	749	749	749	749	749	749	749
Non-PCP Practitioners	2,636	2,636	2,636	2,636	2,636	2,636	2,636	2,636	2,636	2,636	2,636
Hospitals	12	12	12	12	12	12	12	12	12	12	12
Health Home / Care Management	17	17	17	17	17	17	17	17	17	17	17
Community Based Organizations	46	46	46	46	46	46	46	46	46	46	46
All Other	560	560	560	560	560	560	560	560	560	560	560
Total Committed Providers	**4,020**	**4,020**	**4,020**	**4,020**	**4,020**	**4,020**	**4,020**	**4,020**	**4,020**	**4,020**	**4,020**
Percent Committed Providers(%)		**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

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Current File Uploads

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No Records Found

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

Instructions :

Please specify how many patients will have become 'Actively Engaged' (as set out in the Project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.
Note: data entered into this table must represent CUMULATIVE figures.

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

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	0	0	0	2,389	4,778	7,166	9,555	3,675	7,350
Percent of Expected Patient Engagement(%)	**0.00**	**0.00**	**0.00**	**0.00**	**16.25**	**32.50**	**48.75**	**65.00**	**25.00**	**50.00**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	11,025	14,700	3,675	7,350	11,025	14,700	0	0	0	0
Percent of Expected Patient Engagement(%)	**75.00**	**100.00**	**25.00**	**50.00**	**75.00**	**100.00**	**0.00**	**0.00**	**0.00**	**0.00**

Current File Uploads

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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IPQR Module 2.b.iv.4 - Prescribed Milestones

Instructions :

Please enter baseline target dates and work breakdown tasks with target dates for each of the milestones below.

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	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	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Engage partners, including health homes (HH), to promote project understanding and partner alignment.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify key stakeholders and initiate Care Transitions (CT) work group	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Conduct preliminary site visits to participating in-patient settings	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Orient hospital staff to the project	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop job description and staffing plan, in consultation with the Workforce Subcommittee	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Map comprehensive list of care and social services used by patients in the home or other non-medical setting	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop criteria for identifying and targeting patients most at risk for readmission, to facilitate the creation of patient registries and alerts	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify electronic patient stratification tool or algorithm to identify the 'at risk' population	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Establish workflow triage model with input from CT work group and participating site-specific implementation teams	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop guidelines and assessment template/tools for assisting patient in selecting a PCP	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop standard procedures for notifying and sharing information with PCP / HH care manager / or other provider, as needed	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop standard procedures for referral to behavioral health support services for eligible patients	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Finalize compilation of all documentation into a Clinical Operations Plan (COP) for CT intervention	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Finalize budget for CT intervention	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Submit elements of COP to Quality and Care Innovation Sub-Committee (QCIS) for approval	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Define the population to be targeted by Critical Time Intervention strategies	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop financial model to cost out Critical Time Intervention team	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Working with Workforce Subcommittee, design training and recruitment strategy for Critical Time Intervention staffing	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop Critical Time Intervention implementation budget	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Submit elements of Critical Time Intervention COP to QCIS for approval	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Complete assessment of Critical Time Intervention staffing needs across the PPS in conjunction with the Workforce Subcommittee	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop a registry of patients to be targeted for intervention	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Establish technology interfaces to ensure frequent automated updates of registry data	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Implement CCMS and/or other systems and services with patient registries and other features required for PHM	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Recruit and hire needed CT staff	Project		In Progress	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	03/31/2017	DY2 Q4
Task Identify implementation teams for Critical Time Intervention	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Launch recruitment and training programs with Critical Time Intervention	Project		In Progress	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
participating providers							
Task Establish mechanisms for feedback and monitoring for Continuous Quality Improvement (CQI)	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task CT staff implement Care Transitions interventions, using project-specific templates, tools and procedures	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Modify COP procedures to reflect lessons learned, in conjunction with task force	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop partnership agreements with payers affirming coverage and coordination of service benefits. Include HHs in the development of this payment strategy.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Review final State value-based payment roadmap and PPS value-based payment plan	Project		In Progress	07/01/2015	08/31/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Establish partner value-based payment reporting requirements and procedures to enable ongoing monitoring of value-based payments and care transitions.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Engage MCOs in defining PPS MCO contracting strategy and organizational requirements necessary to support the development of contracts with Medicaid MCOs	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop value-based payment arrangements for presentation to Medicaid MCOs and other payers	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Monitor use of assessment tool to identify HH-eligible patients	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Ensure eligibility is noted in patient's EHR	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Monitor rates of referrals to HH services based on eligibility	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #3 Ensure required social services participate in the project.	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Required network social services, including medically tailored home food services, are provided in care transitions.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify and catalog available community resources, using the CNA as a starting point to create a Community Resources Database	Project		In Progress	05/15/2015	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	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Establish the schedule and materials for periodic staff training on the warm	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Primary Care Physicians	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Non-PCP Practitioners	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Hospitals	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop and implement policies and procedures for early notification of planned discharges.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop communications plan between in-patient and CT staff	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Monitor early notification of planned discharge and modify procedures as necessary, using CQI	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Ensure hospital policies and procedures allow access by care managers for patients identified for CT intervention	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop and implement policies and procedures for including care transitions plans in the patient's medical record	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Deploy systems to improve and promote effective care transitions, include protocols for tracking and follow-up	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	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)	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project		In Progress	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	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Establish a process and structure to conduct a detailed review of all discharges leading to readmission within 30 days.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Use the analysis and the ongoing review data to inform services to involve in this project.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Work with partners to define how to document and communicate 30-day transition period of care.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Incorporate the 30 day care transition period into payer agreements.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.	Project		In Progress	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		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task	Project		In Progress	04/01/2015	11/30/2015	12/31/2015	DY1 Q3

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SBH Health System (PPS ID:36)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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)	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Create budget to build registry and acquire necessary resources	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	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	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	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	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	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	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	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		On Hold	04/01/2016	09/30/2016	09/30/2016	DY2 Q2

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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 #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 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										

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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 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.										
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										

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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 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										
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										

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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 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										
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.										

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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 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.										
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.										

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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 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										
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	0	0	0	0	0

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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 are in place for early notification of planned discharges.	0	0	0	0	0	0	0	0	0	0
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	0	0	0	0	0	0	0
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: 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										

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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
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 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.										

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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 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 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 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										

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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
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 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										

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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 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 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										

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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 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										
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										

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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
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										
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										

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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 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										
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										

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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
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.	0	0	0	0	0	0	0	0	0	0
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	0	0	0	0	0	0	0
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	0	0	0	0	0	0	0
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.										

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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 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										
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										

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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 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 to involve in this project.										
Task Work with partners to define how to document and communicate 30-day transition period of 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 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										
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										

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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
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 Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	
Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	
Ensure required social services participate in the project.	
Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
services.	
Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	
Ensure that a 30-day transition of care period is established.	
Use EHRs and other technical platforms to track all patients engaged in the project.	

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IPQR Module 2.b.iv.5 - 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	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 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.6 - IA Monitoring

Instructions :

Milestone 5: PPS may consider task of convening providers from different care settings to define specific information and clinical data between sending and receiving providers as patient goes from one care setting to another to include as part of care transition record. The National Transition of Care Coalition is a good resource. http://www.ntocc.org/Toolbox/

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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 - Project Implementation Speed

Instructions :

Please specify how many providers will have met all of the project requirements (as set out in the project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.
Note: data entered into this table must represent CUMULATIVE figures.

Benchmarks
100% Total Committed By
DY4,Q2

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Primary Care Physicians	796	0	0	0	0	0	0	0	0	0	0
Non-PCP Practitioners	824	0	0	0	0	0	0	0	38	80	122
Clinics	44	0	0	0	0	0	0	0	1	2	5
Behavioral Health	195	0	0	0	0	0	0	0	0	0	0
Substance Abuse	32	0	0	0	0	0	0	0	0	0	0
Community Based Organizations	41	0	0	0	0	0	0	0	2	4	6
All Other	560	0	0	0	0	0	0	0	28	56	84
Total Committed Providers	**2,492**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**69**	**142**	**217**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**2.77**	**5.70**	**8.71**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Primary Care Physicians	796	78	158	318	796	796	796	796	796	796	796
Non-PCP Practitioners	824	205	329	494	824	824	824	824	824	824	824
Clinics	44	10	17	26	44	44	44	44	44	44	44
Behavioral Health	195	19	39	78	195	195	195	195	195	195	195
Substance Abuse	32	2	5	12	32	32	32	32	32	32	32
Community Based Organizations	41	8	15	24	41	41	41	41	41	41	41
All Other	560	140	224	336	560	560	560	560	560	560	560

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Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Total Committed Providers	2,492	462	787	1,288	2,492	2,492	2,492	2,492	2,492	2,492	2,492
Percent Committed Providers(%)		18.54	31.58	51.69	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Current File Uploads

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

Instructions :

Please specify how many patients will have become 'Actively Engaged' (as set out in the Project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.
Note: data entered into this table must represent CUMULATIVE figures.

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	91,800

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	0	4,585	13,770	15,258	30,517	45,775	61,034	22,950	45,900
Percent of Expected Patient Engagement(%)	**0.00**	**0.00**	**4.99**	**15.00**	**16.62**	**33.24**	**49.86**	**66.49**	**25.00**	**50.00**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	68,850	91,800	22,950	45,900	68,850	91,800	0	0	0	0
Percent of Expected Patient Engagement(%)	**75.00**	**100.00**	**25.00**	**50.00**	**75.00**	**100.00**	**0.00**	**0.00**	**0.00**	**0.00**

Current File Uploads

User ID	File Name	File Description	Upload Date

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Narrative Text :

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IPQR Module 3.a.i.4 - Prescribed Milestones

Instructions :

Please enter baseline target dates and work breakdown tasks with target dates for each of the milestones below.

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	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	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.		Provider	Primary Care Physicians	In Progress	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	Behavioral Health	In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Finalize contract with vendor		Project		In Progress	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	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Assess current state, including physical health services , current PCMH level if applicable, IT infrastructure, interoperability, staffing, etc.		Project		In Progress	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices		Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recruit or contract for PCMH practice certification resources as needed		Project		In Progress	05/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Assess current state of PCPs engaged in project, including behavioral health service delivery capabilities, work flow, IT infrastructure, interoperability, staffing, etc		Project		On Hold	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task		Project		In Progress	07/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.		Project		In Progress	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		On Hold	09/30/2015	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		On Hold	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Perform gap analysis by practice and identify key priorities		Project		On Hold	10/01/2015	06/30/2016	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		On Hold	10/01/2015	06/30/2016	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		On Hold	12/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition		Project		On Hold	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed		Project		On Hold	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		On Hold	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Finalize collaborative care practices, reviewed and approved by the QCIS		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Assess current participating providers practice models with vendors and PCBH workgroup		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Complete best practice care protocols draft, including those needed for specific conditions, for QCIS review		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Finalize PPS wide evidence- based protocols with approval by QCIS		Project		On Hold	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Provide vendor and CSO support as needed for successful implementation of protocols.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Finalize and implement evidence- based practice guidelines		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Task Finalize and implement evidence- based practice guidelines		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop mechanisms for evaluation, accountability, and continuous quality improvement		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	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		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Policies and procedures are in place to facilitate and document completion of screenings.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Screenings are documented in Electronic Health Record.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.		Provider	Primary Care Physicians	On Hold	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Assess participating providers current rates of patient assessments		Project		In Progress	08/01/2015	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		On Hold	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Assess participating providers current process for identifying unmet needs		Project		On Hold	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task		Project		In Progress	07/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.		Project		On Hold	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		On Hold	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize policy around timely documentation of screenings in the electronic health record.		Project		In Progress	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop process to monitor progress towards completing screenings on 90% of patient population using approved screenings		Project		In Progress	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Assess participating providers current procedures for patients who receive a positive screening, as well as for completion of referrals.		Project		On Hold	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		On Hold	03/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Provide education/training as needed to ensure successful implementation.		Project		On Hold	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Implement "warm transfer" policies and procedures, as well as instructions on appropriate documentation in the electronic health record.		Project		On Hold	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
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	03/31/2017	DY2 Q4
Task Monitor success and sustainability of implemented screening protocols		Project		On Hold	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		On Hold	03/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task		Project		On Hold	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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		Project		On Hold	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	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	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	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		In Progress	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		In Progress	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		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities		Project		In Progress	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		In Progress	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		On Hold	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		On Hold	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task		Project		On Hold	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	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		On Hold	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		On Hold	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		On Hold	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		On Hold	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		On Hold	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		On Hold	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	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	Primary Care Physicians	In Progress	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	Primary Care Physicians	In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care services are co-located within behavioral Health		Provider	Behavioral Health	In Progress	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
practices and are available.								
Task Finalize contract with vendor		Project		In Progress	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	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
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	12/31/2015	12/31/2015	DY1 Q3
Task Assess eligible participating PCP PCMH recognition status and opportunity to expand access to primary care based on PCMH-enabled practices		Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recruit or contract for PCMH practice certification resources as needed		Project		In Progress	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		On Hold	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform gap analysis and identify key priorities to successful completion of co-located services.		Project		On Hold	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		On Hold	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Perform gap analysis by practice and identify key priorities.		Project		On Hold	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		On Hold	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition		Project		On Hold	01/01/2016	11/30/2016	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Develop best practice policies and procedures by PCBH workgroup, send for review and approval by QCIS		Project		On Hold	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		On Hold	09/01/2015	03/31/2017	03/31/2017	DY2 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		On Hold	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		On Hold	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		On Hold	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		On Hold	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	On Hold	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		On Hold	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		On Hold	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Assess current participating providers practice models with vendors and PCBH workgroup		Project		On Hold	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		On Hold	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task		Project		On Hold	12/31/2015	03/31/2016	03/31/2016	DY1 Q4

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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.		Project		On Hold	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize and implement evidence- based practice guidelines.		Project		On Hold	12/31/2015	07/31/2016	09/30/2016	DY2 Q2
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		On Hold	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Finalization of collaborative care practices, reviewed and approved by the QCIS		Project		On Hold	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		On Hold	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Develop mechanisms for evaluation, accountability, and continuous quality improvement		Project		On Hold	12/31/2015	12/31/2016	12/31/2016	DY2 Q3
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		On Hold	03/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task Provide vendor and CSO support as needed for successful implementation of protocols.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Task Screenings are documented in Electronic Health Record.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.		Provider	Primary Care Physicians	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Assess participating providers current process for identifying unmet physical needs of patients		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Finalize draft policies and procedures to facilitate and document behavioral health and primary care screenings by PCBH workgroup, approval by QCIS		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Perform gap analysis,including provider capability for documenting screenings in EMR, and identify steps to meet standards.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Finalize policy around timely documentation of screenings in the electronic health record.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Monitor success with timely and accurate documentation in the electronic health record.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Monitor success and sustainability of implemented screening protocols.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Assess participating providers current rates of patient assessments.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Monitor success towards completion of screenings on 90% of patients engaged in project, as needed to ensure success.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Create and Finalize policies on implementing "warm transfers" back to BH specialist for patients who have a positive screening.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Implement "warm transfer" policies and procedures, as well as instructions on appropriate documentation in the electronic health record.		Project		On Hold	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	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Provide education/training as needed to ensure success in conjunction with Workforce Sub-committee		Project		On Hold	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Provide education and training as needed to achieve goal.		Project		On Hold	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Provide education/training as needed to ensure successful implementation.		Project		On Hold	09/01/2015	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	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	03/31/2017	DY2 Q4

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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	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		In Progress	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		In Progress	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		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.		Project		In Progress	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		In Progress	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		On Hold	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		On Hold	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget to build registry and acquire necessary resources		Project		On Hold	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		On Hold	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		On Hold	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop training plan and curriculum to deploy risk assessment		Project		On Hold	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.		Project		On Hold	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		On Hold	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		On Hold	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	On Hold	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has implemented IMPACT Model at Primary Care Sites.		Provider	Primary Care Physicians	On Hold	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		On Hold	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Educate senior leadership of participating providers regarding IMPACT Model and requirements.		Project		On Hold	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		On Hold	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		On Hold	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		On Hold	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	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		On Hold	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		On Hold	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	On Hold	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		On Hold	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures include process for consulting with Psychiatrist.		Project		On Hold	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Assess current participating providers practice models		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop best practice care protocols draft, integrating IMPACT model standards into best practice protocol design. Utilize the IMPACT manual.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Finalize PPS wide evidence- based protocols with approval by QCIS		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Perform Gap analysis to identify key priorities for participating providers to meeting best practice standards.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Provide support as needed to ensure successful implementation.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Finalize and implement evidence- based practice guidelines.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Monitor success of developed protocols, updates made as needed with approval by QCIS		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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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		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Finalize policies, procedures and protocols with approval by the QCIS.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Provide education, training and resources as needed for successful implementation of policies and procedures.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Implement policies, procedures and protocols for successful consultation with psychiatrist.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Monitor success of developed policies, procedures and protocol, as well as sustainability for consulting with psychiatrist.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Establish mechanisms for continuous quality improvement		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Model 3	Project	N/A	On Hold	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		On Hold	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.		Project		On Hold	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Determine the type of DCM needed for each participating provider to meet the DCM role requirements, in conjunction with Workforce Sub-Committee, .		Project		On Hold	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		Project		On Hold	03/31/2016	12/31/2016	12/31/2016	DY2 Q3

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of DCM with Workforce Sub-committee								
Task Finalize the formal hiring and creation of DCM role with Workforce Sub-committee		Project		On Hold	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		On Hold	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		On Hold	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		On Hold	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		On Hold	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Implement IMPACT model policies, procedures and protocols.		Project		On Hold	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		On Hold	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
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		On Hold	03/31/2016	03/31/2018	03/31/2018	DY3 Q4
Task Establish continuous quality improvement. Develop mechanisms for evaluation, accountability, and continuous quality improvement		Project		On Hold	03/31/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	Model 3	Project	N/A	On Hold	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task All IMPACT participants in PPS have a designated Psychiatrist.		Project		On Hold	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		On Hold	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Finalize job-related policies and procedures regarding		Project		On Hold	09/01/2015	03/31/2016	03/31/2016	DY1 Q4

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psychiatrists' responsibilities for approval by QCIS								
Task Provide assistance with resources for hiring designated psychiatrists, as needed.		Project		On Hold	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Develop mechanisms for evaluation, accountability, and continuous quality improvement		Project		On Hold	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Provide training of designated psychiatrists to ensure they are able to adequately perform the requirements of the position		Project		On Hold	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		On Hold	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		On Hold	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #13 Measure outcomes as required in the IMPACT Model.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Assess participating providers current rates of patient assessments.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Provide education and training as needed to achieve goal.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop process to monitor, via EHRs/RHIO/CCMS, progress towards completing screenings on 90% of patient population using approved screenings		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #14 Provide "stepped care" as required by the IMPACT Model.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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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.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Evidence Based Protocols for stepped care, as aligned with IMPACT model, are approved by QCIS		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Implement IMPACT model aligned protocols related to stepped care across practices using the IMPACT model		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop mechanisms for evaluating successful stepped care, accountability, and continuous quality improvement		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 3	Project	N/A	In Progress	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	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	03/31/2017	DY2 Q4
Task Develop a project specific strategy for tracking patient engagement, employing PHM tools and processes outlined below.		Project		In Progress	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		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.		Project		In Progress	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		In Progress	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Define business requirements and data elements for patient		Project		On Hold	10/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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)		Project		On Hold	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.		Project		On Hold	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget to build registry and acquire necessary resources		Project		On Hold	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		On Hold	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		On Hold	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		On Hold	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		On Hold	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		On Hold	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		Project		On Hold	04/01/2016	09/30/2016	09/30/2016	DY2 Q2

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primary care.								

Project 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										

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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
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.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices.										
Task Coordinated evidence-based care protocols are in place,										

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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
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										
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										

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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
health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.										
Task Policies and procedures are in place to facilitate and document completion of screenings.										
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	0	0	0	0	0	0	0	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										

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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 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										

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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
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										

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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
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.	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,										

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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.										
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.										

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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 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.										
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.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.										
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	0	0	0	0	0	0	0	0	0	0
Task 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										
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										

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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.										
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										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
engaged patients for project milestone reporting.										
Task 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										

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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 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.	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										

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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										
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										

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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
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										
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										

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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
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 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.										

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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										
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.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
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										
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)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
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 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										

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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
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 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										

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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 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.										
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										
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										

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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 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.										
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										

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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
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 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.										

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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										
Task Develop training plan and curriculum to deploy risk assessment tool, registry and CCMS tool for providers and care managers,										

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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 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										

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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 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 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.										

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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
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 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										

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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
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.										
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										
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.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Assess 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.										
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.										

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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 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 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										

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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 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 #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.										

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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 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.										
Task Policies and procedures include process for consulting with Psychiatrist.										
Task Assess current participating providers practice models										
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.										

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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 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.										
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.).										

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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 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.										
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										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Provide training 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 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										

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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 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.										
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										

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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 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.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	
Use EHRs or other technical platforms to track all patients engaged in this project.	
Co-locate primary care services at behavioral health sites.	
Develop collaborative evidence-based standards of care including medication management and care engagement process.	
Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	
Use EHRs or other technical platforms to track all patients engaged in this project.	
Implement IMPACT Model at Primary Care Sites.	
Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	
Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	
Designate a Psychiatrist meeting requirements of the IMPACT Model.	
Measure outcomes as required in the IMPACT Model.	
Provide "stepped care" as required by the IMPACT Model.	
Use EHRs or other technical platforms to track all patients engaged in this project.	

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IPQR Module 3.a.i.5 - 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	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 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.6 - 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.

Some primary care physicians (PCPs) may resist the imposition of standard treatment protocols & new workflows. To mitigate this risk, our disease management work groups will bring PCPs & other project participants together to review & develop consensus on evidence-based (EB) guidelines & workflows for each disease-specific intervention. Members will recommend these EB protocols to the PPS Quality & Care Innovation Sub-Committee, & the Executive Committee for approval to deploy across the PPS. Implementation of these protocols will be part of contractual agreements between partners & the PPS. BPHC will allocate the necessary resources to provide online & in-person training, support & follow up with physicians & other care team members at times that accommodate their clinical schedules to encourage adoption of program elements.
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 will train all members of the care teams, including physicians, frontline staff, & office staff, on BPHC's forthcoming EB cardiovascular disease protocols & the DSRIP performance metrics & provide additional resources to primary care practices where needed to meet project intervention requirements. In addition, the CSO will audit medical records to ensure that documentation is occurring.
It will be challenging to recruit & train sufficient care management staff to serve the needs of the Bronx population. 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.
Attaining 2014 PCMH Level 3 recognition is difficult & resource intensive, particularly for smaller primary care practices. The CSO will provide technical & financial assistance, including IT support & training, to primary care practices as they work to attain PCMH Level 3 recognition.
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 - Project Implementation Speed

Instructions :

Please specify how many providers will have met all of the project requirements (as set out in the project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.
Note: data entered into this table must represent CUMULATIVE figures.

Benchmarks
100% Total Committed By
DY3,Q4

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Primary Care Physicians	494	0	0	0	0	0	0	0	0	0	0
Non-PCP Practitioners	1,812	0	0	0	0	0	0	0	0	180	543
Clinics	44	0	0	0	0	0	0	0	0	0	0
Health Home / Care Management	17	0	0	0	0	0	0	0	0	0	0
Behavioral Health	122	0	0	0	0	0	0	0	0	0	0
Substance Abuse	26	0	0	0	0	0	0	0	0	0	0
Pharmacies	8	0	0	0	0	0	0	0	0	1	3
Community Based Organizations	49	0	0	0	0	0	0	0	0	4	14
All Other	560	0	0	0	0	0	0	0	0	56	168
Total Committed Providers	**3,132**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**241**	**728**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**7.69**	**23.24**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Primary Care Physicians	494	74	494	494	494	494	494	494	494	494	494
Non-PCP Practitioners	1,812	1,087	1,812	1,812	1,812	1,812	1,812	1,812	1,812	1,812	1,812
Clinics	44	6	44	44	44	44	44	44	44	44	44
Health Home / Care Management	17	2	17	17	17	17	17	17	17	17	17
Behavioral Health	122	18	122	122	122	122	122	122	122	122	122

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Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Substance Abuse	26	3	26	26	26	26	26	26	26	26	26
Pharmacies	8	3	8	8	8	8	8	8	8	8	8
Community Based Organizations	49	29	49	49	49	49	49	49	49	49	49
All Other	560	336	560	560	560	560	560	560	560	560	560
Total Committed Providers	**3,132**	**1,558**	**3,132**	**3,132**	**3,132**	**3,132**	**3,132**	**3,132**	**3,132**	**3,132**	**3,132**
Percent Committed Providers(%)		**49.74**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Current File Uploads

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

Instructions :

Please specify how many patients will have become 'Actively Engaged' (as set out in the Project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.
Note: data entered into this table must represent CUMULATIVE figures.

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

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	0	3,850	7,700	5,005	10,010	15,015	20,020	7,700	15,400
Percent of Expected Patient Engagement(%)	**0.00**	**0.00**	**12.50**	**25.00**	**16.25**	**32.50**	**48.75**	**65.00**	**25.00**	**50.00**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	23,100	30,800	7,700	15,400	23,100	30,800	0	0	0	0
Percent of Expected Patient Engagement(%)	**75.00**	**100.00**	**25.00**	**50.00**	**75.00**	**100.00**	**0.00**	**0.00**	**0.00**	**0.00**

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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)

IPQR Module 3.b.i.4 - Prescribed Milestones

Instructions :

Please enter baseline target dates and work breakdown tasks with target dates for each of the milestones below.

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	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	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	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	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		In Progress	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		In Progress	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		In Progress	06/11/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify partner organizations participating in project (sites and CBOs)	Project		In Progress	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		In Progress	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 health information exchange and technology requirements, and evidence-based guidelines and high-value treatment protocols	Project		In Progress	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Develop the project implementation budget	Project		In Progress	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		On Hold	07/28/2015	03/31/2016	03/31/2016	DY1 Q4
Task Submit COP to Quality and Care Innovation Sub-Committee (QCIS) for approval	Project		On Hold	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Prepare/disseminate gap analysis tool based on COP to participating providers to determine implementaton support needs	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Hold webinar for participating partner organizations	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	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		On Hold	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 exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	Project	N/A	In Progress	06/30/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Primary Care Physicians	On Hold	09/30/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Non-PCP Practitioners	On Hold	09/30/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Behavioral Health	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	Project		In Progress	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		In Progress	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Begin coordinated interface and service development with Bronx RHIO	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	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		On Hold	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	On Hold	04/01/2015	03/31/2020	03/31/2020	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).	Project		On Hold	09/30/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Primary Care Physicians	On Hold	09/30/2015	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		In Progress	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		On Hold	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Recruit or contract for EHR implementation resources as needed	Project		On Hold	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		On Hold	08/01/2016	12/31/2016	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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		On Hold	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		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recruit or contract for PCMH practice certification resources as needed	Project		In Progress	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		On Hold	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Perform gap analysis by practice and identify key priorities.	Project		On Hold	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		On Hold	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition	Project		On Hold	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		On Hold	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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	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	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		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task	Project		In Progress	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Perform current state assessment of E.H.R. capabilities.							
Task Perform gap analysis and identify priories to achieving integration of patient record.	Project		In Progress	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		In Progress	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Create budget to build registry and acquire necessary resources	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	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	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		In Progress	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		On Hold	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		On Hold	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		On Hold	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task	Project		On Hold	01/01/2017	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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).	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has implemented an automated scheduling system to facilitate tobacco control protocols.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify/establish the protocols for the 5A's of tobacco control and services/programs to incorporate into COP	Project		In Progress	07/07/2015	03/31/2016	03/31/2016	DY1 Q4
Task Identify/develop member educational material and smoking cessation support tools for inclusion in COP	Project		In Progress	06/15/2015	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Site-specific Implementation Teams establish and map interim manual processes to fulfill protocols in COP	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	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		On Hold	04/01/2017	03/31/2020	03/31/2020	DY5 Q4
Task Develop feedback mechansims for accountability and continuous quality improvement	Project		On Hold	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Adopt and follow standardized treatment protocols for hypertension and	Project	N/A	In Progress	05/04/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
elevated cholesterol.							
Task Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).	Project		In Progress	06/30/2015	03/31/2017	03/31/2017	DY2 Q4
Task Define target population, select EBGs for target population and make recommendations to Quality & Care Innovation Sub-Committee (QCIS)	Project		In Progress	05/04/2015	12/31/2015	12/31/2015	DY1 Q3
Task QCIS reviews and recommends EBGs for adoption and implementation across the PPS	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task QCIS reviews educational materials and revises as needed; QCIS approves educational materials	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify clinical champions to drive adoption of guidelines	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Implement EBG and educational material dissemination plan across the PPS with support of RDC and site-specific implementation teams	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		On Hold	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.	Project		On Hold	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination processes are in place.	Project		On Hold	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,	Project		In Progress	06/30/2015	10/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
community health workers, and Health Home care managers							
Task Present care management model to QCIS for review and approval	Project		In Progress	06/30/2015	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		In Progress	06/30/2015	10/31/2015	12/31/2015	DY1 Q3
Task Begin to recruit, hire and train new and existing staff as needed.	Project		On Hold	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
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		On Hold	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Develop a mechanism to gather feedback and share best practices	Project		On Hold	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		On Hold	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		On Hold	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		On Hold	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Deploy systems to improve and promote effective care transitions	Project		On Hold	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		On Hold	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		On Hold	02/01/2016	06/15/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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		On Hold	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	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	Primary Care Physicians	On Hold	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	Project		In Progress	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	03/31/2017	DY2 Q4
Task Conduct gap analysis to assess resources required to meet this requirement	Project		On Hold	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		On Hold	10/15/2015	03/31/2020	03/31/2020	DY5 Q4
Task Conduct periodic meetings/learning collaboratives with PCP practice partners to gather feedback and share best practices	Project		On Hold	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Provide guidance for ongoing assesment to ensure that practices are providing access for such visits	Project		On Hold	09/30/2016	03/31/2020	03/31/2020	DY5 Q4
Task Develop feedback mechansims for accountability and continuous quality improvement	Project		On Hold	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	Project	N/A	In Progress	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		On Hold	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task	Project		In Progress	07/28/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	Project		On Hold	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		On Hold	04/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task Develop feedback mechansims for accountability and continuous quality improvement	Project		On Hold	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	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		On Hold	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		On Hold	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		On Hold	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, enrollment and hypertension visit frequency	Project		In Progress	07/07/2015	06/30/2016	06/30/2016	DY2 Q1
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		On Hold	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		On Hold	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		On Hold	09/30/2016	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Provide guidance for ongoing assesment of competencies to ensure that practices are following training requirements and protocols	Project		On Hold	09/30/2016	03/31/2020	03/31/2020	DY5 Q4
Task Develop feedback mechansims for accountability and continuous quality improvement	Project		On Hold	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	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		On Hold	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	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		On Hold	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		On Hold	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
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	Project		On Hold	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	Project	N/A	In Progress	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	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.	Project		On Hold	06/30/2016	03/31/2020	03/31/2020	DY5 Q4
Task Identify best practices for identification and follow-up of self-management goals into COP	Project		In Progress	05/04/2015	12/31/2015	12/31/2015	DY1 Q3

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SBH Health System (PPS ID:36)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Identify relevant training resources /competencies in conjuction with workforce subcommittee	Project		On Hold	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		On Hold	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Establish requirements and processes to ensure documentation of the goals	Project		On Hold	04/01/2016	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		On Hold	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		On Hold	04/01/2017	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	Project	N/A	In Progress	05/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed referral and follow-up process and adheres to process.	Project		In Progress	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		On Hold	06/30/2016	03/31/2020	03/31/2020	DY5 Q4
Task Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.	Project		On Hold	06/30/2016	03/31/2020	03/31/2020	DY5 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		On Hold	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		On Hold	04/01/2016	09/30/2017	09/30/2017	DY3 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	Project		On Hold	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	Project		On Hold	01/01/2017	03/31/2020	03/31/2020	DY5 Q4
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices	Project		On Hold	04/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task Establish the schedule and materials for periodic staff training on the warm transfer and referral tracking	Project		On Hold	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	03/31/2017	DY2 Q4
Task PPS has developed and implemented protocols for home blood pressure monitoring.	Project		In Progress	06/30/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.	Project		On Hold	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		On Hold	06/30/2017	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		In Progress	06/11/2015	03/31/2016	03/31/2016	DY1 Q4
Task Conduct gap analysis with partners to identify implementation support needs	Project		On Hold	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Individual sites adopt protocols for at-home BP monitoring	Project		On Hold	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		On Hold	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		On Hold	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		On Hold	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Define training requirements in conjuction with Workforce Subcommittee	Project		In Progress	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		On Hold	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		On Hold	04/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Conduct periodic meetings/learning collaboratives with community organization partners to gather feedback and share best practices	Project		On Hold	04/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task Establish schedule and materials for periodic staff training on the warm transfer and referral follow-up process	Project		On Hold	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop feedback mechansims for accountability and continuous quality improvement	Project		On Hold	09/30/2016	03/31/2016	03/31/2016	DY1 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	On Hold	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		On Hold	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		On Hold	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		On Hold	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		On Hold	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		On Hold	04/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task Provide guidance for ongoing assesment of competencies to ensure that sites are following training requirements and protocols	Project		On Hold	09/30/2016	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Develop feedback mechansims for accountability and continuous quality improvement	Project		On Hold	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has developed referral and follow-up process and adheres to process.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Define criteria for referral to Quitline	Project		In Progress	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	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop feedback mechansims for accountability and continuous quality improvement	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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	06/30/2017	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		On Hold	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		On Hold	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Using claims data to identify "hotspot" areas/patient groups for outreach	Project		On Hold	04/01/2015	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Implement collection of valid and reliable REAL (Race, Ethnicity, and	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Implement the Stanford Model through partnerships with community based organizations, including Health People	Project		On Hold	04/01/2015	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	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Primary Care Physicians	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Non-PCP Practitioners	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Behavioral Health	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify relevant resources and protocols earmarked as useful by Million Hearts to incorporate into COP	Project		In Progress	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify relevant patient tools for inclusion in COP	Project		In Progress	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		In Progress	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify clinical champions from the the Site-Specific Implementation Team in each participating organization to drive adoption of Million Hearts strategies and materials identified in COP	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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	03/31/2020	DY5 Q4
Task PPS has agreement in place with MCO related to coordination of services for	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project		In Progress	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		On Hold	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Build prompts to these tools and services into provider EHRs	Project		On Hold	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		On Hold	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		On Hold	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	03/31/2017	DY2 Q4
Task PPS has engaged at least 80% of their PCPs in this activity.	Provider	Primary Care Physicians	In Progress	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	03/31/2016	DY1 Q4
Task Ensure that all participating practices have signed MSA	Project		On Hold	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	03/31/2016	DY1 Q4
Task Ensure that hypertension program training is incoporated/included in other care coordination training sessions.	Project		On Hold	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Monitor activity/engagement and make periodic reports to QCIS / EC	Project		On Hold	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop feedback mechansims for accountability and continuous quality	Project		On Hold	04/01/2016	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
improvement for Site-Specific Implementation Teams.							

Project 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										
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										

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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 Design training and recruitment strategy in conjunction with workforce team and CVD/DM TWG										
Task Submit 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 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

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task PPS 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 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.										
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										

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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 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										
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,										

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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.										
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										
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										

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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
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 make recommendations 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 QCIS reviews educational materials and revises as needed; QCIS approves educational materials										
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.										
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										

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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 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										
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										

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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										
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 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										

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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 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										

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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 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										

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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 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 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										

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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 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										

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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 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										
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.										

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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.										
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.										

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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	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	0	0
Task Identify relevant resources and protocols earmarked as useful by Million Hearts to incorporate into COP										
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 the Site-Specific Implementation Team in each participating organization 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										

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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.										
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										

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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										
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										

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Task Design training and recruitment strategy in conjunction with workforce team and CVD/DM TWG										
Task Submit 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 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.	0	0	0	0	0	0	0	0	0	0

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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 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.										
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										

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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										
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,										

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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.										
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										
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										

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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 make recommendations 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 QCIS reviews educational materials and revises as needed; QCIS approves educational materials										
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.										
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										

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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
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										
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										

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 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										
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 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										

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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)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
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 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										

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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
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 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										

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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 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 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 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										

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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
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 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										

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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 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										
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.										

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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 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.										
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.										

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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 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	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	0	0
Task Identify relevant resources and protocols earmarked as useful by Million Hearts to incorporate into COP										
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 the Site-Specific Implementation Team in each participating organization 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										

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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
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.										
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										

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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
continuous quality improvement for Site-Specific Implementation Teams.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date
Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	jpacesbh	36_PMDL4203_1_1_20150731082623_Requirement 1 CVD Diabetes Minutes Combined.pdf	The file "Requirement 1 CVD Diabetes Minutes Combined" applies to Milestone 1, Task 2.	07/31/2015 08:25 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	
Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	
Use EHRs or other technical platforms to track all patients engaged in this project.	
Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	
Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	
Develop care coordination teams including use of nursing staff, pharmacists, dieticians and	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	
Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	
Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	
Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	
Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	
Document patient driven self-management goals in the medical record and review with patients at each visit.	
Follow up with referrals to community based programs to document participation and behavioral and health status changes.	
Develop and implement protocols for home blood pressure monitoring with follow up support.	
Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	
Facilitate referrals to NYS Smoker's Quitline.	
Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	
Adopt strategies from the Million Hearts Campaign.	
Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Engage a majority (at least 80%) of primary care providers in this project.	

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SBH Health System (PPS ID:36)

IPQR Module 3.b.i.5 - 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	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 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.6 - IA Monitoring

Instructions :

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SBH Health System (PPS ID:36)

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.

Some primary care physicians (PCPs) may resist the imposition of standard treatment protocols & new workflows. To mitigate this risk, our disease management work groups will bring PCPs & other project participants together to review & develop a consensus on evidence-based (EB) guidelines & workflows for each disease-specific intervention. Members will recommend these EB protocols to the PPS Quality & Care Innovation Sub-Committee, & the Executive Committee. Implementation of these protocols will be part of contractual agreements between partners & the PPS. BPHC will allocate the necessary resources to provide online & in-person training, support & follow up with physicians & other care team members at times that accommodate their clinical schedules to encourage adoption of program elements.
It will be challenging to recruit & train sufficient care management staff to serve the needs of the Bronx population. 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.
Attaining 2014 PCMH Level 3 recognition is difficult & resource intensive, particularly for smaller primary care practices. The CSO will provide technical & financial assistance, including IT support & training, to primary care practices as they work to attain PCMH Level 3 recognition.
Medication adherence is a chronic problem for individuals with chronic illness including those with diabetes. 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. Many patients do not grasp the effects of diabetes & unmanaged diabetes, risks that are compounded in the Bronx population by low health literacy & educational attainment. These challenges are exacerbated by the complex, multi-organ nature of diabetes, requiring an interdisciplinary treatment approach. Among its mitigation tactics, BPHC plans to implement the Stanford Model across the PPS to address this risk. This peer led model requires a large time commitment from participants, & few certified trainers are available. BPHC will contract 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.
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 & provide customized technical assistance, coaching, & training modules.

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IPQR Module 3.c.i.2 - Project Implementation Speed

Instructions :

Please specify how many providers will have met all of the project requirements (as set out in the project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.
Note: data entered into this table must represent CUMULATIVE figures.

Benchmarks
100% Total Committed By
DY3,Q4

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Primary Care Physicians	494	0	0	0	0	0	0	0	0	0	0
Non-PCP Practitioners	1,812	0	0	0	0	0	0	0	0	180	543
Clinics	44	0	0	0	0	0	0	0	0	0	0
Health Home / Care Management	17	0	0	0	0	0	0	0	0	0	0
Behavioral Health	122	0	0	0	0	0	0	0	0	0	0
Substance Abuse	16	0	0	0	0	0	0	0	0	0	0
Pharmacies	8	0	0	0	0	0	0	0	0	1	3
Community Based Organizations	41	0	0	0	0	0	0	0	0	2	11
All Other	560	0	0	0	0	0	0	0	0	56	168
Total Committed Providers	**3,114**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**239**	**725**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**7.68**	**23.28**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Primary Care Physicians	494	74	494	494	494	494	494	494	494	494	494
Non-PCP Practitioners	1,812	1,087	1,812	1,812	1,812	1,812	1,812	1,812	1,812	1,812	1,812
Clinics	44	6	44	44	44	44	44	44	44	44	44
Health Home / Care Management	17	2	17	17	17	17	17	17	17	17	17
Behavioral Health	122	18	122	122	122	122	122	122	122	122	122

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SBH Health System (PPS ID:36)

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Substance Abuse	16	2	16	16	16	16	16	16	16	16	16
Pharmacies	8	8	8	8	8	8	8	8	8	8	8
Community Based Organizations	41	24	41	41	41	41	41	41	41	41	41
All Other	560	336	560	560	560	560	560	560	560	560	560
Total Committed Providers	**3,114**	**1,557**	**3,114**	**3,114**	**3,114**	**3,114**	**3,114**	**3,114**	**3,114**	**3,114**	**3,114**
Percent Committed Providers(%)		**50.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Current File Uploads

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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)

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

Instructions :

Please specify how many patients will have become 'Actively Engaged' (as set out in the Project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.
Note: data entered into this table must represent CUMULATIVE figures.

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY2,Q4	25,800

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	4,300	8,600	12,900	6,450	12,900	19,350	25,800	6,450	12,900
Percent of Expected Patient Engagement(%)	**0.00**	**16.67**	**33.33**	**50.00**	**25.00**	**50.00**	**75.00**	**100.00**	**25.00**	**50.00**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	19,350	25,800	6,450	12,900	19,350	25,800	0	0	0	0
Percent of Expected Patient Engagement(%)	**75.00**	**100.00**	**25.00**	**50.00**	**75.00**	**100.00**	**0.00**	**0.00**	**0.00**	**0.00**

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IPQR Module 3.c.i.4 - Prescribed Milestones

Instructions :

Please enter baseline target dates and work breakdown tasks with target dates for each of the milestones below.

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	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	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	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	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		In Progress	05/15/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify relevant evidence-based guidelines for diabetes	Project		In Progress	05/04/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify partner organizations participating in project (sites and CBOs)	Project		In Progress	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		In Progress	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 health information exchange and technology requirements, and evidence-based guidelines and high-value treatment protocols	Project		In Progress	05/04/2015	10/31/2015	12/31/2015	DY1 Q3
Task Develop the project implementation budget	Project		In Progress	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task	Project		On Hold	07/28/2016	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Design training and recruitment strategy in conjunction with workforce team and CVD/DM TWG							
Task Submit COP to Quality and Care Innovation Sub-Committee (QCIS) for approval	Project		In Progress	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		On Hold	10/01/2015	04/01/2016	06/30/2016	DY2 Q1
Task Prepare/disseminate gap analysis tool based on COP to participating providers to determine implementaton support needs	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Hold webinar for participating partner organizations	Project		On Hold	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		On Hold	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		On Hold	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	03/31/2017	DY2 Q4
Task PPS has engaged at least 80% of their PCPs in this activity.	Provider	Primary Care Physicians	In Progress	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	03/31/2016	DY1 Q4
Task Ensure that all participating practices have signed MSA	Project		On Hold	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	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	Project		On Hold	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
coordination training sessions.							
Task Monitor acitivity/engagement and make periodic reports to QCIS / EC	Project		On Hold	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Develop methodology for evaluation, feedback and Continuous Quality Improvement.	Project		On Hold	04/01/2016	03/31/2020	03/31/2020	DY5 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	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		On Hold	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.	Project		On Hold	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination processes are established and implemented.	Project		On Hold	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, including nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.	Project		In Progress	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Present care management model to QCIS for review and approval	Project		On Hold	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		On Hold	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		In Progress	06/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Identify site-specific implementation teams.	Project		On Hold	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	Project		On Hold	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		On Hold	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		On Hold	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		On Hold	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		On Hold	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		On Hold	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	On Hold	06/30/2017	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		On Hold	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		On Hold	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task	Project		On Hold	06/30/2016	09/30/2017	09/30/2017	DY3 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.							
Task Using claims data identify "hotspot" areas/patient groups for outreach	Project		On Hold	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		On Hold	09/30/2017	03/31/2018	03/31/2018	DY3 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 disparities, if feasible.	Project		On Hold	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Establish linkages to health homes for targeted patient populations	Project		On Hold	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		On Hold	07/01/2016	03/31/2020	03/31/2020	DY5 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	03/31/2020	DY5 Q4
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.	Project		On Hold	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	06/30/2016	DY2 Q1
Task Distribute materials regarding extant services and benefits available to members to providers participting in project	Project		On Hold	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Build prompts to these tools and services into provider EHRs	Project		On Hold	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		On Hold	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task	Project		On Hold	04/01/2017	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project	N/A	In Progress	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	03/31/2017	DY2 Q4
Task PPS uses a recall system that allows staff to report which patients are overdue for which preventive services and to track when and how patients were notified of needed services.	Project		On Hold	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		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.	Project		In Progress	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		In Progress	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		In Progress	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		On Hold	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		On Hold	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Create budget to build registry and acquire necessary resources	Project		On Hold	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		On Hold	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Develop project implementation and testing plan for building registry as	Project		On Hold	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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		On Hold	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		On Hold	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Site-specific implementation teams establish processes to use PHM tools/registry, to identify, reach out and track patients due for preventive services.	Project		On Hold	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		On Hold	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Conduct training around closed loop processing/referral and preventive service tracking.	Project		On Hold	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		On Hold	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		In Progress	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Coordinate with Bronx RHIO to develop comprehensive HIE adoption program	Project		In Progress	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
to encourage and support partner participation and integration							
Task Begin coordinated interface and service development with Bronx RHIO	Project		On Hold	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		On Hold	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		On Hold	03/01/2016	03/31/2018	03/31/2018	DY3 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		On Hold	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		On Hold	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		On Hold	04/01/2016	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	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		On Hold	09/30/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Primary Care Physicians	On Hold	09/30/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	Provider	Safety Net Primary Care Physicians	On Hold	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	Provider	Safety Net Non-PCP Practitioners	On Hold	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	Provider	Safety Net Behavioral Health	On Hold	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task	Project		In Progress	06/30/2015	08/30/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	Project		On Hold	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Recruit or contract for EHR implementation resources as needed	Project		On Hold	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		On Hold	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		On Hold	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		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Recruit or contract for PCMH practice certification resources as needed	Project		In Progress	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		On Hold	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Perform gap analysis by practice and identify key priorities.	Project		On Hold	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		On Hold	10/01/2015	04/15/2016	06/30/2016	DY2 Q1
Task Begin actively encouraging, tracking and supporting partner efforts towards PCMH recognition	Project		On Hold	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		On Hold	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Monitor practice transformation sustainability after receiving 2014 NCQA level 3	Project		On Hold	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
PCMH certification, and provide support as needed.							

Project 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 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										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Submit 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
Task Identify sites participating in project										
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.										

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 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 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.										

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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 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.										
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.										
Task If applicable, PPS has established linkages to health homes for targeted patient populations.										

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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 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 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										

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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
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										
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										

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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
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 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										

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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
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.	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

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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 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										
Task Monitor progress with achieving 2014 NCQA level 3 PCMH certification, support provided by PPS as needed.										

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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 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 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										

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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
Design training and recruitment strategy in conjunction with workforce team and CVD/DM TWG										
Task Submit 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										
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										

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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
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 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.										

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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 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.										
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										

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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 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 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										

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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
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										
Task Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries										

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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 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 assess partner and QE data sharing capabilities and current HIE participation										

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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 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
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

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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.	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										
Task Monitor progress with achieving 2014 NCQA level 3 PCMH										

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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
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 Name	Description	Upload Date
Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.	lrobsbh	36_PMDL4403_1_1_20150730103313_Requirement 1 CVD Diabetes Minutes Combined.pdf	Corresponds to task: Create a Transitional Work Group (CVD/Diabetes TWG) comprised of representatives from partner organizations to support development of and approve elements...	07/30/2015 10:31 AM

Prescribed Milestones Narrative Text

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

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	

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IPQR Module 3.c.i.5 - 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	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 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.6 - 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 - Project Implementation Speed

Instructions :

Please specify how many providers will have met all of the project requirements (as set out in the project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.
Note: data entered into this table must represent CUMULATIVE figures.

Benchmarks
100% Total Committed By
DY3,Q2

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Primary Care Physicians	749	0	0	0	0	74	149	149	374	749	749
Non-PCP Practitioners	1,812	0	0	0	0	0	0	0	906	1,812	1,812
Clinics	44	0	0	0	0	4	9	9	22	44	44
Health Home / Care Management	17	0	0	0	0	0	0	0	9	17	17
Pharmacies	8	0	0	0	0	2	4	4	8	8	8
Community Based Organizations	41	0	0	0	0	4	8	8	20	41	41
All Other	560	0	0	0	0	0	0	0	280	560	560
Total Committed Providers	**3,231**	**0**	**0**	**0**	**0**	**84**	**170**	**170**	**1,619**	**3,231**	**3,231**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**2.60**	**5.26**	**5.26**	**50.11**	**100.00**	**100.00**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Primary Care Physicians	749	749	749	749	749	749	749	749	749	749	749
Non-PCP Practitioners	1,812	1,812	1,812	1,812	1,812	1,812	1,812	1,812	1,812	1,812	1,812
Clinics	44	44	44	44	44	44	44	44	44	44	44
Health Home / Care Management	17	17	17	17	17	17	17	17	17	17	17
Pharmacies	8	8	8	8	8	8	8	8	8	8	8
Community Based Organizations	41	41	41	41	41	41	41	41	41	41	41
All Other	560	560	560	560	560	560	560	560	560	560	560

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Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Total Committed Providers	3,231	3,231	3,231	3,231	3,231	3,231	3,231	3,231	3,231	3,231	3,231
Percent Committed Providers(%)		100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Current File Uploads

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

Instructions :

Please specify how many patients will have become 'Actively Engaged' (as set out in the Project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.
Note: data entered into this table must represent CUMULATIVE figures.

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

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	0	0	0	969	1,938	2,905	3,875	2,422	4,844
Percent of Expected Patient Engagement(%)	**0.00**	**0.00**	**0.00**	**0.00**	**6.25**	**12.50**	**18.74**	**25.00**	**15.63**	**31.25**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	7,266	9,688	3,875	7,750	11,625	15,500	0	0	0	0
Percent of Expected Patient Engagement(%)	**46.88**	**62.50**	**25.00**	**50.00**	**75.00**	**100.00**	**0.00**	**0.00**	**0.00**	**0.00**

Current File Uploads

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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IPQR Module 3.d.ii.4 - Prescribed Milestones

Instructions :

Please enter baseline target dates and work breakdown tasks with target dates for each of the milestones below.

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	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	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	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	09/30/2015	09/30/2015	DY1 Q2
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	09/30/2015	09/30/2015	DY1 Q2
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	06/30/2015	DY1 Q1
Task Develop workplan and time line to develop COP.	Project		In Progress	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 productive collaborative relationships and linkages among them.	Project		In Progress	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Develop and finalize Asthma Action Plan form	Project		In Progress	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify PPS members who will participate in project.	Project		In Progress	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Define target population.	Project		In Progress	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop methodology evaluation, feedback and Continuous Quality Improvement (CQI) for Site-Specific Implementation Teams.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence-based trigger reduction interventions.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify integrated pest management (IPM) vendors who provide services in the Bronx.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop policies, procedures and workflows for engaging IPM vendors when needed, including responsible resources at each stage of the workflow.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop patient educational materials on indoor asthma triggers and availability of IPM resources to reduce exposure to the triggers.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #3 Develop and implement evidence-based asthma management guidelines.	Project	N/A	In Progress	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	03/31/2017	DY2 Q4
Task Global Initiative for Asthma (GINA) guidelines for Asthma Management and Prevention 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	Project		In Progress	06/29/2015	08/03/2015	09/30/2015	DY1 Q2
Task Quality and Care Innovation Sub-Committee (QCIS) will review and revise the evidence-based guidelines for clinical practice, as needed, and approve.	Project		In Progress	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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: 10.1016/j.anai.2014.12.014.)	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Disseminate/embed (in EHR/PHR, where feasible) patient/caregiver educational information and materials across participating PPS providers.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Conduct ongoing education/training to introduce/update/refresh care teams' knowledge of new patient educational materials and evidence-based guidelines	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Establish protocols and methods that promote medication adherence, including local participating pharmacists to support patient education, especially on inhaler/spacer use.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #5 Ensure coordinated care for asthma patients includes social services and support.	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has developed and conducted training of all providers, including social services and support.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task All practices in PPS have a Clinical Interoperability System in place for all participating providers.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has assembled a care coordination team that includes use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Conduct educational sessions/webinar and ongoing training as needed for providers on use of Asthma Project COP.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop and implement provider-specific technical assistance program to facilitate use of various interoperable IT systems.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Deploy systems to improve and promote effective care transitions, include protocols for tracking and follow-up	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Operationalize partner and workforce roles by providing gap analysis and appropriate training.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task In conjunction with Workforce Subcommittee, describe roles and responsibilities of care coordination team that includes clinical practice care	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	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		On Hold	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		On Hold	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	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's family.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Establish protocols for frequency of follow-up services	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Establish processes and timelines for additional follow-up to ensure root causes have been sustainably eliminated.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify patients with ED or hospital visits for an asthma diagnosis, via	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Establish processes to share root causes with family/care givers and to provide support to eliminate/rectify root causes, as needed	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop mechanisms for ongoing evaluation of the above processes and follow up to assure accountability and continuous quality improvement.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has agreement in place with MCOs to address coverage of patients with asthma health issues	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	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.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Develop partnership agreements with MCOs affirming coverage and coordination of asthma service benefits.	Project		On Hold	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	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform current state assessment of E.H.R. capabilities.	Project		In Progress	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		In Progress	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		In Progress	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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Create budget to build registry and acquire necessary resources	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	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	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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SBH Health System (PPS ID:36)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 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										

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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
(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 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										

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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
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.										
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 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:										

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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
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 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										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
participating 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.										
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,										

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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
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 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										

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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 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 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										

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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
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, 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										

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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
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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Project 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.										
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.										

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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 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.										
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										

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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
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 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.										

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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 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.										
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,										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
health 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 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										

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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
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 ensure root causes have been sustainably eliminated.										
Task Identify patients with ED or hospital visits for an asthma										

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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
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.										
Task Using Master Services Agreements and schedules, develop partnership agreements with participating health home managers, PCPs and speciality providers that define services										

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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
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 frequent automated updates of registry data										
Task Develop training plan and curriculum to deploy risk assessment										

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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
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 Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	
Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	
Develop and implement evidence-based asthma management guidelines.	

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Prescribed Milestones Narrative Text

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

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IPQR Module 3.d.ii.5 - 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	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 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.6 - IA Monitoring

Instructions :

Milestone 3: NEAPP EPR 3 Guidelines for the Diagnosis and Management of Asthma should serve as the 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

Milestone 4: The IA recommends that the PPS review the National Standards for asthma self-management education to ensure that training is comprehensive and utilizes national guidelines for asthma self-management education: (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.)

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

IPQR Module 4.a.iii.1 - PPS Defined Milestones

Instructions :

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones. For Domain 4 projects, these milestones must align with content submitted in the PPS Application.

Milestone/Task Name	Status	Description	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	03/31/2016	DY1 Q4
Task Participate in cross-PPS workgroup	In Progress	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	09/30/2015	DY1 Q2
Task Identify subject matter experts for workgroup	In Progress	Identify PPS subject matter experts to join cross-PPS Work Group	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Invite city agency representatives for workgroup	In Progress	Invite representatives from DOE-affiliated Office of School Health and DOHMH to join Workgroup as advisory members	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	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	03/31/2016	DY1 Q4
Task Confirm commitment to cross-PPS collaboration	In Progress	BPHC will confirm its commitment to partner in City-wide implementation of MHSA Project	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Develop governance structure	In Progress	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	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 adolescent population. The PPSs will work together to conduct research and adapt evidence-based models of	06/30/2015	03/31/2017	03/31/2017	DY2 Q4

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
		collaborative care for adolescents.				
Task Conduct baseline analysis	In Progress	A baseline analysis of existing programs and CBOs providing MHSA services to adolescents in schools will be conducted	06/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Review of evidence based interventions	In Progress	Review evidence-based adaptations of Collaborative Care (CC) model that have targeted adolescents	06/30/2015	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	06/30/2015	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	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	03/31/2016	DY1 Q4
Task Develop selection process for lead agency	In Progress	Design/implement process to select well qualified Lead agency to manage detailed program planning and implementation of the MHSA cross-PPS initiative	06/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Contract with selected Lead Agency	On Hold	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	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Draft operational plan	On Hold	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	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Finalize operational plan	On Hold	Finalize draft operational plan and budget; share with MHSA Collaborative cross-PPS Governance body for approval	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone Implement Collaborative Care (CC) Adaptation in schools	On Hold	Implementation will encompass details on contracting, collaboration with NYCDOE, school selection, and launch of intervention in schools.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Implement process for community agency selection	On Hold	Design and implement process to select and contract with community mental/behavioral agencies to implement programs in the schools	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Solicit DOE input on school selection methodology	On Hold	DOE will provide input and feedback on proposed process for community mental/behavioral health agency selection	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Identify target schools	On Hold	Identify target schools for implementation of CC adaptation	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop project activities schedule	On Hold	Develop schedule for MHSA project activities, including activities preparatory to launch of CC adaptation in schools such as contracting, staff recruitment and deployment, training	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Launch MHSA project in schools	On Hold	Launch implementation of MHSA Project CC adaptation in schools	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone Design programs for young adults	On Hold	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.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify target young adult groups	On Hold	Identify target young adult groups, including, but not limited to, community college students	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Refine MHSA intervention	On Hold	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	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Launch young adult programs	On Hold	Launch young adult programs	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Participate in citywide MHSA Workgroup meetings	The PPSs have organized and convened regular MHSA Workgroup meetings since Fall 2014. They are currently in the process of formalizing a standing structure for the MHSA Workgroup meetings for the remainder of the DSRIP demonstration period and expect to complete that task by 3/31/16.
Establish cross-PPS Collaboration structure	The PPSs have added this new milestone to reflect their significant work to date in formalizing a structure for cross-PPS governance and implementation of the project, given the PPSs' decision to completely align project activities across the City.
Review of existing programs	This baseline analysis is underway, and the PPSs have added an additional step of ensuring that the findings are incorporated into the MSHA project concept document by 3/31/16.

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Develop operations plan	
Implement Collaborative Care (CC) Adaptation in schools	Given their advanced state of project planning, the PPSs have committed to accelerating their launch date for this set of activities. They will begin work in select schools in 9/30/16.
Design programs for young adults	Given their advanced state of project planning, the PPSs have committed to accelerating their launch date for this set of activities. They will begin work in select schools in 9/30/16.

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

Instructions :

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones. For Domain 4 projects, these milestones must align with content submitted in the PPS Application.

Milestone/Task Name	Status	Description	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	06/30/2017	DY3 Q1
Task Create the BPHC HIV Work Group	On Hold	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.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify evidence-based guidelines	On Hold	Identify relevant evidence-based guidelines for HIV and Viral Load Suppression (VLS)	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify DSRIP project requirements related to PCMH elements	On Hold	Identify DSRIP project requirements which are related to PCMH elements and incorporate into PCMH strategy and project planning documents	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop budget	On Hold	Develop the project implementation budget	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop evidence-based strategies for disease management and control	On Hold	Develop evidence-based strategies for the management and control of HIV in the PPS designated area.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify clinical champions and operational leaders in each participating organization	On Hold	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	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Create detailed implementation workplan and	On Hold	Develop a workplan and timeline to guide implementation of strategies for the HIV population	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
timelines						
Task Design culturally competent training and recruitment strategy	On Hold	In conjunction with workforce subcommittee, evaluate staffing needs to design culturally competent training and recruitment strategy	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Obtain approval of implementation workplan and timelines	On Hold	Submit elements of implementation plan to Quality and Care Innovation Sub-Committee (QCIS) for approval	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Disseminate gap analysis tool to providers	On Hold	PPrepare and disseminate gap analysis tool based on Clinical Operations Plan to participating providers to determine implementaton support needs	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Hold informational webinar	On Hold	Hold webinar for participating partner organizations	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify partner and target organizations for project implementation	On Hold	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.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Define program elements	On Hold	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	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Create a rapid deployment collaborative	On Hold	The rapid deployment collaborative, or implementation workgroup, will be comprised of representatives from partner organizations to support implementation of the implementation plan.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop and implement plans for CQI	On Hold	Develop feedback mechansims for accountability and continuous quality improvement and implement in appropriate settings	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Regular review of evidence-based guidelines	On Hold	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.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
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 and will continue to collaborate throughout implementation.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify cross-PPS convener	In Progress	Participate in contract negotiations with DOHMH to house the cross-PPS collaborative	08/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task	On Hold	Participate in drafting shared contract with DOHMH	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Convener contract Development						
Task Convener contract execution	On Hold	Participate in getting contract with DOHMH approved and signed	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify data sharing needs	On Hold	Identify data sharing needs and the resources to support effective data sharing	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Create cross-PPS workplan	On Hold	Contribute to development of cross-PPS workplan in alignment with internal BPHC project implementation	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Establish cross-PPS milestones	On Hold	Establish agreed upon milestones for cross-PPS project implementation	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Collaborate with NYCDOHMH to develop and implement broad-based education campaigns	On Hold	Collaborate with NYCDOHMH to develop and implement broad-based education campaigns	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify population health and data management tools	On Hold	Identify existing population health management tools and data interfacing tools within the PPSs	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Conduct gap analysis	On Hold	Conduct gap analysis on available data and needed data to meet project requirements	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Conduct gap analysis on available data and needed data to meet project requirements	On Hold	Conduct gap analysis on available data and needed data to meet project requirements	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Leverage existing capacities	On Hold	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	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Vet cross-PPS projects with rapid deployment collaborative and Executive Committee	On Hold	Vet agreed upon project commonalities and shared resources with relevant BPHC sub-committees and Executive Committee	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Vet cross-PPS data sharing proposal with BPHC sub-committees and Executive Committee	On Hold	Vet agreed-upon data sharing system to address reporting and implementation needs with relevant BPHC sub-committees and Executive Committee	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task	On Hold	Participate in a cross-PPS HIV Learning Collaborative	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Participate in a cross-PPS HIV Learning Collaborative						
Milestone Develop adherence protocol and staffing plans	On Hold	Engage with HHs and CM agencies to develop plans for PHM to improve retention in care and medication adherence to support VLS	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop workplan for Retention to Care Unit	On Hold	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.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Review and develop protocols for evidence-based guidelines	On Hold	Engage HHs and CM agencies in HIV workgroup (from milestone 1) to review evidence-based guidelines and develop protocols	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Establish partnerships	On Hold	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.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify sites for VLS intervention implementation	On Hold	Identify HHs and CM agencies to implement VLS interventions	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Conduct a gap analysis	On Hold	Conduct a gap analysis on staffing and resource needs	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Hire and train staff	On Hold	In conjuction with Workforce Subcommittee, recruit, hire and train existing and new staff. Include cultural competence around LGBTQ community and SUD.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Recruit peer leaders	On Hold	Identify peer leaders who have achieved VLS to co-facilitate support groups, assist with education and outreach, and act as escorts for apointments	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Establish Retention to Care Unit.	On Hold	Establish Retention to Care Unit with trained staff and peer supports	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Implement interventions	On Hold	Identify and implement interventions targeting high-needs populations	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop and implement plans for CQI	On Hold	Develop feedback mechansims for accountability and continuous quality improvement	04/01/2015	03/31/2020	03/31/2020	DY5 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	03/31/2017	DY2 Q4
Task Define population health management requirements	In Progress	Define population health management (PHM) requirements, establish PHM function and recruit or contract with partner for PHM staff	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Assess EHR capabilities	In Progress	Perform current state assessment of EHR capabilities among participating safety net providers	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Perform gap analysis	In Progress	Perform gap analysis and identify priorities to achieving integration of patient record.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Define requirements and elements for patient registry	In Progress	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	12/31/2015	DY1 Q3
Task Vet patient registry proposal with BPHC sub-committees and Executive Committee	On Hold	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)	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify technology and resource requirements for registry	On Hold	Engage IT Subcommittee to identify technology and resource requirements for registry, including technical platform for hosting registry.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Create budget	On Hold	Create budget to build registry and acquire necessary resources	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Secure Care Coordination Management Solution	On Hold	Assess and acquire or contract for care coordination management solution (CCMS) and other systems and services as required to support PHM and registries	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop project implementation and testing for registry	On Hold	Develop project implementation and testing plan for building registry as required for PHM, including technical support, ensure frequent automated updates of registry data	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop training plan and curriculum on registry use	On Hold	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	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Execute registry testing plan and training program	On Hold	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.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Issue user credentials and provide trainings on CCMS	On Hold	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.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Launch and monitor registry	On Hold	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.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone Implement peer-based supports	On Hold	Develop and implement peer-based educational support and self-management programs	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Hold trainings	On Hold	Hold trainings for providers,care managers and peer support teams on cultural competency, motivational interviewing, and other adherence support strategies.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Launch support programs	On Hold	Launch peer educator support programs that focus on adherence to HIV management	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Provide complementary resources to reinforce trainings	On Hold	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.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Develop and implement plans for CQI	On Hold	Develop feedback mechanisms for continuous quality improvement	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Execute educational campaigns	On Hold	Execute educational campaigns developed in collaboration with cross-PPS collaborative and NYCDOHMH	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Identify training curricula	On Hold	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.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	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	

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
load suppression, in community and ambulatory care settings.	
Participate in a NYC cross-PPS Collaborative	
Develop adherence protocol and staffing plans	
Utlize EHR and other IT platforms for population health management	
Implement peer-based supports	

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IPQR Module 4.c.ii.2 - 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**.

Primary Lead PPS Provider:	ST BARNABAS HOSPITAL
Secondary Lead PPS Provider:	
Lead Representative:	Leonard Walsh
Submission Date:	09/24/2015 04:45 PM
Comments:	

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Status Log				
Quarterly Report (DY,Q)	**Status**	**Lead Representative Name**	**User ID**	**Date Timestamp**
DY1, Q1	Submitted	Leonard Walsh	lwalsh22	09/24/2015 04:45 PM
DY1, Q1	Returned	Leonard Walsh	sv590918	09/08/2015 07:52 AM
DY1, Q1	Submitted	Leonard Walsh	lwalsh22	08/06/2015 03:31 PM
DY1, Q1	In Process		system	07/01/2015 12:12 AM

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Comments Log			
Status	**Comments**	**User ID**	**Date Timestamp**
Returned	Please address the IA comments provided in the specific sections of your Implementation Plan during the remediation period.	sv590918	09/08/2015 07:52 AM

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Section	Module	Status
Section 01	IPQR Module 1.1 - PPS Budget Report	Completed
	IPQR Module 1.2 - PPS Flow of Funds	Completed
	IPQR Module 1.3 - Prescribed Milestones	Completed
	IPQR Module 1.4 - PPS Defined Milestones	Completed
	IPQR Module 1.5 - IA Monitoring	
Section 02	IPQR Module 2.1 - Prescribed Milestones	Completed
	IPQR Module 2.2 - PPS Defined Milestones	Completed
	IPQR Module 2.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 2.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 2.5 - Roles and Responsibilities	Completed
	IPQR Module 2.6 - Key Stakeholders	Completed
	IPQR Module 2.7 - IT Expectations	Completed
	IPQR Module 2.8 - Progress Reporting	Completed
	IPQR Module 2.9 - IA Monitoring	
Section 03	IPQR Module 3.1 - Prescribed Milestones	Completed
	IPQR Module 3.2 - PPS Defined Milestones	Completed
	IPQR Module 3.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 3.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 3.5 - Roles and Responsibilities	Completed
	IPQR Module 3.6 - Key Stakeholders	Completed
	IPQR Module 3.7 - IT Expectations	Completed
	IPQR Module 3.8 - Progress Reporting	Completed
	IPQR Module 3.9 - IA Monitoring	
Section 04	IPQR Module 4.1 - Prescribed Milestones	Completed
	IPQR Module 4.2 - PPS Defined Milestones	Completed
	IPQR Module 4.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 4.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 4.5 - Roles and Responsibilities	Completed

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Section	Module	Status
	IPQR Module 4.6 - Key Stakeholders	Completed
	IPQR Module 4.7 - IT Expectations	Completed
	IPQR Module 4.8 - Progress Reporting	Completed
	IPQR Module 4.9 - IA Monitoring	
Section 05	IPQR Module 5.1 - Prescribed Milestones	Completed
	IPQR Module 5.2 - PPS Defined Milestones	Completed
	IPQR Module 5.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 5.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 5.5 - Roles and Responsibilities	Completed
	IPQR Module 5.6 - Key Stakeholders	Completed
	IPQR Module 5.7 - Progress Reporting	Completed
	IPQR Module 5.8 - IA Monitoring	
Section 06	IPQR Module 6.1 - Prescribed Milestones	Completed
	IPQR Module 6.2 - PPS Defined Milestones	Completed
	IPQR Module 6.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 6.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 6.5 - Roles and Responsibilities	Completed
	IPQR Module 6.6 - Key Stakeholders	Completed
	IPQR Module 6.7 - IT Expectations	Completed
	IPQR Module 6.8 - Progress Reporting	Completed
	IPQR Module 6.9 - IA Monitoring	
Section 07	IPQR Module 7.1 - Prescribed Milestones	Completed
	IPQR Module 7.2 - PPS Defined Milestones	Completed
	IPQR Module 7.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 7.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 7.5 - Roles and Responsibilities	Completed
	IPQR Module 7.6 - Key Stakeholders	Completed
	IPQR Module 7.7 - IT Expectations	Completed
	IPQR Module 7.8 - Progress Reporting	Completed

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Section	Module	Status
	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 - IA Monitoring	

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Project ID	Module	Status
2.a.i	IPQR Module 2.a.i.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 2.a.i.2 - Project Implementation Speed	Completed
	IPQR Module 2.a.i.3 - Prescribed Milestones	Completed
	IPQR Module 2.a.i.4 - PPS Defined Milestones	Completed
	IPQR Module 2.a.i.5 - 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 - Project Implementation Speed	Completed
	IPQR Module 2.a.iii.3 - Patient Engagement Speed	Completed
	IPQR Module 2.a.iii.4 - Prescribed Milestones	Completed
	IPQR Module 2.a.iii.5 - PPS Defined Milestones	Completed
	IPQR Module 2.a.iii.6 - 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 - Project Implementation Speed	Completed
	IPQR Module 2.b.iii.3 - Patient Engagement Speed	Completed
	IPQR Module 2.b.iii.4 - Prescribed Milestones	Completed
	IPQR Module 2.b.iii.5 - PPS Defined Milestones	Completed
	IPQR Module 2.b.iii.6 - 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 - Project Implementation Speed	Completed
	IPQR Module 2.b.iv.3 - Patient Engagement Speed	Completed
	IPQR Module 2.b.iv.4 - Prescribed Milestones	Completed
	IPQR Module 2.b.iv.5 - PPS Defined Milestones	Completed
	IPQR Module 2.b.iv.6 - 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 - Project Implementation Speed	Completed
	IPQR Module 3.a.i.3 - Patient Engagement Speed	Completed
	IPQR Module 3.a.i.4 - Prescribed Milestones	Completed
	IPQR Module 3.a.i.5 - PPS Defined Milestones	Completed

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Project ID	Module	Status
	IPQR Module 3.a.i.6 - 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 - Project Implementation Speed	Completed
	IPQR Module 3.b.i.3 - Patient Engagement Speed	Completed
	IPQR Module 3.b.i.4 - Prescribed Milestones	Completed
	IPQR Module 3.b.i.5 - PPS Defined Milestones	Completed
	IPQR Module 3.b.i.6 - 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 - Project Implementation Speed	Completed
	IPQR Module 3.c.i.3 - Patient Engagement Speed	Completed
	IPQR Module 3.c.i.4 - Prescribed Milestones	Completed
	IPQR Module 3.c.i.5 - PPS Defined Milestones	Completed
	IPQR Module 3.c.i.6 - 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 - Project Implementation Speed	Completed
	IPQR Module 3.d.ii.3 - Patient Engagement Speed	Completed
	IPQR Module 3.d.ii.4 - Prescribed Milestones	Completed
	IPQR Module 3.d.ii.5 - PPS Defined Milestones	Completed
	IPQR Module 3.d.ii.6 - IA Monitoring	
4.a.iii	IPQR Module 4.a.iii.1 - PPS Defined Milestones	Completed
	IPQR Module 4.a.iii.2 - IA Monitoring	
4.c.ii	IPQR Module 4.c.ii.1 - PPS Defined Milestones	Completed
	IPQR Module 4.c.ii.2 - IA Monitoring	